

A PROPOSAL FOR FUTURE FUNDING OF CHRONIC AND EPISODIC MENTAL ILLNESS

John A. Talbott, M.D., and Steven S. Sharfstein, M.D.

The estimated 1.7 to 2.4 million Americans who suffer from chronic mental illness are poorly served by the current nonsystem of services. No agency at any level is responsible for coordination of funding, treatment, and care. Since the mid-1950s funding has become increasingly fragmented as state mental hospitals have been depopulated, community services have been developed, and federal entitlement programs such as Medicaid, Medicare, and Social Security Disability Insurance have been introduced. To overcome the problems of fragmented funding and uncoordinated services, the authors propose establishment of a new federal entitlement program for the chronic mentally ill that would pool all existing funds regardless of the source. States would be empowered to develop a single administrative agency with responsibility for coordinating a comprehensive program of services.

Americans suffering from chronic illnesses face an uncertain future, especially when they require expensive medical care and related support services over an extended period. For those with chronic and episodic mental illnesses, the future is even more uncertain. They can expect only piecemeal treatment and care—unplanned and uncoordinated—that varies enormously in cost among the different regions of the country. As has been pointed out so often that it has become a cliché, there is no “system” of treatment and care for the chronic mentally ill, and no simple method for funding services.

In this presentation we will review the historical background that has led us to this perilous situation and the problems it has created. We will explore several options for future funding to solve the problems and

present a proposal to fund treatment and support for episodic and chronic mental illness. First, however, we will review some of the features of the population we are concerned with and some facts about the costs of funding their care.

The population and the costs of care

The patient population we are concerned with includes all those who are suffering from severe and chronic mental illness and also have significant mental disability. Bachrach (1) has characterized this population as those “who are, have been, or might have been, but for the deinstitutionalization movement, on the rolls of long-term mental institutions, especially state hospitals.”

Goldman and associates (2) have estimated this population at approximately 2.4 million, with 1.7 million suffering not only from severe mental illness but also from severe prolonged disability.

While the recently published Epidemiologic Catchment Area (ECA) study revealed a lower lifetime prevalence of chronic and episodic disorders, such as schizophrenia and major depression, than that of phobias or substance abuse disorders (3), the economic and social burden of these

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While the recently published Epidemiologic Catchment Area (ECA) study revealed a lower lifetime prevalence of chronic and episodic disorders, such as schizophrenia and major depression, than that of phobias or substance abuse disorders (3), the economic and social burden of these chronic mental illnesses on patients, families, and the rest of society is

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chronic mental illnesses on patients, families, and the rest of society is staggering.

In the United States in 1983 the cost to society of all mental illnesses, exclusive of alcoholism and drug abuse, was estimated to be almost \$73 billion, about half of which could be attributed to direct costs (treatment and support) and half to indirect costs (loss of productivity or employment) (4). It has been estimated that approximately 43 percent of the direct annual costs of mental illness are related to treatment and care of the chronic mentally ill (Goldman HH, Frank RG, unpublished paper, 1985). A significant portion of the direct costs, amounting to more than 50 percent, is paid to nursing homes and state and county hospitals.

The cost of treatment and care of the chronic mentally ill is complicated by the fact that many of the services critical to continuing community tenure are not considered medical or do not constitute treatment. Thus they are not usually included in estimates of the cost of treating nonpsychiatric chronic illnesses. Examples are many of the costs of basic care such as housing, clothing, and food; many of the costs involved in social and vocational rehabilitation; and many social welfare costs, such as social services; legal services, and income maintenance.

In addition, monies for the support and treatment of the chronic mentally ill are provided through a multiplicity of sources. Some funds come directly from federal, state, and local governments, while others filter through federal entitlement programs such as Medicaid, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI). Still others come from state and local social, vocational, housing, and other agencies.

Traditionally, regardless of the source of payment—Medicare, Medicaid, or private insurance carriers—health care has been paid for after it was delivered through retrospective reimbursement. But now it is clearly the intent of Congress, as well as the business community, to move toward prospective pricing that will enable both more accurate predictions of costs and better control of them.

History of services and their funding

In the early years of our nation's history, care for the mentally ill was a local responsibility, provided, albeit primitively, in county poorhouses, almshouses, and workhouses. However, in the 19th century, largely as a result of the singular efforts of Dorothea Dix and a coalition of citizen advocates and physicians, this responsibility was shifted to the state governments. For the most part, until relatively recently, care and treatment of the chronic mentally ill was carried out in state mental hospitals funded almost entirely from state tax levies in an aggregate manner; that is, the hospital received a lump sum and designated line items for the provision of psychiatric, medical, social, vocational, and other services.

The approach to funding of mental hospitals began to change in 1955 with the onset of passive depopulation of these facilities—passive because it was the result of economic and legal forces rather than an active, articulated public policy. This depopulation was followed in the 1960s

by massive new federal entitlement programs—Medicare, Medicaid, SSI, and SSDI—and the introduction of categorical funding in the federal community mental health centers program.

As a result of these changes, funding of services for chronically ill persons, who by then resided in “the community,” took on new characteristics:

- ◆ It became disaggregated rather than aggregated; that is, separate entitlement and categorical monies supported separate services.

- ◆ It was based on unit cost rather than institutional bed cost; that is, there was per diem reimbursement for inpatient care and fee-for-service reimbursement for outpatient care.

- ◆ Services were federally initiated and supported, rather than initiated and supported by the states, with residual state monies very gradually shifting from institutional to community care.

- ◆ Services were supported by retrospective fee-for-service third-party payments, both governmental and private, rather than by state line-item allocations. This development has led to the growth of private, not-for-profit psychiatric units in general hospitals, a larger number of private psychiatric hospitals, and an increase in the number of mentally ill persons residing in private nursing homes.

In 1978 the American Psychiatric Association issued its first report on the chronic mentally ill (5), entitled *The Chronic Mental Patient: Problems, Solutions, and Recommendations for a Public Policy*, which advocated simplification of the current funding and administrative systems so that federal funds would be targeted for the chronically ill but services would be provided by a local governmental entity. It was followed by a report from the Department of Health and Human Services entitled *Toward a National Plan for the Chronically Mentally Ill* (6), which spelled out the steps necessary to implement these policy guidelines.

When the resultant federal legislation, the short-lived Mental Health Systems Act of 1980, was folded into the newly designed state block grants by the Reagan Administration, the only remnant of all these recommendations was the tenuous continuance of the community support program, a federal program for the chronic mentally ill that attempts to ensure comprehensive care through case management at the local level. As a result of the establishment of block grants, most of the decision making about resource allocation for community care has moved back to the state level. State dollars remain the largest direct source of funds for the care and support of the chronic mentally ill. Yet in many states, such as New York, 80 to 90 percent of mental health funding continues to be directed to state mental hospitals rather than to community-based care.

Current problems

Assuming that 60 percent of the nearly 120,000 patients now in state mental hospitals are chronically mentally ill, at this point in the depopulation process only 72,000 of the estimated 1.7 to 2.4 million Americans with chronic men-

tal illness reside in state facilities (unpublished estimate, National Institute of Mental Health, 1986).

Approximately 1.1 million of the chronic mentally ill live at home, most often with their families. Somewhat less than three quarters of a million are in nursing homes, which are ill equipped to provide psychiatric services and are neither mandated nor funded to do so. The remaining 800,000 to 1.4 million are in a variety of other settings, including board-and-care homes, unsupervised community residences, and jails and prisons, or are on the streets. In all of these settings there are virtually no services available (2,7).

Currently no governmental agency or authority is capable of prospective budgeting that incorporates all sources of clinical and financial support for this community-based population. In addition, no agency at any level, public or private, has undertaken responsibility for coordinating funding, treatment, and care for the chronically ill. There is also no private or public funding mechanism for long-term care or asylum for that small proportion of the chronically ill population, estimated at between 2 and 3 percent, who need such care (8).

Finally, the fragmentation of funding streams further complicates comprehensive service delivery and deters preventive intervention and systems change. There is virtually no support for families who are the primary caretakers for the chronic mentally ill. Thus funding ironically often rewards the most undesirable treatment or service—for example, nursing home care rather than home care or residence in a supervised group home; public rather than private, acute rather than chronic, cure promising rather than care providing, inpatient rather than prevention of admission, direct rather than indirect, and hospitalization rather than community care.

Goals of a new funding system

Any proposal to change for the better the funding of treatment and care of the chronic mentally ill in America must be based on several goals.

First, such care, wherever it is delivered, should be *comprehensive* and should cover all the services that were once provided to the chronically ill in public facilities. These services include treatment, shelter, and support.

Second, fiscal, administrative, and programmatic *responsibility* for the implementation of treatment and care of the population should be fixed.

Third, any funding scheme should prove *adequate* for the chronic mentally ill and should not be designed with the cynical notion of enabling rapid ratcheting down of costs once it is in place.

Fourth, funding should provide for *all* who are afflicted and not target only selected patients, age groups, facilities, or levels of government.

Fifth, such funding should *integrate* needs for acute and chronic care with needs for shelter and support, and thus permit the money to truly follow the patients.

Sixth, the funding mechanism should provide incentives for *systems changes* in desirable directions (for example, toward good community and hospital care) rather than un-

desirable directions (toward nursing homes or unsupervised group residences). It should encourage utilization of treatment settings, such as day hospitals, outpatient clinics, and private offices, that are less restrictive than hospital facilities. Families who care for mentally ill relatives should receive more support and should not have to face economic disaster.

Seventh, the funding approach should give patients some *choice* in the type of care provided and who will provide it. It should also give providers some incentives to be *cost-effective* and to deliver *high-quality care*.

Options for funding

As noted before, funding for the chronic mentally ill has been provided predominately by either private or local, state, or federal governmental entities, depending on the country's stage in history. We will therefore consider all these governmental levels as possible options for future funding.

Private programs. Private prepaid insurance programs specifically designed for the chronic mentally ill could be devised. To date health maintenance organizations (HMOs) have not delivered adequate treatment and care for the severely or chronically mentally ill (9,10); however, they certainly could do so if thus mandated and if a specific prepaid contract could be negotiated between the state and the HMO for a total chronic care package at a capitated price.

In addition, preferred provider organizations (PPOs) also offer an opportunity for states and private providers to enter into contracts to deliver comprehensive services in a cost-effective manner. Such programs, if forced to utilize prospective pricing, could provide a full range of psychiatric treatments and settings within these economic constraints (11).

State and local programs. State and local programs constitute another potential level of involvement. Both California and Wisconsin have already experimented with capitation funding of local governmental entities by providing a specific amount of funding for each citizen at risk and allowing local authorities to decide where those monies should be spent (12). Alternatively, states could establish unified services systems that would serve as umbrella organizations empowered to provide comprehensive services (13).

Federal programs. Federal support for a comprehensive treatment and care program for the chronic mentally ill could involve any number of possible alternatives. The first and most traditional proposal would be a national health insurance program with specific provisions for comprehensive care and treatment of the chronically ill.

Another alternative would be for the federal government to embark on an entirely new entitlement program for the chronically ill that would incorporate all the services mentioned above into a new Social Security title utilizing all the monies currently directed in an uncoordinated manner toward these individuals. Either program—a national health insurance program or an entitlement program—could be implemented through a voucher system that provides an

indirect payment for specified services. The voucher system could segregate care provision into three categories: medical-psychiatric services, social services, and support services such as shelter, food, and clothing.

A proposal

It is our opinion that the size of the chronic mentally ill population is so large (between 1.7 and 2.4 million), the amount of money spent annually on this group so staggering, and the resultant care so abysmal or altogether lacking that a new federal entitlement program must be established. The program would take all existing funds regardless of the source or the service provided—medical, psychiatric, social, vocational, or other support service—and pool them into a single Social Security title for the chronic mentally ill.

Such a program would encourage and promote all the cost-efficiencies that occur with flexibility in funding; it could involve both governmental and private for-profit entities; and it should move the delivery of psychiatric care for the chronic mentally ill toward day care and home care. It would also be supportive of families who care for the mentally ill.

To start, the federal program would take all existing monies from the various federal sources we have specified and lump them into one new program. Then those federal dollars would be channeled via indexed capitation grants through a state-administered authority to local community programs. At the outset the amount of each state's grant would be established to reflect the state's current federal share of long-term-care expenditures.

The total state grant would be automatically indexed, with the amount determined by the per capita premium and the number of potentially eligible individuals in each state. The precise amount of the federal capitation grant to a state would be based on the number of individuals at risk in the state. It would include those who are currently residing in state and county mental hospitals; those with a primary diagnosis of mental disorder who are residing in nursing home facilities; those with a diagnosis of mental illness who are receiving disability income as their prime source of support and who are on the rolls of a community mental health program; recipients of SSI or SSDI; and those who were previously hospitalized and are now living at home with their families.

The federal funding authority would remove the regulatory requirements of the current Social Security entitlements and provide incentives for states to develop a managed system of medical and mental health care, social services, residential alternatives, and personal care. Federal guidelines would specify the essential elements of such a program for the long-term patient, and the states would then be empowered to develop a single administrative agency with responsibility for coordinating all the programs that are needed by the chronic mentally ill population, including both institutional and noninstitutional care.

States would not have to spend the full capitation amount for each eligible individual. However, they would

provide a coordinated system of medical and nonmedical care through a variety of mechanisms, including vouchers to the individuals or families and contracts or grants to local agencies. Actual services would be delivered by local agencies that would be required to work with families, provide case management, and perform gatekeeping functions for long-term institutional care.

Rationale for our proposal

Past federal Social Security financing, primarily through Medicare and Medicaid, has been biased toward acute inpatient care (funded by Medicare) and long-term nursing home care (funded by Medicaid). The new federal authority that we propose would constitute a unique effort to develop incentives to use long-term rehabilitative, community-based services. Community care would become a more economically feasible alternative because it would be provided within a total case-managed system on an equal footing with inpatient and long-term institutional care and would be financed through a prospectively determined capitation grant. Further, governmental accountability and responsibility for the delivery of care, as well as local agency control, would be established. It is expected that states would supplement the federal capitation grant as necessary, and that private dollars could also be pooled with these public programs to augment services provided to the chronically ill.

It is important to underscore the fact that our proposal recognizes that such long-term responsibility is best carried out by the state governments and local service delivery agencies. At the same time, we realize that federal dollars are critical in the delivery of care to this population. The inclusion of federal dollars, which would be derived from a larger population, would reflect the national scope of chronic mental illness. Today funding for the chronic mentally ill is piecemeal and fragmented, and only by channeling federal funds and lumping them together under one tide, as a capitation grant, would it be possible to finance the coordinated long-term service system that these individuals need.

Prospective financing, capitation grants, local agency responsibility, and local services control are crucial to this program's success. With the dollars provided up front, local agency gatekeeping to carefully control the use of long-term institutional care becomes critical if local programs are to maintain their capacity to function and remain solvent.

The local agency would also be responsible for the provision of a variety of other services through vouchers, purchase-of-service contracts, capitation arrangements, and subsidies to families. The states would be expected to develop quality assurance and accountability procedures.

Removing the regulatory requirements of the current Social Security entitlements and providing general capitation payment through states to local agencies would permit more funds to be used to purchase shelter and supportive housing. Alternative living arrangements, day treatment, and home care are most critical if the chronic mentally ill are to survive outside institutions. This approach would

provide fiscal incentives to develop the continuum of care, shelter, and support necessary to maintain the chronic mentally ill in the community.

The proposed capitation payments would have to continue whether a person resides in or outside of an institution or at home. Currently SSI payments are suspended if a patient is institutionalized. This practice has made the transition from institutional to community care extremely difficult. Another SSI rule reduces benefits by one-third for individuals living in the household of another. Our capitation grant proposal does not discourage the return of mentally ill individuals to their families, which is often advantageous to their recovery and rehabilitation.

The Monroe-Livingston demonstration project for the chronically mentally ill in New York State is one example of how our proposed funding mechanism might work (Marshall P, unpublished paper, Rochester, NY, 1985). Here state, local, and United Way monies are combined into a single pool, and services are designed, developed, and utilized to meet criteria of outpatient need, cost-effectiveness, and appropriateness rather than of community availability or necessity.

Interim steps

Presuming that the legislation for a new entitlement program might take some time, we strongly believe that further experiments should be encouraged, such as replication of Wisconsin's capitation mechanism, study of a voucher system, and establishment of comprehensive psychiatric HMOs. It must be borne in mind that what works well in Madison, Wisconsin, may not be easily transplanted to the South Bronx or Alaska, and that any scheme that imposes a template of requirements rather than fostering the provision of services will surely fail.

In addition, experts who have examined our proposal warn of several potential dangers. First, what is most difficult to cost out are the consequences of disability rather than of diagnosis. They advise, therefore, that any new entitlement program must take into consideration patients' various levels of functioning. Second, there is a risk of loss or reduction of funds in cutting the strings between hospital beds and funding sources. And third, if all monies for the chronic mentally ill are pooled, demands to fulfill their basic needs for food, shelter, and other support services may be so overwhelming that they could crowd out the provision of needed treatment and rehabilitation.

We would welcome additional scrutiny, criticism, and discussion of our proposal; however, we believe the situation is urgent. Failure to act now carries with it considerable social as well as human risks. Thousands of chronically mentally ill persons—the “new” chronic population—are appearing daily in our streets and are increasingly confined in nursing homes and prisons. They are poorly served by our fragmented and inefficient funding of treatment and support. We must begin to test out a variety of new solutions and be prepared to put one of them into action before it is too late for legions of our most disabled and disorganized fellow Americans.

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