The Journal of Mental Health Policy and Economics
J Ment Health Policy Econ **8**, 1-2 (2005)

Editorial

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The articles in this issue consider the impact of reimbursement models on outpatient mental health services utilization (Chou *et al.*), the role of key patient characteristics in informing a prospective payment system for psychiatric inpatient facilities in the U.S. Medicare program for the elderly and disabled (Cromwell *et al.*), the influence of mental health status of children with special health care needs and of their caregivers on their access to psychiatric and general medical care (Gaskin *et al.*), and the consequences of the implementation of new social service facilities on the care provided to chronic psychiatric patients in a mental health district in Poland (Zaluska *et al.*).

Chou *et al.* (p. 3) assess outpatient service delivery to Medicaid-eligible consumers in the U.S. state of Colorado and compare the fee-for-service (FFS) model with two capitated models: (i) direct capitation (DC), where the state contracts with a non-profit entity to provide the services and administer the capitated financing, and (ii) managed behavioral health organization (MBHO), a joint venture between a for-profit company that manages the capitated financing and a number of non-profit entitites that deliver the services. The study employs a pre-post design, referring to a period (1994-1995) before capitation, and two periods after its implementation (1995-1996 and 1996-1997). The utilization of services was derived from a sample of 522 patients: 176 from DC, 195 from MBHO and 151 from FFS. The authors report differences in service delivery and integration among the three reimbursement models over time and their effects on the utilization and cost of specific types of outpatient services. They suggest substitution between group therapy and individual psychotherapy.

Cromwell *et al.* (p. 15) examine the Medicare prospective payment system for psychiatric inpatient facilities and the proposed U.S. Congressional mandate to develop a patient-level case-mix adjusted prospective payment system for all Medicare beneficiaries currently treated in exempt psychiatric facilities. Payment levels by case-mix category have been proposed by the government based on claims and facility cost reports. The authors observe that due to claims data limitations, the levels of reimbursement do not account for patient-specific staffing costs within a facility's routine units, nor are certain key patient characteristics considered for higher payment. In order to quantify heretofore unmeasured differences in daily staffing intensity, the authors collect primary data on patient and staff times from 40 psychiatric facilities and 66 psychiatric units, nation-wide. They construct a measure of resource intensity on a daily basis for 4,149 Medicare and 4,667 non-Medicare patient days, and identify 16 potential case mix groups. The authors report that Medicare patient days were 12.5% more staff-intensive than non-Medicare days (this may be due to age and other differences) and that age, psychiatric and medical severity, deficits in activities of daily living, dangerous behaviors, and electroconvulsive therapy contribute substantially to higher staffing intensity. They conclude that costing on the basis of Medicare cost reports unduly compresses estimates of inter-group case-mix cost differences.

Gaskin *et al.* (p. 29) focus on the determinants of unmet care needs in children who have special health care needs (CSHCN), and analyze the association between their access to care, their mental health status and the mental health status of their caregivers. The study is conducted in a random sample of 1,088 caregivers of CSHCN enrolled in the Medicaid program of the U.S. District of Columbia. Caregivers were asked a series of questions to determine if their child had an unmet need in the last six months, and five indicators of unmet need were created on the basis of their replies. Children's and their caregivers' mental health status were assessed by a parent-reported measure (PARS) of the disabled child's psycho-social functioning, and by a scale of caregivers' self-reported depressive symptoms (CES-D, 7 item version). The authors report that children whose caregivers experience symptoms of depression are significantly more likely to encounter difficulties obtaining needed medical and mental health care services. Children with poor psychological adjustment are significantly more likely to experience unmeet needs for medical and mental health care. The authors, while considering with caution the limitations related to the sample characteristics and the possibility that child and caregiver mental health is potentially endogenous, underline that policymakers should be concerned about the mental health status of children with special health care needs and their caregivers. Such problems appear to be barriers against obtaining needed care, and the provision of mental health care for CSHCN children and their caregivers has the potential for improving overall access to care for CSHCN children.

Zaluska *et al.* (p. 37) explore the impact on care of new social services for the cronically mentally ill: vocational rehabilitation (VRC), community center of mutual help (CCOMH) and specialized social help services at client homes (SSHS), implemented in 1998 in a Polish mental health district and financed by the social welfare system with a separate budget from the mental health services budget. This reform aimed at providing social services in the

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community to the chronically mentally ill. The authors focus on a group of 73 chronic patients who were prospectively admitted for the first time to these new social services in 1998, comparing their mental health services use and costs during the two years before 1998 (Period A) with their use and costs of mental health services and of the new social services during the two years after 1998 (Period B). The authors report in this group a sharp decrease of full and partial hospitalization in Period B and an increase in the use of outpatient mental health facilities. They also observe increasing use of the new social services. The costs of care in Period A were mainly driven by full time hospitalization delivered by the mental health system. In Period B there was a general decrease in the total costs of the mental health system, while significant costs emerged in the new social services system. The authors conclude that the amount and diversity of community based mental health and social services available for the severely mentally ill after 1998 require a new coordination and a re-definition of the role of mental health and social support services.

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