
Mental Health Issues

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The following overview discusses and compares the findings and implications of the articles in this issue of the Health Care Financing Review that deal with mental health topics—particularly children’s mental health—in the Medicaid context. It also briefly describes articles concerning prospective payments for psychiatric patients under Medicare.

INTRODUCTION

This issue focuses largely on mental health issues. Five of the articles deal directly or indirectly with children’s mental health matters in the context of Medicaid. This overview compares and discusses the findings of these articles in some detail before briefly outlining the remaining articles on more specialized topics.

The President’s New Freedom Commission on Mental Health issued its final report in July 2003, setting forth a number of key goals and findings. Among those particularly relevant to matters discussed in this issue is Goal 1, which emphasized, “Mental health is essential to overall health...,” and Goal 3, that disparities in mental health services [specifically, the underserving of minority populations] should be eliminated. In 2004, SAMSHA expects to issue its action agenda for implementing the Commission’s recommendations. A key part of that agenda will be the conduct of research to understand disparities in mental health treatment and provide a basis for their elimination. The first three

articles in this issue contain findings that underscore the continued existence of the disparities noted by the Commission, and, to some extent, particularize those disparities—information that can be helpful in addressing this critical problem.

Children’s Mental Health Services under Medicaid

The article by Larson, Miller, Sharma, and Manderscheid examines data on service use and payments for children in racial/ethnic subgroups in Medicaid Programs of four States, and compares the service use of children treated for mental health/substance abuse conditions with those without such conditions. The authors note previous findings that mental health problems among children and adolescents affect about 10 to 20 percent of children age 9-13, and that treatment rates appear to be increasing. Most importantly, they note that previous evidence suggests that the overall rate of diagnosable mental health/substance abuse disorders is comparable across racial and ethnic groups. In this article, the authors present updated analyses of Medicaid data that predate many State health care reform initiatives in order to provide baseline data for the analysis of reforms. The Larson et al. study resulted in a number of complex findings concerning demographic differences in treatment rates and types of conditions treated for various groups. Particularly striking are the findings that: nearly all diagnoses are more common among Medicaid recipients who are white; mental health/substance abuse diagnoses among white claimants

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are over two times the rate of diagnoses of children in other racial or ethnic groups combined; and major depression, bipolar disorders, and other psychoses are nearly three times more common among white child/adolescent claimants than youth in other race/ethnicity groups. Not surprisingly, similar findings of concern related to disparities in the actual use of mental health/substance abuse services, such as physician services and inpatient hospital care. Their article closes with some helpful suggestions as to approaches to address disparities in diagnosis and treatment of mental health/substance abuse disorders, noting that, ultimately, public insurance programs such as Medicaid "...must use multiple points of leverage to increase access, address stigma and misperceptions of care, and influence the quality of care delivered."

The article by Saunders and Heflinger examines the effects of introducing Medicaid managed care into a previously fee-for-service (FFS) environment on children and adolescents' access to behavioral health care services, and on the mix of such services that will be available. It does this by comparing access and service mix in Mississippi (FFS) and Tennessee (managed care). It also examines access and service mix in these States based on race, sex, age, and Medicaid enrollment category. The study found, among other things, that although each State experienced positive annual growth in behavioral health service access (with the exception of Tennessee's overnight services), female and minority youth were less likely to access behavioral health services, both overall and by type of service. The authors comment that their logistic regressions "...offer evidence that managed care not only reduces access to behavioral services overall and both access to and mix of inpa-

tient services..., but it also may lead to reductions in specialty outpatient services as well." In the Medicaid categories, the authors report "...a consistent pattern of lower access to behavioral health services among poverty-related youth and greater access of foster care youth relative to youth on supplemental security income."

On the other hand, the authors state: "Nevertheless, the news [coming from this study] is not all bad for managed care..." explaining that Tennessee experienced significant positive increases in case management services. This suggests that the problem of reduced access to mental health service providers is offset by increased use of the services of case managers.

The article by Cook et al. examines the association between caregivers' (parents and families) satisfaction with services and the likelihood that children with severe emotional disturbance will receive mental health services. Unlike much of the previous research in this area, Cook et al. focuses on caregivers' satisfaction with services provided under managed care (as opposed to FFS) arrangements that are increasingly used to control costs in programs for low-income children and their families. The study confirmed a robust association between caregivers' prior level of satisfaction with features of Medicaid-funded behavioral health care plans and children's later mental health service utilization. Moreover, it identified particular areas in which caregivers were least satisfied, and thus, areas for possible improvement in service delivery by focusing on improving caregiver satisfaction. The area most in need of improvement was the adequacy of plans' information about the availability of services and providers. Also sources of dissatisfaction were the number of forms to be filled out, the willingness of plans to pay for inpatient hospital or residential care,

the inability to find providers willing to accept the plans, and the truthfulness of information provided about plan benefits and services.

Consistent with the findings of Saunders and Heflinger, Cook et al. found that children in managed care plans were significantly less likely to use a number of services. They also note a trend toward lesser likelihood of psychiatric inpatient care (as well as other services) among those enrolled in managed care, and counsels: "Efforts to control the rising costs of health care must not occur at the expense of this vulnerable group of America's children." In closing, they suggest a number of policy protections to avoid this result, including increasing the involvement of caregivers in the design and implementation of managed care arrangements.

The three articles in this issue devoted directly to children's mental health in the Medicaid context, when viewed together, suggest that the "baseline" from which we must work to eliminate disparities in access and quality of mental health/substance abuse services to minority or other underserved populations presents a great challenge. In addition, these articles suggest that the increasing use of managed care, with its inherent pressure toward controlling health care costs, tends to exacerbate that challenge. The article by Baugh, Pine, Blackwell, and Cibrowski concerning Medicaid spending for central nervous system and antipsychotic drugs further illustrates the challenge of meeting the goals of the President's New Freedom Commission on Mental Health. It shows that, in 1998, central nervous system drugs were the most expensive therapeutic category of drugs for State Medicaid Programs. Given, as the Commission found, that "...mental health is essential to overall health..." it is critical that these important drugs be provided to consumers

as needed. At the same time, mounting cost-control pressures in connection with meeting this need can be expected to increase the trend toward managed care arrangements, which to date have a relatively poor track record in terms of removal of disparities in access to quality mental health/substance abuse treatments by minorities and other underserved populations.

The article by Holmes and Deb examines whether, in one State (Indiana), community mental health centers differ in their ability to serve at-risk populations. It succeeded in identifying certain exemplary centers whose practices may be worth emulating, as well as centers operating on a sub-par level. The empirical model used in this study in Indiana may be useful for evaluating community mental health centers' performance in other States as a basis for improving Medicaid service delivery nationwide.

Prospective Payment for Medicare Psychiatric Services

Two articles in this issue relate to prospective payment for psychiatric services under Medicare. The article by Cotterill and Thomas reports the findings of an empirical analysis of per case and per diem models of prospective payment for Medicare inpatient psychiatric care. Their study supports the viability of the per diem model and identifies directions for future research.

The article by Cromwell, Maier, Gage, Drozd, Osber, Richter, Greenwald, and Goldman addresses limitations in previous studies of the costs of Medicare psychiatric inpatients caused by the use of claims and provider cost reports that failed to identify differences in patient characteristics and routine costs. This article is based on new primary data from 66 units in 40 facilities

nationwide to measure the times spent by staff in caring for Medicare patients. The study identifies key patient characteristics associated with high staffing days, including severe psychiatric diagnosis, deficits in activities of daily living, and assaultive or agitated behaviors.

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