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Encouraging Rural Health Clinics to Provide Mental Health Services: What are the Options?

Long-standing shortages of mental health services have shifted much of the burden of care for mental health issues to the primary care sector.¹ Almost 3,800 Rural Health Clinics (RHCs) provide important primary care services in rural communities.² An earlier study found that few RHCs offered mental health services by employing doctoral level psychologists (0.12%) or clinical social workers (0.07%).³ This study examined changes in the delivery of mental health services by RHCs, their operational characteristics, barriers to the development of services, and policy options to encourage more RHCs to deliver mental health services.

Methodology

Using 2005-2006 Medicare Hospital and Independent RHC Cost Reports, we identified 62 independent and 28 provider-based RHCs that employed doctoral-level psychologists or clinical social workers. From this group, we conducted semi-structured interviews with staff from 14 randomly selected (six independent and eight provider-based) RHCs to explore the reasons for developing mental health services, barriers to doing so, their operational and clinical characteristics, and challenges to their sustainability. At the time of our interviews, 13 of these clinics provided mental health services and had done so for an average of eight years. The remaining clinic had closed its service upon losing its mental health provider.

Findings

Approximately 6% of independent and 2% of provider-based RHCs offer mental health services using doctoral-level psychologists and/or clinical social workers. The 28 independent and 7 provider-based RHCs with psychologists employed an average of 0.4 full time equivalent (FTE) psychologists. The 48 independent RHCs with social workers employed an average of 0.6 FTE social workers, the 23 provider-based RHCs, an average of 0.7 FTE.

Models used to provide services included contracted and/or employed clinicians co-located with primary care services. The most commonly treated conditions were depression, attention deficit hyperactivity/attention deficit disorders, and anxiety. Participating RHCs appeared to maintain or increase access to services; most accepted new patients and did not limit referrals to existing patients. RHCs accepted patients of all ages and reported short waiting times to access services. Providing mental health services is challenging. Five (38%) reported that their services were not profitable, four (31%) reported that they were profitable, three (23%) thought they might be profitable but were not sure, and one (5%) could not respond. Primary reasons for developing these services included community and patient needs and a lack of available local services.

A key element in the development of services is the presence of an internal mental health champion. Internal champions are typically clinicians or administrators, who identify the need for and undertake implementation of services. Champions serve as motivators and problem-solvers; help to overcome barriers; and direct necessary resources to support service development.

Fast Facts

- Approximately 6% of independent and 2% of provider-based RHCs offer mental health services.
- 38% of study RHCs reported their mental health services were not profitable but continued to provide them in response to community and patient needs.
- An important factor in the development of RHC mental health services is the presence of a local “champion” who spearheads the development effort.

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Barriers to the Development of Mental Health Services

- *Recruitment and retention barriers:*

Respondents reported difficulties recruiting mental health staff due to chronic shortages of clinical social workers, psychologists, psychiatrists, or other clinicians in rural areas and policies established by some payers restricting reimbursement to certain providers (e.g., Medicare limits reimbursement to clinical social workers and doctoral-level psychologists). Retaining clinicians is difficult due to the challenges of rural practice including professional isolation and professional boundary issues.

- *Reimbursement barriers:* Respondents identified poor reimbursement rates paid by Medicaid and commercial insurers; patient cost-shifting by Medicare* and commercial insurers through high deductibles and co-payments; high no-show rates among mental health clients; and high rates of uninsurance among rural residents.

- *Administrative barriers:* Respondents described the administrative burdens of dealing with multiple third party payers; inconsistent reimbursement and credentialing policies; managed care and prior authorization requirements used to control utilization costs; and complex state licensure laws. These administrative demands imposed additional costs on clinics and increased staff workload.

- *Information and resource barriers:* Respondents described limited availability of RHC-specific resources and technical assistance to assist in developing services.

These barriers are similar to those reported by other types of primary care providers, so why have RHCs been slow to develop mental health services? We suggest the following reasons:

- RHCs are located in rural underserved areas plagued by chronic shortages of mental health providers.
- Many RHCs, particularly independent RHCs, operate like small private practices with limited administrative, financial, and facility resources.
- The RHC Program lacks the policy leverage (e.g., specific policy direction and financial and technical assistance

* The Medicare Improvements for Patients and Providers Act of 2008 established a schedule to phase out Medicare's 62.5% outpatient psychiatric payment limitation by 2014 (HR 6331). Beginning in 2010, Medicare's psychiatric outpatient payment limitation, a barrier identified by respondents to our study, will be gradually phased out. For expenses incurred in 2014 and later, outpatient psychiatric payment limitation will be eliminated. The deductible on psychiatric services for Medicare beneficiaries will be 20% of Medicare's approved amount for services, the same as for medical and physical health services.

† FQHCs are required to provide, directly or by arrangement with another provider, mental health services. The Bureau of Primary Health Care supports FQHCs in fulfilling this requirement by offering Service Expansion Grants as well as technical assistance and educational resources.

resources) used by the FQHC program to encourage development of mental health services.†

Given these issues, growth in RHC mental health services will likely remain stagnant unless efforts are undertaken to increase interest in developing these services among RHC staff and resources are provided to support them in doing so.

Options to Encourage RHCs to Offer Mental Health Services

The number of RHCs providing specialty mental health services remains very limited and the growth patterns (or lack thereof) provide little reason to believe that this situation will turn around without greater policy direction and action. Given the limited access to mental health care in rural communities, the limited provision of mental health services by the nation's 3,800 RHCs may present a missed opportunity to increase access to these needed services. Policymakers should develop approaches to address reimbursement and administrative barriers identified here, while also considering how to train and ultimately recruit mental health providers to rural areas. Practical, comparatively low cost options to support the development of mental services by RHCs in the short-term include:

- The development of RHC-specific mental health educational and technical assistance resources;
- The identification of existing mental health resources developed by the Bureau of Primary Health Care, and the Substance Abuse and Mental Health Services Administration, and other Federal agencies that could be adapted for use by RHCs; and
- The development of an RHC mental health toolkit (similar to the ORHP-funded Starting a Rural Health Clinic: A How-To Manual) to provide practical resources on mental health billing, coding, and reimbursement; quality management and improvement; provider selection and management; risk management; service development; managed care, prior authorization, and utilization management processes; evidence-based practices; service models; record keeping; and confidentiality.

References

1. *Fact Sheet: Rural Health Clinic*. Baltimore, MD: Centers for Medicare and Medicaid Services; 2009.
2. Gale JA, Coburn AF. *The Characteristics and Roles of Rural Health Clinics in the United States: A Chartbook*. Portland, ME: University of Southern Maine, Muskie School of Public Service; 2003.
3. Gale JA, Lambert D. Mental Health Care in Rural Communities: The Once and Future Role of Primary Care. *North Carolina Medical Journal*. 2006; 67:66-70.