MEDICAID MANAGED BEHAVIORAL HEALTH IN RURAL AREAS

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EXECUTIVE SUMMARY

OVERVIEW

Thirty-five states have implemented Medicaid managed behavioral health (MMBH) programs in rural areas. It is not clear how MMBH programs may work in rural areas since they are primarily designed to control mental health utilization. In rural areas the challenge is often to enhance service delivery, not to reduce it. Policymakers have wondered how MMBH programs would work. Could MMBH programs control costs while maintaining access? How well could they serve the needs of different Medicaid populations, including the general, income-eligible population (Temporary Assistance for Needy Families) and special, disability- eligible population (adults with serious and persistent mental illness; children with serious emotional disturbances)? Could the broader range of services required by persons with chronic mental illness be provided? Would enough mental health specialists be available? Would adequate coordination with other service systems be established?

A growing research literature has begun to answer these questions for MMBH programs in general. However, there are few accounts describing the implementation and experience of MMBH programs in rural areas. This paper addresses this gap, based on a national inventory of states implementing MMBH in rural areas.

PURPOSE AND METHODS

The goals of this project were to (1) determine which states have implemented MMBH programs in rural areas; (2) describe these programs in terms of Medicaid populations served, program design, and implementation model; and (3) describe the experience of programs regarding access to and coordination of services. This paper is based on a survey of states implementing MMBH programs in rural counties conducted by the Maine Rural Health Research Center during 1999 and 2000.

FINDINGS

Profile of MMBH Programs in Rural Areas

As of January 1, 2000, thirty-five states had implemented MMBH programs in rural counties. In thirteen states, implementation is limited to rural counties containing a very small proportion of the state's overall population or close to and dominated by metro counties. This study focuses on the twenty-two states with more significant implementation in rural areas.

- All (22) states include the general Medicaid population. Seventeen states include special populations.
- Slightly less than half the states integrate (carve-in) behavioral health with physical health services in serving the general Medicaid population under managed care. Only one state (New Mexico) carves-in behavioral with physical health services for the special Medicaid population.
- Two-thirds of the states have implemented MMBH program on a regional basis for both general and special Medicaid populations.

- Nearly all states serve both the general and special Medicaid populations on some form of risk basis. Risk sharing does not usually extend to rural providers.

MMBH and Rural Service Delivery: Experience So far

Medicaid Managed Behavioral Health (MMBH) programs pose both opportunities and risks for rural service delivery systems. Opportunities reside in the potential to recognize the mental health needs of different groups, or populations, of Medicaid beneficiaries, including persons with moderate and persons with chronic and severe mental illness. States have more flexibility (than under fee-for-service based reimbursement) in how they spend their money to meet these needs. However, managed care's emphasis on controlling costs, combined with limited rural mental health infrastructure, raise concern that MMBH may hinder access to and coordination of rural mental health services. MMBH may have this effect by restricting already scarce rural mental health services and by weakening the link between primary care and mental health providers.

Access

Access to mental health care has generally not been restricted under MMBH. In many states, inpatient mental health utilization has decreased and outpatient utilization increased. Some of the increased outpatient utilization is likely to be a shift from inpatient to outpatient settings. We don't know, however, how well the needs of persons formerly treated in inpatient settings are being met in outpatient settings. Nor do we know what impact this shift in service patterns has had on access to services for the different Medicaid populations. For example, it is possible that the shift of care for persons with severe mental health problems to outpatient settings may reduce access to outpatient services for beneficiaries with less severe mental health problems.

Utilization of children's outpatient mental health services has increased in a number of states. It is difficult to know how much this represents increased access. At the same time that MMBH has been developed in many rural areas, there has been a national trend to reduce children's mental health inpatient beds as well as an influx of funding for children's mental health services through other sources.

Primary care – mental health linkage

MMBH has had little impact on the linkage between primary care and mental health. Many MMBH programs anticipate that primary care providers (PCPs) will provide some level of behavioral health services (as they had under traditional fee for service programs) to the Medicaid population. However, relatively little attention has been directed to how to improve the ability of PCPs to recognize, diagnose, and treat behavioral health problems. MMBH programs have tended to pursue integration at organizational and financial levels. To make progress toward integrating primary care and behavioral health services, the goals of integration need to be defined at the clinical/patient level. Concrete roles and tasks related to the delivery of behavioral health services must be established for primary care and for behavioral health providers.

CONCLUSIONS

Implementation of MMBH in rural areas has leveled off. This reflects the usual pattern of diffusion of a new approach or innovation and the technical and political issues in extending managed care to special-needs populations.

MMBH programs must continually contend with limited rural infrastructure. The problem of limited infrastructure predates and will remain after managed care. Developing MMBH programs in rural areas requires candid assessment of supply and infrastructure problems and modest, but concrete, approaches to these realities.

Local Managed Behavioral Health Organizations are playing an increasingly important role in the evolution of MMBH. The role of national managed behavioral health organizations has been declining. Increasingly, states are turning to local managed behavioral health organizations (LMBHOs) formed by public sector entities and/or providers to deliver MMBH services in rural areas.

Major program design decisions, such as whether to carve-in or carve-out behavioral from general health services or to implement regional or a state wide model, often reflect prevailing political and state program concerns. Policymakers should more carefully assess and monitor how MMBH programs may enhance or diminish the capacity of local service systems to serve rural persons. Policymakers should:

1. Continue to monitor the impact of MMBH on access to mental health care for the general and special Medicaid populations. The shift of care from inpatient to outpatient settings for special populations may crowd out outpatient care for the general population.

2. Identify the distinct clinical needs and access issues of the general and special Medicaid populations.

3. Address these needs by improving the ability of primary care providers to identify behavioral problems within the general Medicaid population and facilitating referral of patients across behavioral and physical health care systems.

4. Define expectations for integration between behavioral health and primary care services and between behavioral and substance abuse services.

5. Assess the impact of MMBH programs (direct and indirect) on traditional mental health safety net providers (e.g., hospitals, community health centers, and community mental health centers). *

6. Assess the impact of contracting with LMBHOs on the consistency of access and service capacity across regions; ability of organizations to manage and absorb risk; and effect of assuming risk on participating members.*

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* Recommendations 5 and 6 require that specific studies be conducted. These studies can be conducted as part of a state's ongoing monitoring of the implementation of a new MMBH program. Federal agencies can also support multi-state assessments and evaluations of these issues.

INTRODUCTION

Over forty states provide at least some behavioral health services to Medicaid beneficiaries under managed care. In most states Medicaid programs started serving beneficiaries under managed care by including physical health services with a limited behavioral health benefit; over half now cover beneficiaries with chronic and serious behavioral problems (Substance Abuse and Mental Health Services Administration, 1998). Just a few years ago, providing Medicaid managed behavioral health services in rural areas was relatively rare. Low population densities, limited supply of mental health providers, and limited infrastructure (e.g., transportation, institutional providers, support services) stood in the way.

These challenges are still there. However, pressure to control behavioral health costs has led thirty-five states to expand Medicaid managed behavioral health (MMBH) to rural areas. It is still not entirely clear how well these programs may work since managed behavioral health care is primarily designed to control mental health utilization. In rural areas the challenge is often to enhance service delivery, not to reduce it.

There is a growing literature on MMBH (Callahan et al. 1995; Christianson et al. 1995; Frank et al. 1996; Norton et al. 1997; Ma and McGuire 1998; Grazier and Eselius 1999; Huskamp 1999) and a smaller literature on general Medicaid managed care in rural areas (Slifkin et al. 1998; Felt-Lisk et al. 1999). The Health Care Financing Administration has required formal longitudinal evaluations of the impact of MMBH in states implementing an 1115 waiver, including those with substantial rural populations (e.g., Colorado and Oregon). However, there are no published accounts describing the penetration of MMBH programs in rural areas and few published accounts of what has happened where these programs have been implemented.

This paper addresses this gap, based on a national inventory of states implementing MMBH in rural areas. The paper first describes the challenges of developing MMBH in rural areas. Next, the paper reports the number of states implementing MMBH programs in rural counties and describes these programs in terms of populations served, implementation model, and program design. The paper then discusses the experience of programs regarding access to and coordination of services. The paper concludes by discussing current issues for states developing and implementing MMBH in rural areas.

BACKGROUND

The number of states developing MMBH programs rose steadily throughout the 1990s. Many of these programs have taken the form of a "carve-out" arrangement, so-called because responsibility (both administrative and financial) for the provision of behavioral (mental health and substance abuse) services is separated from physical health services. A state may choose a carve-out to protect the mental health budget from being spent on physical health care. Alternatively, a state may choose to carve out behavioral from physical health services to protect the usually larger physical health plan from the high utilization and cost associated with behavioral health services. In this way, carve-outs serve to protect the physical health plan from an adverse selection of enrollees (selecting the plan specifically to receive behavioral health services) and also to direct enrollees to a mental health plan presumably better able to manage their utilization (Huskamp 1999).

In contrast, programs in some states have taken the form of a "carve-in", where physical health plans are responsible for providing both physical and behavioral health services. Carve-ins are thought to better integrate the delivery of physical and behavioral health services by assigning responsibility for both services to one entity. This integration is assumed to better enable plans to coordinate the behavioral and physical health needs of patients and provide services in a timely fashion. As we discuss, this ideal is far from being realized. Carve-out and carve-in programs should be considered in terms of the populations they serve. Most summaries and discussions of carve-outs under MMBH do not distinguish between general (beneficiaries eligible through the Temporary Assistance for Needy Families Program) and special (beneficiaries eligible through designated disability status) Medicaid populations. A state may structure services differently to these populations.

MMBH programs have received considerable attention since their rapid adoption throughout the 1990s.[1] While states have multiple objectives in developing MMBH programs, controlling utilization and cost are usually driving forces. Managed care also presents an opportunity to increase access to a broader range of services and providers through flexible benefit design and provider panel creation. Since the Hennepin County (Minneapolis) Medicaid Pre-Paid Demonstration Program in the mid-1980s and first generation MMBH programs in Massachusetts and Utah in the early 1990s, policymakers and advocates alike have wondered how these programs would work. Could they control costs while maintaining access? Could the broader range of services

often required by persons with chronic mental illness be provided? Would a sufficient number of mental health specialists be available and included in provider panels? Would adequate coordination with other service systems be established?

A growing research literature has begun to answer these questions (Grazier and Eselius 1999; GAO 1999; Huskamp 1999). Evaluation studies have found that MMBH has shifted care from inpatient to outpatient settings and in a number of states – Utah (Christianson et al. 1995; Stoner et al. 1997), Oregon (Ross, 1997), Colorado (Bloom et al.1998), and Massachusetts (Callahan et al. 1995) – has maintained or even increased access. Successful implementation of MMBH programs in many states has been described in a report based on a national survey sponsored by the Substance Abuse and Mental Health Services Administration (Substance Abuse and Mental Health Services Administration,1998).

These success stories have been tempered by well-publicized problems in several states. Tennessee's TennCare program was implemented statewide in 1994. Initially, participating managed care organizations (MCOs) resisted providing even basic mental health services. However, the MCOs agreed to carve out mental health dollars and direct them to five private managed behavioral health organizations (MBHOs) through the TennCare Partners Program. These organizations were later consolidated into two MBHOs covering the state. A variety of problems involving pharmacy services, claims processing and funding for community services arose and participating rural community mental health centers complained that their capitation rates were set too low. The Health Care Financing Administration (HCFA) was asked to investigate (Tennessee Justice Center 1997). The Governor announced a series of changes designed to increase payments and reduce pharmacy costs to MBHOs.[2] These changes did not result in immediate relief for rural community providers. By mid-1998, three community mental health centers operating in three rural counties had closed (Oak Ridger Online, June 10, 1998).

In April 1997, Montana began a mental health managed care plan for the state's Medicaid population. An assessment authorized by the Governor and conducted by the Montana Primary Care Association found that there were fewer primary care providers willing to accept reimbursement rates for mental health services under the new program compared to a year before when Medicaid reimbursed providers directly. Not surprisingly, access to mental health services soon became a problem for many persons in the state's 24 counties without a mental health provider (Strange 1997). This and

other problems continued to plague Montana's MMBH program, leading Montana to revert to fee-for-service based reimbursement in July 1999 (State Health Watch, 1999).

North Carolina also reverted to a fee-for-service delivery system in July 1999 following administrative problems and difficulty containing program costs resulting from the expansion of Medicaid covered services when the program began. Carolina Alternatives was implemented in January 1994 through ten area mental health agencies. At its peak, it covered as many as 131,000 children and adolescents in seventeen rural and fifteen urban counties. North Carolina's request to expand the program to all of its forty area mental health agencies was repeatedly denied by HCFA before the state withdrew its pending waiver renewal in 1999. HCFA's refusal to expand their waiver was based primarily on the program's inability to demonstrate costs savings.

The political, bureaucratic, and administrative contexts in which MMBH programs are developed often preclude specific attention being devoted to the needs and concerns of rural areas. Development and planning for MMBH tends to be system- or state-wide and does not focus on rural areas, even in states that are largely rural. Several factors contribute to this. Developing MMBH involves coordinating funding and services across state-level agencies, such as Medicaid and mental health. The politics behind the development of MMBH are usually statewide or urban, not rural. The squeaky wheel is often a statewide association, or organized providers, most likely to be found in urban areas, even in largely rural states (e.g., Nebraska). National managed behavioral health organizations (MBHOs) have played a major, although changing, role in developing new MMBH programs. Because many states lack, or believe they lack, the knowledge, infrastructure, and experience to develop MMBH, they have often deferred to the national MBHOs. The MBHOs tend to focus on specialty mental health providers and services often not found in rural areas.

Some states have recently turned to local managed behavioral health organizations (LMBHOs) as an alternative to national MBHOs. LMBHOs are formed by public sector entities (e.g., county governments, local mental health authorities) and/or providers (e.g., community mental health centers, provider organizations) to deliver MMBH services in rural areas. MBHOs are often still involved, although in more limited and subordinate roles. Incentives for creating LMBHOs include maximizing the use of available money to deliver services (as opposed to going to the MBHO), maintaining local accountability for providing services, and increasing financial security for providers that often serve as their communities' safety net.

Choices in Developing MMBH Programs

States policymakers confront a series of choices in designing and implementing MMBH. While these choices are seldom based entirely, or even largely, on rural considerations, they are likely to influence how care is provided in rural areas, including access, cost, and quality. State policymakers involved may include staff from Medicaid programs, mental health departments, human service departments, inter-departmental taskforces, and other departments or offices, including substance abuse and children's services. The Medicaid program, or its home department, is usually the official applicant to HCFA for the waiver creating or modifying the program. The story behind how these choices are made (where strategic planning, politics, and opportunism converge) is beyond the scope of this paper. We focus on the choices under MMBH of who is served, where, under what models, and under what financial conditions.

Which populations to serve? A state must choose whether and how to serve different populations with varying levels of needs under managed care. States need not decide this question all at once. Minnesota provides both physical and mental health care to the general Medicaid population under its integrated programs and is covering special Medicaid populations under a two -site demonstration project. Other states have explicitly included mental heath coverage for special populations, but in limited geographic areas. Oregon implemented its Mental Health Capitation Program in 1995 under the framework of the Oregon Health Plan, initially limited to 25 percent of the state's Medicaid population. The program was expanded statewide in 1997.

The ***general Medicaid population*** includes women and dependent children eligible in the past through the Aid for Families with Dependent Children (AFDC) Program and currently eligible through the Temporary Assistance for Needy Families (TANF) Program, which has replaced AFDC. Persons eligible for TANF under Medicaid often have modest mental health needs and typically have a mental health benefit comparable to outpatient and inpatient coverage available under private insurance. Low-income persons comprise a higher proportion of rural than urban populations (Sumner 1991; Rural Policy Research Institute 1999). Mental health supply is lower in rural than in urban areas (Lambert and Agger 1995). Including TANF– eligible beneficiaries under MMBH may strain rural more than urban service systems

Special Medicaid populations include adults with serious and persistent mental illness (SPMI) and children and adolescents with serious emotional disturbances (SED). These groups are eligible for Medicaid by virtue of their mental health diagnosis. The

process of determining eligibility varies among states and involves certifying a disability stemming from the mental illness for adults and certifying problems in behavior and functioning for children and adolescents. Some states are beginning to address the mental health needs of older Medicaid beneficiaries by including persons who are eligible for both Medicare and Medicaid ("dually eligible") under MMBH. Serving these special populations (children, adults, and older persons) often requires specialized services that may not be available in many rural areas (e.g., congregate housing, crisis services, home health care).

Carve in or Carve out? A related choice that a state must make is whether to include administration and provision of mental health benefits with general health benefits **(carve-in)** or to separate mental health from general health **(carve-out)**. This choice must be made for both general and special Medicaid populations. Carve-ins are generally assumed to foster coordination between primary care and mental health and may be easier to develop for the general Medicaid population. Carve-outs may provide a firewall between physical and behavioral health plans that may protect the physical health plan from experiencing an adverse selection of enrollees with high mental health utilization and cost. This same firewall may also protect enrollees needing behavioral health care from having funding for behavioral services shifted over to the larger, and usually dominant, physical health plan.

Statewide or Regional Model? A state may choose to implement its MMBH program with one or more vendors responsible for serving clients across the entire state, or to use plans responsible for serving different defined regions. A single statewide model may promote more consistent program administration and is likely to have lower transaction costs (e.g., administrative costs related to the management of the contractual relationships) because the program contracts with only one entity. A potential problem is that the state may have limited short-term options if the single or principal vendor performs poorly or pulls out of the contract. A vendor may also be less able under a statewide than a regional model to respond to different consumer needs and service capacities across geographic areas. In theory, one would expect regional models to be more responsive than a statewide model to these variations.

How Should Substance Abuse Be Included? Substance abuse is a significant problem among the general population and among persons with co-occurring mental health problems. Persons with serious and persistent mental illness are more likely than the general population to have substance abuse problems. (Drake et al. 1991). The

efficacy of concurrently treating mental health and substance abuse problems is well documented (Osher and Drake 1996).

Substance abuse and mental health service systems have developed separately in most states. MMBH may exacerbate this separation, either through different reimbursement policies or by positioning coverage in either the physical health or mental health programs. Increased separation may compromise progress made in treating persons with dual disorders. In many states substance abuse services have a lower level of benefits than mental health services and or are provided and managed under physical health plans. These arrangements have the strong potential to hinder coordination between mental health and substance abuse services.

Should financial risk be shared? Managed care programs involve a degree of risk. Risk is an important incentive for controlling utilization and cost and provides significant profit potential for those entities that assume this responsibility. At the same time, persons with behavioral health problems often have high treatment needs. Little clear actuarial or clinical guidance exists to help program developers understand and quantify “reasonable utilization” relative to these needs. As a result, policymakers are prompted to avoid full capitation. Partial capitation has been the usual arrangement in MMBH programs (Frank, McGuire, and Newhouse 1995; Substance Abuse and Mental Health Services Administration, 1998). This will often take the form of a cap on health plan profits with the expectation that revenues generated above allowable profit levels will be used to expand services.

A related issue is who bears the risk. Risk can be borne solely by, or shared among, managed care organizations, managed behavioral health organizations, and providers. Rural areas pose particular problems with respect to risk because there are fewer clients over whom to spread risk and provider groups are often not large enough nor have the administrative capacity and financial stability to assume and manage risk.

PURPOSE AND METHODS

The goals of this project were to (1) determine which states have implemented MMBH programs in rural areas; (2) describe these programs in terms of Medicaid populations served, program design, and implementation model; and (3) describe experience of programs regarding access to and coordination of services. This paper is based on a survey of states implementing MMBH programs in rural counties conducted during 1999 and 2000. We drafted descriptions of each state’s MMBH program using

secondary sources including the SAMHSA /Lewin survey of Medicaid mental health managed care programs (Substance Abuse and Mental Health Services Administration, 1998) and state-based web-sites. Descriptions included an overview of the program, and geographic areas covered, populations groups covered, services included, service configuration, financial risk, and coordination of services (primary care, mental health, and substance abuse). We mailed the draft narrative and rural-specific follow-up questions to a state contact for review and comment, then conducted follow-up telephone interviews. Additional contacts were made as necessary.[3]

Terms and Definitions

MMBH has grown rapidly, as has the literature describing and evaluating it. Not surprisingly, a number of key terms and definitions central to this literature are used somewhat differently. Definitions of key terms used in this study are presented in Figure 1. These definitions are presented to give the reader a clear idea of how we are using these terms and to better place findings in the context of other studies and literature.

The term behavioral health refers to the potential inclusion of both mental health and substance abuse services in the program's benefit package. Management may vary from administrative functions such as gate keeping and utilization review to more substantial control over clinical services. The element of financial risk is often present and that presence is often used to define managed care. To be classified as an MMBH program in this study, a program must include more than a gate keeping or straight utilization review function.

Rural refers to non-metropolitan areas, as defined by the federal Office of Management and Budget (OMB 1998). This definition considers non-metropolitan areas to be counties that are not in metropolitan areas. Metropolitan areas are counties with urbanized areas of 50,000 or more residents, as well as any adjacent counties having significant social and economic integration with the urban county.[4]

A state with a rural MMBH program is one in which the program has been implemented in one or more rural counties. This definition establishes a minimum threshold for including states in the inventory. We examine the degree of *rural diffusion* of MMBH programs in a state by calculating the ratio of total population in non-metro counties with MMBH programs to the total population in all non-metro counties. This is used as a proxy for rural penetration. Although actual penetration (ratio of users to

enrollees) would be a preferred measure, current data on county-level Medicaid enrollment is not available for many states.

Which Medicaid beneficiaries are included under MMBH is described in terms of the *general Medicaid population* (TANF and income expanded eligibility programs, including CHIP - the Children's Health Insurance Program) and *special Medicaid populations* (SSI, SED, dually eligible).

Risk is the degree to which different entities are responsible for administrative and claims costs under MMBH. There are three important dimensions to risk: (1) type of risk assumed (administrative, claims cost, or both); (2) how much risk is borne for claims, which may range from none to partial to full; and (3) who bears the risk (how it is shared among participating entities).

In a *statewide implementation model*, the structure, vendors, and requirements of the MMBH program are standardized in all areas of the state. A *regional implementation model* allows for different structures, vendors, and arrangements to be put in place in different areas.

PROFILE OF MMBH PROGRAMS IN RURAL AREAS

Scope of Implementation and Populations Served

As of January 1, 2000, thirty-five states had implemented MMBH programs in rural counties. In thirteen of these states, implementation is limited to rural counties that contain a very small proportion of the state's overall population or are adjacent to and dominated by metro counties (Appendix 1). This study focuses on the twenty-two states with more significant implementation in rural areas (Table 1). Four states listed in Table 1 -- Arkansas, Montana, New Mexico, and North Carolina -- provided MMBH in rural areas for several years, but have suspended their programs. We include these states in this study to draw upon their instructive experiences with MMBH in rural areas.

All of the states listed in Table 1 include the general Medicaid population (TANF, CHIP) in some fashion. Seventeen states also include special populations (SSI, SED) under MMBH. Seven states also cover persons dually eligible for Medicare and Medicaid. Over half of the nineteen states with active MMBH programs in Table 1 had implemented MMBH in all of their non-metro counties as of January 1, 2000 (data not shown). A number of states started with a limited or phased-in implementation of MMBH programs in rural counties (e.g., Colorado, New Mexico, Oregon), but later expanded MMBH programs to all rural counties. Among the states with partial diffusion of MMBH

programs to rural counties are Pennsylvania and Minnesota with rural MMBH diffusion rates of sixteen and fifty percent respectively.

Models Used to Serve Medicaid Populations

Nine of the twenty-two states integrate (carve-in) behavioral health with physical health services in serving the general Medicaid population under managed care (Table 1). However, only New Mexico carved in behavioral with physical health services for the special Medicaid population. Carve-in models appear to be more feasible for the general Medicaid population because these beneficiaries do not typically have high demand for mental health services. Often, carve-in programs for the general Medicaid population have a provision that shifts care to a carve-out program if the beneficiary exceeds a utilization threshold or is diagnosed with certain mental illnesses.

Many policymakers still assume that integrating (carving in) behavioral and physical health services is desirable for both general and special populations. Why this is so and what it suggests about integration as a “policy ideal” are discussed later in this paper.

Statewide vs. Regional Implementation

About two-thirds of the twenty-two states have implemented their MMBH program on a regional basis (Table 1) for both general and special Medicaid populations. Five states (Arkansas, Iowa, Montana, Nebraska, and New Mexico) have implemented a statewide program for both Medicaid populations. Hawaii has implemented a statewide model to serve the special Medicaid populations and a regional model for its general Medicaid population. Why a state chooses a statewide or regional approach involves a number of factors. Some factors are strategic and include transaction costs (assumed to be lower in a statewide model), ability to replace a low performing vendor (assumed to be easier in a regional model), and responsiveness to varying consumer needs and service capacities (assumed to higher in a regional model). Other factors are political and include affiliations between state policymakers and MBHO staff, a desire to protect and ensure a role for local mental health providers, and interest of state program policymakers to retain oversight in the contracting process.

There are often complex reasons for a given state choosing a regional or statewide approach. These reasons often do not easily lend themselves to evaluating the relative advantages / disadvantages of statewide vs. regional models. For example,

both Iowa and Montana awarded a statewide contract to a single vendor. These awards soon generated controversy. Iowa rescinded its original contract award to Value Behavioral Health Care (Value Iowa) after the bidder finishing second, MEDCO, filed a lawsuit alleging conflict of interest between state officials and Value Iowa. Iowa then awarded the contract to MEDCO (later acquired by Magellan). Iowa's program experienced some early access problems stemming from inadequate participation of primary care providers resulting from delays in reimbursement. The state moved quickly to solve this problem and proceeded to implement a very successful program. Montana also experienced early access difficulties and was never able to overcome the initial problems experienced with its MBHO contractor, CMG Health. Montana's program was terminated two years after implementation.

States with statewide implementation models tend to contract with national health plans or managed behavioral health organizations. Nebraska contracts with Value Options. Iowa contracts with Magellan to serve both its general and special Medicaid populations on a statewide basis. Hawaii contracts with Hawaii Biodyne, a division of Magellan, to serve its special population on a statewide basis. Hawaii Biodyne also serves the general Medicaid population on a regional basis through a subcontract with Hawaii Medical Services Association (Hawaii's Blue Cross Blue Shield affiliate).

States implementing regional models tend to use more of a mix of local, statewide, and national contractors than states implementing statewide models. States often try to blend the resources and managed care experience of national MBHOs with the knowledge and acceptability of local providers. Colorado and Oregon have encouraged diversity in the composition of mental health managed care plans. Both states implemented MMBH demonstration programs in 1995 and have since expanded these programs statewide.

Oregon originally planned to use two types of managed care organizations to provide mental health services under MMBH – Fully Capitated Health Plans and Mental Health Organizations. As originally envisioned, Fully Capitated Health Plans were to provide physical health and chemical dependency services and sub-contract out management of mental health services for the general population. Eight Mental Health Organizations (considered carve-outs) were to serve the special Medicaid populations under three models: (1) local mental health authorities that provide services only within their county; (2) private mental health organizations; (3) regional county consortiums serving multiple counties. This plan was revised to provide mental health services to

both the general and special populations through the Mental Health Organizations. In addition to physical health services, Fully Capitated Health Plans provide chemical dependency services to both populations.

In Colorado, three types of programs serve rural areas: (1) independent community mental health centers serving individual counties; (2) community mental health center consortiums; and (3) partnerships between community mental health centers and an MBHO (ValueOptions). The CMHC consortiums developed when the state combined the respective service areas of individual CMHCs into one managed care area.

Newer programs in Minnesota, Pennsylvania, Hawaii, and Kentucky also allow for alternative configurations of managed care providers. Minnesota contracts with nine different prepaid health plans (PHPs), which are non-profit HMOs, to provide general and mental health services. Under its contract with the state, a PHP is responsible for serving a defined geographic area that may include all or part of multiple counties. More than one PHP may serve the same area. Legislation promoted by the Minnesota Association of Counties granted county governments the right of first refusal to develop PHPs in any county not currently served by the Prepaid Medical Assistance Plan (PMAP). This legislation, passed in 1995 and 1997, also allows counties to develop competitive PHPs where a PMAP is operational.[5]

Pennsylvania is also using a phased-in regional model to implement its mandatory Medicaid managed care program – HealthChoices – that provides physical and behavioral health services under separate contracts. HealthChoices was first implemented in the Southeast region of the state in February 1997 in five primarily urban counties. In January 1999 HealthChoices expanded to a ten county area in the Southwest region of the state. One of these counties includes Pittsburgh; five are smaller metro counties, and four are non-metro.

Hawaii has implemented a regional model for its general Medicaid population (Hawaii QUEST) by contracting with health plans on each island. To promote competition among plans, the state contracts with at least two plans on each island. An explicit goal of Hawaii in awarding contracts is to prevent any one plan from obtaining a dominant market position. The health plans are free to subcontract with managed behavioral health organizations (MBHOs) to provide behavioral health services at the local level.

Kentucky proposed to build its managed care strategy around eight regional non-competitive provider networks known as “partnerships” for physical health services and “coalitions” for behavioral health services. Kentucky’s plan to phase in its program statewide fell significantly behind schedule and the state has delayed implementing its MMBH program to focus its efforts on developing a new strategy for managing physical health services.

One would expect, everything else being equal, that a regional model might be more responsive to the local needs of rural areas than a statewide model. Since relatively few states have implemented statewide models, it is difficult to assess this hypothesis with the current data. Whether a state adopts a regional or statewide model may be less important than how well it responds once issues or problems emerge.

Inclusion and Coverage of Substance Abuse Services

Many states offer substance abuse treatment services, but generally try to minimize their exposure by limiting coverage (Appendix 2). California, Montana, Utah and Washington provide no substance abuse coverage through their MMBHs. Arkansas, Colorado, and Kentucky limit substance abuse coverage through their MMBHs to persons dually diagnosed with mental health and substance abuse problems. Seven states integrate substance abuse with their physical health plan, eight states include substance abuse within a mental health carve-out, and one state (Missouri) operates a separate substance abuse carve-out. In most states, substance abuse and mental health delivery systems have historically been separate from each other. This remains largely the case under MMBH and has contributed to problems in several states in coordinating mental health and substance abuse services described in the next section.

Assumption of Risk

The vast majority of states implementing MMBH serve both the general and special Medicaid populations on some form of risk basis.[6] However, risk sharing rarely extends below managed behavioral health organizations (MBHOs) and managed care organizations (MCOs) and their risk is usually limited (data not shown). Rural providers are very rarely placed at individual financial risk.

Three factors appear to be at play here. First, the ability to successfully assume risk is a function of managing a large number of patients. Without the offsetting income of a sufficiently large patient population, a small number of high cost patients may compromise the financial viability of providers operating under risk contracts. Consequently, few provider practices, either urban or rural, operate under financial risk.

Most practices do not employ sufficient numbers of clinicians nor possess the necessary administrative and/or financial infrastructure to manage the volume of patients needed to balance risk adequately. This is particularly true in rural areas, where the number of covered lives in may be insufficient to balance risk at the program, let alone at the provider, level. Second, managed care "profits" are generated through the management of excess utilization for the enrolled population for whom the plan assumes the financial risk of providing care. In order to protect their profit potential, many plans minimize the risk that they will share with providers by paying them on a discounted fee for service basis. Third, the challenge for MMBH plans in most rural areas is to build the capacity of the local infrastructure to accommodate the needs of their enrolled beneficiaries. As a result, rural MMBH plans are generally more concerned with having a sufficient number of providers to treat the basic needs of their enrolled population than with controlling the utilization of services.

The very limited amount of risk-sharing among rural providers is seen in both the Presbyterian Medical Services (PMS) plan that participated in New Mexico's Salud! program and in the Accountable Behavioral health Alliance (ABHA) serving five rural counties in Oregon. Both the Oregon and New Mexico MMBH programs are generally described as "fully capitated." However, this risk resides at the managed care organization (PMS, ABHA) level. Presbyterian Medical Services, which was financially responsible for the behavioral health care of over half of the enrollees in the Salud! program, contracted with inpatient facilities, rural clinics, community mental health centers, and specialty provider practices. Only two provider contracts involved true risk sharing. The Accountable Behavioral Health Alliance, which serves five rural Oregon counties, developed provider panels that include county mental health clinics, private practices, acute psychiatric hospitals, crisis/respite facilities, and a child/adolescent residential facility. Services delivered by these providers are monitored closely to see if provider performance meets access and other service utilization standards established under the Oregon Health Plan. Panel providers are reimbursed according to contracted (generally discounted) fee schedules that do not involve the assumption of risk.

MMBH AND RURAL SERVICE DELIVERY: EXPERIENCE SO FAR

Medicaid Managed Behavioral Health (MMBH) programs pose both opportunities and risks for rural mental health service delivery systems. Opportunities reside in the potential to recognize the mental health needs of different groups, or populations, of Medicaid beneficiaries, including persons with moderate and persons with chronic and

severe mental illness. States have more flexibility (than under fee-for-service based reimbursement) in how they spend their money to meet these needs. However, managed care's emphasis on controlling costs, combined with limited rural mental health infrastructure, raise concern that MMBH may hinder access to and coordination of rural mental health services. MMBH may have this effect by restricting already scarce rural mental health services and by weakening the already tenuous link between primary care and mental health systems of care.

Some states have almost a decade's worth of experience with MMBH programs serving rural areas. It is a challenge to summarize this experience because many of the programs and the environments within which they operate are constantly changing. States frequently change or modify the MMBH program, sometimes because of problems encountered with delivering services, sometimes because of local political pressures, and sometimes because of changes with the MBHO or MCO with which they contract (e.g., merger/acquisition, legal or financial problems).

This section summarizes what we have learned from our current and earlier studies about the effects of MMBH programs on service delivery level in rural areas. We focus on three areas: (1) access to behavioral health care; (2) children's mental health services; and the (3) linkage between primary care and mental health.

Access to mental health care has generally not been restricted under MMBH. Most MMBH programs assume that psychiatrists and other mental health providers are available and accessible. Under a carve out, managed care organizations typically direct mental health care away from the primary care setting toward the specialty mental health setting. This may reduce access to mental health services in rural areas, where mental health providers are in low supply. Iowa experienced such access problems early on, but moved quickly to resolve them (Lambert et al. 1998). Montana's initial access problems were never fully resolved and, coupled with other problems, led to termination of its MMBH program in June 1999. In contrast, Nebraska allows primary care physicians to be credentialed under their statewide behavioral health carve-out, thereby allowing them to provide services and be reimbursed directly for the provision of those services through the carve-out plan.

Under managed care, one would expect utilization to be constrained on the inpatient side. This has happened in Colorado (Colorado Capitation Project, 1997; Lambert et al. 1998), Oregon (Ross, 1997; Lambert et al. 1998), and Utah (Christianson et al. 1995; Stoner et al. 1997). At the same time, utilization of outpatient services in

these states increased over time (Ross, 1997; Colorado Capitation Project, 1997; Christianson et al. 1995; Stoner et al. 1997; Liu et al. 1999). It is likely that some of this increased outpatient utilization represents a shift in care from inpatient to outpatient settings.

We don't know, however, how well the needs of persons formerly treated in inpatient settings are being met in outpatient settings. Nor do we know what impact this shift in service patterns has had on access to services for the different Medicaid populations. It is possible, for example, that this shift in service level, given the limited capacity of many rural mental health systems, may reduce access to outpatient services for beneficiaries with less severe mental health problems. The system must be alert to the potential for these unintended consequences by monitoring access in rural areas as MMBH matures. Once inpatient utilization has been reduced, MCOs and MBHOs may constrain outpatient care more than they have to date.

Utilization of children's outpatient mental health services has increased in a number of states. It is difficult to know whether this represents increased access. Two national trends have coincided with the development of MMBH in many rural areas. The first has been a reduction in the number of children's mental health inpatient beds. The second has been an influx of funding for children's mental health services through the Family Preservation Act. These trends may help to account for the increased scope and availability of children's mental health services in a number of states, including Colorado, New Mexico, and Oregon.

As states continue to increase coverage of children with serious emotional disturbances (SED) under managed care, the burden and difficulty of serving these children adequately will also increase given that these children have both medical (treatment of their mental illness) and social welfare (e.g., housing, education, social support systems, and rehabilitation) needs. The experiences of New Mexico, Hawaii, and North Carolina are instructive. In New Mexico, many children who used to be in institutional settings are now in the community. In many rural areas, there is not an adequate array of services in place to treat them. Managed care organizations participating in New Mexico's Salud! Program faced the challenge of arranging for the support services necessary to serve these children while reimbursement under the program increasingly reflects a medical -- rather than a social welfare -- model.

The delivery system for services to children with SED has gone through multiple changes in Hawaii. Hawaii initially carved out services for these children to its behavioral

health carrier, who, in turn, subcontracted with a children's service provider to manage the delivery of services. In 1994, Hawaii reached an out-of-court settlement (the Felix Consent Decree) that required developing a new system of care for disabled children and adolescents needing educational and mental health services by June 30, 2000. This Decree coincided with the implementation of Hawaii's MMBH program. As a result, children's services were exempted from the carve-out program. In late 1996, Hawaii launched a demonstration project on the island of Hawaii to explore alternative ways of delivering children's mental health services. Based on this demonstration, a new program was created in July 1999 that carved out children's services to state government, but not to a managed care plan.

North Carolina's MMBH carve-out program for children and adolescents (Carolina Alternatives) successfully expanded access to an array of previously unavailable services and reduced the length of inpatient stays (The News and Observer, 1997 and The Medicaid Letter, 1999). High levels of client satisfaction were reported (Stakeholder's Perspective, 1996). However, overall program and per-recipient spending continued to grow under the program. Because HCFA expressed concern over these increased costs, North Carolina feared that HCFA would not renew its waiver extension without reducing the capitation rates paid to Carolina Alternatives sites. Consequently, North Carolina withdrew its waiver extension application. Carolina Alternatives transitioned back to a fee for service system on July 1, 1999.

MMBH has had little impact on the linkage between primary care and mental health. The important role of primary care providers in delivering behavioral heath care in rural areas is well described in the literature (Wagenfeld et al. 1994; Bird et al. 1998; Lambert and Hartley 1998). Consequently, most MMBH programs in rural areas call for increased coordination (also referred to as "integration") between primary care and mental health. An assumption persists among policymakers that carve-in models may promote better primary care – mental health coordination than carve-out models.

Few MMBH programs have been able to operationalize enhanced coordination in a way that impacts delivery systems. As Croze (1999: p.1) observes, "Current models for integrating health and behavioral health benefits address only organizational and financial dimensions, rarely engendering a specific clinical strategy to effect integration at the patient and practitioner level." MMBH programs have tended to leave intact the existing relationship between the primary care and mental heath systems. Two rural

areas in Oregon illustrate this (Lambert et al. 1998). Although the Oregon Health Plan contains incentives to increase referrals from primary to mental health care and vice versa, these incentives have had little impact on the two systems of care. In Josephine County (in the southwest corner of the state), relations between primary care and mental health were strained before managed care and have remained strained during the first few years of the program. In the Dalles region (in the northern part of the state), relations between primary care and mental health were well established before and improved under managed care. Referrals increased from mental health to primary care providers for physical exams and treatment of physical health problems, however, these changes resulted more from the established relationships among the providers in these two systems of care and less from the incentives created by the plan.

Integration of primary care and mental health remains an elusive goal. MMBH programs tend to focus primarily on communication between providers and, to a lesser extent, on medication management by PCPs. Although contracts typically contain language requiring health plans and/or the MBHOs to be responsible for coordinating behavioral and physical health care, rarely do they detail what level of coordination is to take place or provide for incentives that compensate providers for performing these activities. The behavioral health provider may be required to send written treatment plans to the primary care provider whenever a patient enters behavioral health treatment (e.g., Hawaii, New Mexico). It is often not clear what PCPs do with this information. No corresponding requirement is imposed in New Mexico on the PCPs to communicate with a patient's behavioral health provider. Although many MMBH programs anticipate that PCPs will provide some level of behavioral health services (particularly medication management) to the Medicaid population, they have paid relatively little attention to how to improve the ability of PCPs to recognize, diagnose, and treat behavioral health problems

To make any real progress towards the integration of primary care and behavioral health services, it is necessary to define the goals of integration at the level at which primary care and mental health providers are involved. Primary care providers (PCPs) may screen and diagnose behavioral health problems; refer to appropriate behavioral health providers, communicate with behavioral health providers regarding appropriate treatment, and manage medication related to behavioral health problems. (In theory, PCPs may also provide counseling services. However, providing counseling is time-consuming and is inconsistent with the practice patterns of most PCPs, particularly

under managed care.) In turn, behavioral health providers can identify physical health needs among their clients, communicate treatment issues to the patient's primary care provider, and make appropriate referrals to primary care services.

Although one might expect carve-in programs to address these issues over time, there is insufficient experience with carve-in programs for both general and special Medicaid populations to assess whether this model may actually improve primary care – mental health coordination. Nine states integrate physical and behavioral health services in total, or in part, for the general Medicaid population and fourteen states carve out these services. Only New Mexico integrated these services in some fashion for special Medicaid populations. None of these states have moved beyond limited efforts to develop communications between primary care and behavioral health providers and acknowledging that primary care providers should continue to provide some medication management services.

Several states have suspended their programs during or after we conducted this study. During our study period (January 1, 1999 through December 30, 1999), Montana and North Carolina both suspended their MMBH programs as of July 1, 1999. Kentucky's program was substantially behind its planned implementation schedule and further development efforts were subsequently suspended. Since the end of our study period, Arkansas (July 1, 2000) and New Mexico (October 1, 2000) have terminated their programs. These states offer important insights into the complexities of implementing and operating an MMBH program. Arkansas's and Kentucky's programs were derailed by early implementation issues. After three years of planning, Arkansas's Benefit Arkansas program for Medicaid eligible children under twenty-one became operational on March 1, 2000. Six weeks later, Arkansas's Medicaid officials cancelled the program effective May 31, 2000 because of difficulties in processing claims and receiving referral authorizations. Kentucky's plan called for development of regional behavioral health coalitions comprised of behavioral health providers in each of eight designated regions. Kentucky underestimated the complexity of bringing large groups of providers together to develop a contract with the state and was at least two years behind its planned implementation schedule. Two behavioral health coalitions were established in regions covering both metro and nonmetro counties. However, the state suspended further development of the program before either was able to accept patients.

In contrast, Montana and North Carolina overcame early implementation problems to establish operational MMBH programs. During its two year history,

Montana's program was beset by a number of problems. These problems included changing ownership of the MBHO partner (CMG, the original MBHO partner, was purchased by Merit Behavioral Care Corporation which was subsequently purchased by Magellan Health Services) and ongoing problems surrounding the payment of claims, the development of its provider network, and general state oversight. Despite general satisfaction with the delivery of services, North Carolina terminated Carolina Alternatives due to internal Medicaid documentation problems and an inability to demonstrate cost savings due to an expansion of covered services that occurred in conjunction with the development of the program.

New Mexico's SALUD! program was implemented statewide over a 12-month period and, as we have described, was the only MMBH program to attempt to integrate physical health and behavioral health care. The requirement that each of the three managed care organizations participating in SALUD! contract out behavioral health to a managed behavioral health organization meant that the MMBH was really a "carved-out / carve-in" model. The role of the MBHOs in SALUD! was criticized as adding to the administrative costs of the program. When reports circulated that access and utilization of mental health services was low in some areas of the state, political support for the program waned. In Fall 2000, HCFA did not renew the waiver authorizing the behavioral health component of SALUD! and the program suspended operations on October 1, 2000.

While none of the individual problems faced by these programs were insurmountable in and of themselves, in combination they drained the states of the political capital necessary to address them. They also provided a convenient rallying point around which opponents of the programs could focus their efforts. Ultimately, each state chose to revert to fee for service delivery systems rather than continue with their existing programs. In the final analysis, they were undone not by their failure to manage care but by their inability to address problems that threatened the stability of their key stakeholders.

DISCUSSION AND RECOMMENDATIONS

Thirty-five states have implemented MMBH programs in rural areas over the past decade. (In thirteen states, implementation is limited to rural counties containing a very small proportion of the state's overall population or close to and dominated by metro counties.) There has been an assumption among policymakers and within the literature,

often tacit, that rural MMBH programs were in the process of "catching up" with more urban-based programs. Catching up in the sense that programs could be modified, or adapted, to rural areas after first implemented in urban areas.

MMBH programs in rural areas are viable and most states that have implemented these programs plan to continue them. These programs cannot remain static, they will need to adapt to evolving and volatile state health care systems. This last section discusses the implications for the delivery of mental heath services in rural areas by MMBH programs and offers recommendations for policymakers developing or refining their MMBH programs and for rural behavioral health care in general. This discussion is based primarily on the experience of the twenty-two states with significant-Implementation in rural areas.

Current Issues

Implementation of MMBH in rural areas has leveled off. This reflects the usual pattern of diffusion of a new approach or innovation and the technical and political issues in extending managed care to special-needs populations (Fossett and Thompson 1999). Most states predisposed to move to MMBH and expand it to rural areas have already done so. As described, four states have cancelled their programs – Montana, North Carolina, Arkansas, and New Mexico. A fifth state, Kentucky, has suspended implementation of its behavioral component. The willingness of national managed behavioral health organizations (MBHOs) to contract with states under "any circumstance" has decreased. When there were relatively few states with MMBH programs, MBHOs were eager to win state contracts as they searched for market share. In some states, low reimbursement resulted in significant financial losses for the MBHO (e.g., Nebraska). The amount of reimbursement available often declines in subsequent re-bidding of the MMBH contract. Consolidation within the managed behavioral health care industry has also decreased the likelihood that MBHOs will enter into risky financial contracts in search of market share.

Some states with well established MMBH programs in urban areas and strong Medicaid offices (e.g., Minnesota, Wisconsin) have chosen not to expand their programs significantly into rural areas. Minnesota, a long time leader in the development of managed health care, implemented its integrated Prepaid Medical Assistance Plan (PMAP) for the general Medicaid population in 1985 in the Twin Cities area. By 1999, only 56 percent of Minnesota's 69 non-metro counties had a PMAP plan, compared to

83 percent of its 18 metro counties (PMAP 2000). While Wisconsin has expanded behavioral health coverage for its general Medicaid population to 48 of its 50 non-metro counties through its integrated Medicaid HMO and BadgerCare programs, it has limited implementation of MMBH programs serving special populations to a small number of demonstration programs with limited presence in rural areas.

MMBH programs must continually contend with limited rural infrastructure. MMBH cannot make the problem of limited infrastructure disappear. This problem predates and will remain after managed care. Development of MMBH programs in rural areas requires a candid assessment of supply and infrastructure problems and development of concrete approaches to these realities. New Mexico originally required that all services be available in all geographic areas. During the phase-in of the SALUD! Program, this requirement was relaxed for many rural areas when it became apparent that it was unreasonable to require congregate housing facilities and other specialized services in all areas. Hawaii has recognized that not all islands can support the full range of services needed by its population. Its integrated program for the general population and its carve-out programs for special populations transport patients to other islands or to the mainland for needed services.

Limited infrastructure contributes to low access to services. A problem that states have encountered in addressing low access is how to measure and monitor it. Measures of access often take the form of providers to population ratios or the number of visits per person per year. Standards for these measures, if they exist at all, are usually based on urban areas and may not be appropriate for rural areas. The U.S. DHHS has developed access standards based on the ratio of population to providers for psychiatrists, for core mental health professionals, and for each of these groups in areas of high need. The National Commission on Quality Assurance has developed access standards based on time distance (inpatient 60 minutes, outpatient 30 minutes) and on telephone response (caller must reach a non-recorded voice in 30 seconds) (Oss et al. 1998).

Access standards need to be developed that better reflect the realities of rural service delivery. One way to do this is by having states, as purchasers, define access standards. Colorado has done this by creating Consumer Protection Standards for the Operation of Managed Care Plans. These standards require that Plans develop an access plan for services provided by networks and HMOs and maintain a network sufficient to assure that all covered benefits to eligible individuals are accessible without unreasonable delay.

Integration between behavioral and general health services under MMBH is primarily at organizational and financing levels, not at clinical and service delivery levels. There persists a strong assumption within MMBH that integrating behavioral and physical health is desirable, where possible. However, states have generally not moved beyond very limited efforts (e.g., develop communications between primary care and behavioral health providers; allow PCPs to provide some medication management) to pursue integration in concrete ways at the level at which patients receive care. New Mexico has been heralded as one of the best examples of integrating physical and behavioral health services. However, as managed care organizations and providers in New Mexico attest, this integration occurred at organizational and financing levels, not at clinical and service delivery levels. Primary care – mental health coordination has been strained in some instances where behavioral health providers fear losing patients to primary care providers and in other instances by primary care providers finding mental health patients difficult to work with.

Better integration of behavioral and physical health services holds some promise for addressing limited infrastructure in rural areas. This integration must occur at the patient level and revolve around the concrete roles of primary care and mental health providers (described on page 14) in identifying and assessing persons with mental health problems, treating them (or referring for treatment), and managing their overall care. Policymakers must decide how to give managed care organizations and providers the flexibility and incentives to address these issues while maintaining sufficient oversight. Oregon, for example, has established financial incentives for plans to integrate primary care and mental health services. How well this incentive has worked is not clear and the state is actively working to find ways to further this integration.

Local Managed Behavioral Health Organizations are playing an increasingly important role in the evolution of MMBH. Early MMBH efforts often took the form of carve-out programs in which the states contracted with one of a number of national managed behavioral health organizations (MBHOs), which often drove the design of the program. The role of MBHOs has been declining, as states gained experience with MMBH and found that the dollars going to MBHOs may be high, relative to their performance. Increasingly, states are turning to local managed behavioral health organizations (LMBHOs) formed by public sector entities (e.g., county governments, local mental health authorities) and/or providers (e.g., community mental health centers, provider organizations) to deliver MMBH services in rural areas. MBHOs are often still

involved, albeit in more limited and subordinate roles. These states include Kentucky, Michigan, Colorado, Oregon, Wisconsin, Minnesota, and California.

Incentives for creating LMBHOs include maximizing the use of available money to deliver services (as opposed to going to the MBHO), maintaining local accountability for providing services, and increasing financial security for providers that often serve as their communities' safety net. Preserving or increasing the stability of safety-net providers (hospitals, community health centers and clinics, community mental health centers) is particularly important as the general level of Medicaid reimbursement to these providers has declined in recent years. LMBHOs may also be better able to blend diverse service funding streams for vulnerable populations requiring comprehensive medical and support services.

Because they are new, little is known about the capacity of LMBHOs to manage delivery of services. Important questions revolve around whether rural LMBHOs:

- are able to assume risk in providing behavioral health services in sparsely populated areas;
- are able to support and stabilize rural safety net providers;
- have the administrative infrastructure to develop administrative and client management systems mandated by state MMBH plans and needed to manage risk;
- have the capacity (provider network, management, resources) to provide, build, or leverage the full range of services needed by general and vulnerable Medicaid populations; and
- have the ability to address the shortage of qualified behavioral providers in rural areas.

Recommendations

The devolution of responsibility for Medicaid managed care of both physical and behavioral health from HCFA to the states and elimination of the waiver requirement, gives states much greater latitude in deciding which beneficiaries they may enroll and in what type of managed care plans (Fossett and Thompson 1999). This fluid situation poses both opportunities and challenges for state level policymakers responsible for overseeing and guiding the delivery of mental health care in rural areas.

State level policymakers have focused on important choices and design issues in developing MMBH programs. Decisions to carve-in or carve-out behavioral from general

health services, or to implement a regional or statewide model, often reflect prevailing political and state program concerns, and not the capacity of local rural mental health delivery systems to identify and treat persons with mental health problems. State Medicaid programs and other policymakers should more carefully assess and monitor how MMBH programs may enhance, diminish, or otherwise modify the capacity of local service systems and providers to serve rural persons. Policymakers should:

1. Continue to monitor the impact of MMBH on access to mental health care for the general and special Medicaid populations. The shift of care from inpatient to outpatient settings for special populations may crowd out outpatient care for the general population. Access to outpatient care for special populations may become tighter over time if pressure continues to reduce costs.

2. Identify the distinct clinical needs and access issues of the general (income-eligible) and special (disability/disorder eligible) Medicaid populations.

3. Develop systems to address these differing needs by:

    - improving the ability of primary care systems to identify behavioral problems within the general Medicaid population;
    - facilitating the referral of patients across behavioral and physical health care systems; and
    - distinguishing between medical and support service needs of special Medicaid populations.

4. Define expectations for integration between behavioral health and primary care services and between behavioral and substance abuse services.

5. Assess the impact of MMBH programs (direct and indirect) on traditional mental health safety net providers (e.g., hospitals, emergency and crisis services, community health centers and clinics, and community mental health centers.) *

6. Assess the impact of contracting with local and regional organizations (including LMBHOs) on the:

    - consistency of access and service capacity across regions;
    - ability of organizations to manage and absorb risk; and
    - effect of assuming risk on participating members. [7]

ENDNOTES

[1] Minnesota (1985), Utah (1991), and Massachusetts (1992) were among the first states to implement MMBH. Over the next several years (1994-95), programs were established in a number of states, including Hawaii, North Carolina, Nebraska, Iowa, Colorado, Oregon, Washington, and Wisconsin. MMBH programs followed in California, Montana, Tennessee, New York, Michigan, and New Mexico in 1996-1997. Pennsylvania (1998) and Kentucky (1999) are among the latest states to implement MMBH programs.

[2] The interim changes included: five percent increase in payments to MBHOs; state takeover of the management of the behavioral health pharmacy program; and mandatory reconciliation of 80 percent of MBHOs claims backlog. MBHOs were required to invest savings from these program changes (estimated at $35 million) in community programs.

[3] Information collected by the inventory was supplemented by findings from two earlier projects conducted by the Maine Rural Health Research Center. One study – based on telephone interviews with state officials, managed care directors, and mental health and primary care providers - examined the initial effects of Medicaid mental health carve-outs in rural areas in six states - Colorado, Iowa, Montana, Oregon, Tennessee, and Washington (Lambert et al. 1998). Another project produced a series of papers reporting on best practices in rural Medicaid managed behavioral health in four areas – access, infrastructure, credentialing, and consumer issues (Hartley, 1998).

[4] The actual assignment of counties is based on the 1990 census. The Office of Management and Budget has proposed to revise the standards for defining both metropolitan and non-metropolitan areas and to apply the new standards to counties when the 2000 census population data becomes available.

[5] Minnesota has a pending waiver application to allow for county-based purchasing of Medicaid services. The waiver is based upon the non-metro county of Itasca which, in various forms, has purchased health care services for its residents since 1982. Itasca County Health and Human Services has established a prepaid health plan (IMCare) that is offered to Medicaid enrollees in the nonmetro counties of Itasca, northern Aitkin, and southern Koochiching.

[6] South Dakota serves its general Medicaid populations with elements of managed care including utilization review and budgeting, but not any form of capitation.

[7] Recommendations 5 and 6 require that specific studies be conducted. Studies can be conducted as part of a state's monitoring of the implementation of a new MMBH program. New Mexico researchers have completed a study, funded by the Agency for Health Care Research and Quality, on the impact of the state's Salud! program on safety net providers (Horton et al., 2000). Federal agencies can also support multi-state evaluations of these issues. The Office of Rural Health Policy (ORHP) has funded the Maine Rural Health Research Center to study changes in the role of rural community mental health centers as safety net providers.

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