

Why Do Rural Medicaid Beneficiaries With Depression Use Fewer Mental Health Services: Is Supply The Issue?

THE PROBLEM: Primary care providers are taking on an expanded role in diagnosing and treating depression. This trend holds the promise of improving access to mental health care of rural persons with depression, given the low supply of rural mental health providers. However, the extent to which primary care providers can help improve access for persons in rural areas may be limited. Rural primary care providers often have large patient loads and mental health providers may not be available for referrals or consultation.

THE STUDY: To better understand these issues, this study compares the mental health service use of rural and urban Medicaid beneficiaries with depression and examines the effects of mental health and primary care supply on use rates. Of particular interest is whether primary care providers provide more mental health care for persons with depression in rural areas where there are very few mental health providers. If they do, this would suggest that primary care providers substitute for mental health providers.

The study is based on 1994 Medicaid claims data for AFDC- and SSI-beneficiaries, age 18-64, from the state of Maine. Utilization is measured by the number of Medicaid beneficiaries with an ambulatory care visit for depression, the number of annual mental health visits by beneficiaries with depression, and the likelihood of being hospitalized for depression. The analysis adjusts for the effects of other factors that may influence service use, including type of Medicaid eligibility, severity of depression, and whether or not a beneficiary has another mental health and/or substance use problem.

KEY FINDINGS:

- ◆ Rural beneficiaries have lower use rates of mental health services than urban beneficiaries.
- ◆ Mental health supply and other key factors, including severity of illness, account for most of the rural-urban differences in use of mental health services.
- ◆ There is no evidence that primary care providers provide more care for beneficiaries with depression in areas of low mental health supply. This suggests that access to and use of mental health services depends much more on mental health supply than primary care supply.

POLICY IMPLICATIONS: Current policy efforts to increase the role of primary care providers in diagnosing and treating patients with depression in rural areas should be continued, given the low supply of rural mental health providers. However, this strategy is not likely to be sufficient in increasing access, given the apparent lack of substitution between primary care and mental health providers. The supply of mental health providers in rural areas must also be increased.

Strategies to increase the supply of mental health providers in rural areas must account for changes in the financing and organization of health care, such as the emergence of rural health care networks and managed care. The expansion of Medicaid managed care programs, which often “carve-out” mental health services from the management of general health care, may further deter primary care providers from treating Medicaid beneficiaries with depression in rural areas.

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