Research & Policy Brief

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Medicaid Managed Behavioral Health Programs in Rural Areas

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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. 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 address 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 survey and 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.

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- 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 (i.e.: those with disability-related eligibility).
- 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.
- *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.

MMBH and Rural Service Delivery: Experience to Date

Medicaid Managed Behavioral Health (MMBH) programs pose both opportunities and risks for rural service delivery systems. States have more flexibility (than under fee-for-service based reimbursement) in how they spend their money to meet the needs of Medicaid beneficiaries with moderate and severe mental illness. 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 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 a result of 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.

Integration of primary care and mental health has been pursued primarily at the organizational and financing levels, not at clinical and service delivery levels. As a result, we did not find any clear differences in service delivery between carve-in and carve-out models. 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. Relatively little attention has been directed to how to improve the ability of PCPs to recognize, diagnose, and treat behavioral health problems.

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 rural primary care and for behavioral health providers.

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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.

- *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.

RECOMMENDATIONS

Policymakers should:

- Continue to monitor the impact of MMBH on access to mental health care for the general and special Medicaid populations.
- Identify the distinct clinical needs and access issues of the general and special Medicaid populations.
- Address these needs by developing systems to: improve the ability of primary care systems to identify behavioral problems; facilitate referral of patients across behavioral and physical health care systems; and distinguish between the medical and support service needs of special Medicaid populations.
- Define expectations for integration between behavioral health and primary care services and between behavioral and substance abuse services.
- Assess the impact of MMBH programs (direct and indirect) on traditional mental health safety net providers.
- Assess the impact of contracting with local organizations (including LMBHOs) on the consistency of access and service capacity and the ability of organizations to manage and absorb risk.

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The Maine Rural Health Research Center (MRHRC) was established in 1992 to inform health care policy making and the delivery of rural health services through high quality research and policy analysis. The Center has three areas of special interest in its research agenda: (1) the availability, organization, and financing of rural mental health services, (2) institutional and community-based services for rural elders, and (3) changes in the organization and financing of rural health services.

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