

# Research & Policy Brief

Maine Rural Health Research Center • Institute for Health Policy

November, 1998

## Best Practices in Rural Medicaid Managed Behavioral Health

A Series of Four Papers Addressing: Access, Infrastructure Development, Credentialing and Consumer Issues

Most states are enrolling their Medicaid population in managed care, and many are choosing to separate the financing and management of mental health from physical health care. This separation is often referred to as a “mental health carve-out,” and the firms that manage mental health benefits are typically called “managed behavioral healthcare organizations (MBHOs).” This series of papers seeks to encourage states that are designing or modifying their Medicaid mental health programs to consider and learn from the “best practices” of other states, and MBHOs.

Managed behavioral healthcare raises many of the same concerns currently being raised about managed medical care, such as provider choice, use of financial incentives to limit appropriate care, and interference with the physician-patient relationship. However, rural areas pose significant challenges for both medical and behavioral managed care due to low population density, a limited supply of providers, and limited infrastructure. Thus, this series of papers is narrowly focused on managed behavioral healthcare issues with a unique rural element.

Insufficient access to a wide variety of services has been a constant theme in rural studies, and access to mental health providers has been especially hard to achieve. Thus, we begin the series with “Measuring and Monitoring Access.” Those who read all four papers will find that access and under supply of providers and services are mentioned throughout the series. Similarly, the significant role of primary care practitioners in providing mental health services in the absence of mental health specialty providers is a recurring theme in this series.

In each paper the authors first describe the nature of the rural problem, and then present “best practices,” specific programs, policies or practices that are currently being used in one or more states to address those problems. In many cases, the interviews and research conducted by the authors turned up practices that are being considered or recommended in one or more states. We have labeled these “recommended practices,” because they have not yet been tried and proven, but appear promising.

### Key Best Practices:

#### Measuring and Monitoring Access:

Measures of access have often taken the form of ratios of providers to population or utilization measures such as the number of visits per year. Standards for these measures, if they exist at all, are usually based on urban areas, and may not be appropriate for rural areas. If appropriate standards are set for MBHOs, whether by state, federal or private accrediting organizations, such standards could improve the number and dispersion of providers in rural areas. States are relying on MBHOs to solve long-standing access problems, yet no uniform standards exist. A selection of standards for accessibility and availability of mental health services are shown in Table 1.

*David Hartley, PhD, editor*

#### Measuring and Monitoring Access

*Monica Oss, Sharon Birch and JJ Mackie, Open Minds*

#### Infrastructure Development

*Susan Berger and Holly Korda, ROW Services*

#### Credentialing

*Donna Bird, Maine Rural Health Research Center*

#### Consumer Issues

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*Table 1*  
**Current Standards for Accessibility and Availability of Mental Health Services**

Type of Standard	Authority	Details
Ratio of population to providers	U.S. Public Health Service	psychiatrists 20,000:1 core mental health professionals 6,000:1  <b>FOR AREAS OF HIGH NEED</b> psychiatrists 15,000:1 core mental health professionals 4,500:1
Time/Distance	NCQA	inpatient 60 minutes outpatient 30 minutes
Penetration /Utilization (e.g. mental health claims as percent of all claims)	Some states, e.g. Iowa	No specific standard. Typical application is comparison with previous year, or with pre-managed care rates.
Telephone response	NCQA	Caller must reach a non-recorded voice in 30 seconds. Percentage of callers who terminate call before reaching representative must not exceed 5 percent.
Distance	GeoAccess <a href="http://www.geoaccess.com">http://www.geoaccess.com</a>	one mental health provider within 15 miles for 80 percent of enrollees

**BEST PRACTICE**

States, as purchasers, define access standards. Colorado’s Consumer Protection Standards for the Operation of Managed Care Plans require an access plan for services provided by networks and HMOs. Plans are required to maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay.

**BEST PRACTICE**

Enhance the role of Primary Care Physicians in Rural Mental Health. By some estimates, primary care physicians deliver 60 percent of mental health services in the United States. Enhancing their skills at diagnosing and treating mental health problems can be achieved through integration of services, consultations and training.

**Developing Infrastructure**

Rural mental health services systems have lower availability of mental health providers (particularly psychiatrists), rely more on primary care providers (PCPs), have limited referral options, and encounter stronger barriers to care posed by stigma and travel distance. These problems are familiar to Medicaid programs in rural states, and they often use the mental health carve-out contract to transfer responsibility for infrastructure development to MBHOs.

**BEST PRACTICE**

New services, not previously reimbursed under Medicaid, have been added to the Medicaid benefits structure in some states, through reinvestment of funds made available by decreased inpatient days (e.g. Iowa).

**BEST PRACTICE**

In most rural areas, PCPs provide some mental health services. While MBHOs have not initiated training or technical assistance in mental health treatment to such providers (a recommended practice), some have acknowledged the role of PCPs in the mental health services infrastructure by contracting with federally qualified health centers (FQHCs), and placing mental health providers in the centers. (e.g. Presbyterian Medical Services in New Mexico.)

**BEST PRACTICE**

In some states where existing infrastructure consists primarily of community mental health centers, these centers have either formed networks among themselves, or contracted with MBHOs (e.g. Colorado, Oregon, Utah, Washington and Iowa).

## Credentialing

Credentialing is the process by which the MBHO verifies that each participating practitioner and/or facility meets appropriate professional competence standards. Some rural practitioners lack advanced training and are not eligible for credentialing as independent mental health service providers. Alternatively, rural primary care physicians, who are often the principal source of mental health care for their patients, are often unable to obtain direct credentialing from MBHOs.

### BEST PRACTICE

The Quality Improvement System for Managed Care, developed by the Health Care Financing Administration, suggests the use of “deemed status” to enable accredited mental health service organizations to credential their own staff, including those who are paraprofessionals or non-mental health specialists. The MBHO credentials the organization, and the organization must demonstrate that all members of its professional staff have met its own internal credentialing requirements. (e.g. Colorado Health Networks.)

### BEST PRACTICE

The current credentialing system is costly, time-consuming, and duplicative, with some standards conflicting or inconsistent. In Colorado, many hospitals are taking advantage of a unified credentials application process developed by the Colorado Medical Society.

## Consumer Issues

MBHOs seeking to serve persons with serious and persistent mental illness in rural areas confront long-standing barriers to care. MBHOs have also encountered a growing consumer movement, focused on ensuring that services remain centered on consumer needs. In a number of states, consumers and MBHOs are working together productively to address these challenges.

### BEST PRACTICE

Consumer self-help groups can be used to increase access to services. In Colorado and Tennessee, MBHOs have hired consumers at the management level to help develop self-help groups. MBHOs have found that self-help groups can provide the support needed to keep a person out of the hospital, while consumer-operated drop-in centers have become an important part of the mental health system. In Tennessee, 17 such centers are in rural areas.

### BEST PRACTICE

Grievance procedures are often difficult to understand and lack clear guidelines. Isolation, lack of peer support, and travel distance may deter rural consumers from lodging a grievance, or from following through with the complicated, often drawn-out process. Tennessee’s Advocare has initiated a simplified, timely complaint system that is working well. In Colorado, Options, Inc. has developed a simple and accessible grievance procedure that utilizes a toll-free number staffed by a consumer who assists in filing the complaint.

<http://www.muskie.usm.maine.edu/bestpractice>

## NEW PROJECT

### Monitoring the Implementation and Effects of Mental Health Carve-Outs in Rural Areas

Over the next two years this project will monitor the implementation and effects of carve-outs in rural areas. The project has two components: (1) an inventory of states having operational managed Medicaid mental health care in rural areas; (2) a report on the effects of, and best practices in, rural Medicaid managed behavioral health care. The inventory will be maintained on a website and will describe which rural areas of the state are operating behavioral managed care, provider supply in these areas, and structure of the managed care program (relation to physical healthcare, service delivery models, financing, and risk management).

Effects and best practices will be monitored in four areas, based on interviews with key informants in selected states. These areas are: (1) access to care (2) credentialing of providers, (3) coordination between primary care and mental health, and (4) coordination between substance abuse and mental health. Reports on effects and best practices will be summarized on-line and will be available and distributed in hard copy. The website will include links to other relevant sources of information (state specific and national) for those interested in managed behavioral health care in rural areas. Information will be posted at this website starting spring, 1999. Look for a link to the new website at the above URL.

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Managed Behavioral Health

Established in 1992, the Maine Rural Health Research Center (MRHRC) is one of five national rural health services research and policy analysis centers funded by the federal Office of Rural Health Policy. The Center is also one of five rural managed care centers funded by the federal Agency for Health Care Policy and Research (AHCPR). 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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### Recently Published and Forthcoming Working Papers:

- How Do Primary Care Practitioners Manage Depression: Treatment or Referral? (#7)
- Differences in Nursing Home Discharge Rates for Urban and Rural Nursing Facility Residents with Hip Fracture (#8)
- Mental Health Carve Outs Under Medicaid Managed Care: Impact on the Rural Mental Health Delivery System (#9)
- Rural Models for Integrating and Managing Acute and Long-term Care Services (#10)
- Nursing Home Residents with Depression: What Mental Health Services Are Available to Them? (#11)
- Treatment and Outcomes Among Rural and Urban Nursing Home Residents with Depression (#12)
- Urban-Rural Differences in Employer-based Health Insurance Coverage of Workers (#13)
- How Do Older Rural Medicaid Beneficiaries With Depression Access Care? (#14)
- Effects of Managed Mental Health Care on Service Use in Rural Areas (#16)