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Do Medicaid Mental Health Carve-outs Reduce Access in Rural Areas?

Most states are currently enrolling some or all of their Medicaid population in managed care, and many are choosing to separate the financing and management of mental health from physical health benefits. States hope that these arrangements, often referred to as mental health carve-outs, will save money without compromising quality or access. Unfortunately, such arrangements may add to existing access barriers in rural areas. Due to chronic shortages of mental health providers (particularly psychiatrists) in rural areas, mental health care is often provided by primary care practitioners (PCPs). Yet the managed behavioral health organizations (MBHOs) that administer mental health carve-outs may not recognize or reimburse PCPs. Also, the common managed care strategies of command and control (e.g. utilization review, prior authorization) may amplify existing access problems in rural areas where the challenge is often to enhance service delivery infrastructure, not to trim it. In addition, efforts to improve access and quality by integrating mental health and primary care services may be thwarted when the financing and management of mental health services are separated from physical health services.

This paper explores the experience and impact, to date, of Medicaid mental health managed care in rural areas of six states—Colorado, Iowa, Montana, Oregon, Tennessee and Washington. These states were selected as examples of the two most recent generations of Medicaid mental health carve-outs (see Figure 1).

Figure 1
Generations of Medicaid Mental Health Carve-outs

	States Included in this Study	
	Contract	
Year Implemented	Centralized	Regionalized
1991-1992	Massachusetts	Utah
1995	Iowa	Colorado
	Nebraska	Oregon Washington
1996-1997	Montana Tennessee	New York New Mexico

KEY FINDINGS INCLUDE:

1. Many states have expected managed behavioral health organizations (MBHOs) to solve long-standing problems, such as a lack of mental health providers in rural areas, while lowering mental health costs.
2. Although risk-sharing is a crucial component of a state's approach, rural mental health providers have only assumed a limited amount of risk.
3. Integrating mental health and general health remains a goal, not a reality. However, the linkage between primary care and mental health has not been weakened in rural areas.
4. In the states we studied, access to mental health care has generally not been restricted and in some states access has been improved. Some states experienced problems with access early in their implementation because they did not include PCPs on MBHO panels. How states respond to such problems has varied.
5. Some problems experienced by third generation (more recent) carve-out states might have been avoided by learning from earlier experiences by other states. For example, both Iowa and Montana experienced problems with PCPs not being reimbursed for mental health services. Iowa responded quickly and corrected the problem in 1995. When Montana experienced this problem in 1997, it was not able to respond as quickly, and the statewide mental health carve-out was jeopardized.

CONCLUSIONS. Medicaid mental health managed care is still new and it is not known how well it may eventually work in rural areas. This study provides evidence for cautious optimism. Several issues are raised by this study:

1. States have multiple goals when they choose carve-outs: to save money, ensure access, coordinate services and assure quality. The dominance of saving money in this mix may be one reason that states fail to learn about rural issues from each other.
2. The major challenge in rural areas continues to be how to develop capacity, not how to reduce or trim it. It is important that managed mental health care be adequately funded and that price not be the only criterion upon which bids are judged.
3. How to evaluate adequate access to care in terms of available rural providers is crucial, and is not being adequately addressed. While this issue will be increasingly influenced by credentialing of providers, current quality and access standards leave determination of access standards largely in the hands of the MBHOs.

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