

Effects of Managed Mental Health Care on Service Use in Rural Areas

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EXECUTIVE SUMMARY

Managed behavioral health care is often described as a mental health carve-out because either the purchaser or the managed care organization separates the financial risk for mental health claims from the risk for general medical services by contracting with a managed behavioral health organizations (MBHO). The MBHO can do a better job of eliminating inappropriate utilization, assuring quality, and modifying the practice style of mental health specialty providers than a general service managed care organization. One strategy to accomplish these goals is to direct mental health care away from the primary care setting toward the mental health setting where MBHO management practices have the greatest effect. In rural areas, where a major portion of the mental health care is provided by primary care practitioners, this strategy may result in decreased access to mental health services.

This study takes advantage of a “natural experiment,” resulting from the reassignment of all Maine state employees to a MBHO in December, 1992. By comparing mental health claims before and after that date, the effects of the carve-out on mental health utilization are investigated.

Key Findings:

Following the implementation of the carve-out, the penetration rate, defined as the proportion of beneficiaries who sought help for an affective disorder, increased significantly in both rural and urban areas ($p < .001$). However, the rural penetration rate remained significantly lower than the urban rate (before: 25.8 vs. 52.2 users per 1000 enrollees, $p < .001$); after: 57.8 vs. 85.8 users per 1000 enrollees, $p < .001$). Similarly, rural utilization rates, defined as the average number of outpatient mental health visits per user, were significantly lower than urban rates both before and after implementation of the carve-out (before: 9.2 vs. 12.9 visits per user, $p < .001$; after: 9.8 vs. 13.3 visits per user, $p < .001$). Before-after differences are not significant. In addition, we found that the proportion of mental health care provided in the primary care setting increased after implementation of the carve-out (from 9.5 percent of all visits before, to 12.6 percent of all visits after, $p < .001$).

Conclusions:

The increase in penetration rates, both urban and rural, is attributed, in part, to a member education initiative undertaken during the transition from fee-for-service to managed care. The increase in the proportion of mental health care provided in the primary care setting is attributed to the greater ability of primary care practitioners (PCPs), as compared with mental health specialty providers, to accommodate the increased demand evidenced by the increased penetration rate. We conclude that this type of carve-out arrangement does not threaten to reduce access to mental health services, provided the MBHO managing the carve-out is willing to accept PCPs as part of its provider network.