BEST PRACTICES in Rural Medicaid Managed Behavioral Health

David Hartley, Ph. D. , Editor
Maine Rural Health Research Center

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Susan Berger and Holly Korda
R.O.W. Sciences, Inc.
1700 Research Boulevard, Suite 400
Rockville, MD 20850-3142
301-294-5515 voice
301-294-5401 fax
www.rowsciences.com

Introduction

The inadequacies of the mental health services delivery system in rural areas have been well established (Regier, 1993; Lambert and Agger, 1994) "Rural systems have lower availability of mental health providers (particularly psychiatrists), rely more on primary care providers, have limited referral options, and encounter stronger barriers to care posed by stigma and travel distance" (Lambert et al., 1997). These well-documented deficiencies of the delivery infrastructure are compounded by the characteristics of the rural populations they serve, which include high proportions of working poor and uninsured individuals and families in sparsely populated and often remote locations (Sawyer and Beeson, 1997). With limited access to services and supports outside the mental health system, rural consumers, especially those with serious or chronic mental illness or substance abuse problems, and the providers who serve them face especially daunting challenges managing their conditions.

State Medicaid programs have long struggled to address the mental health needs of rural enrollees. While many state Medicaid programs are turning to behavioral health carve-outs to address the rising costs of providing services for mental illness and addictive disorders, rural states are often using these carve-outs to transfer responsibility for infrastructure development to managed behavioral health organizations (MBHOs) . But the essential challenges of developing a viable infrastructure for behavioral health care carve-outs in rural areas remain equally challenging for MBHOs.

The trend to develop managed behavioral healthcare programs in rural areas continues to gain momentum with little evidence as to "what works and what doesn't"—but with a growing knowledge of best practices developed and refined in state Medicaid programs nationwide. This paper examines the experiences and best practices of states and managed behavioral healthcare organizations in assessing, developing, and improving the integration or coordination of mental health services delivery networks—as the infrastructure of

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behavioral managed healthcare. With the assistance of industry experts, state officials, and review of states' track records to date, we address the following key questions:

- What approaches are states and/or MBHOs using to assess and monitor infrastructure requirements for developing and maintaining behavioral health systems in rural areas?
- What are states and managed behavioral health organizations doing to address the lack of essential services or personnel in rural mental health services delivery systems?
- What approaches are being undertaken to improve the organization, integration, or coordination of services—i.e., to improve the viability and development of infrastructure to support managed behavioral health carve-outs in rural areas?

We review the experience and practices of selected state Medicaid programs, with case examples and input from key informants, below. These lessons of experience suggest guiding principles toward a better understanding of the needs and strategies for assessing, developing, and coordinating infrastructure for behavioral health delivery in rural areas.

Rural Behavioral Health Infrastructure: What Does it Look Like?

Components. Rural mental health services systems include a wide spectrum of components which, when combined, constitute the infrastructure or framework for service delivery. This framework typically includes three categories of services — institutions, individual providers, and informal support services:

- Institutional providers which may include hospitals, psychiatric clinics, community mental health centers, mental health programs and services, and federally-qualified health centers
- Individual providers such as psychiatrists, psychologists, social workers and other licensed professionals (though often these providers are not available in rural areas).
- Enabling support services, including social club programs, “wraparound” services, respite care, consumer support and self-help groups and other alternative services.

Rural delivery systems are characterized by different levels of capacity and capability. In most states, inpatient services for the mentally ill are the most widely available service. While the majority of these services are located in general hospitals, currently less than 20% of rural general hospitals have psychiatric services (Ricketts, forthcoming). In Montana, for example, “of the fifty-two community hospitals throughout the state, only eight have designated psychiatric units (Smith 1998).”

In Colorado, West Virginia and Utah, for example, rural delivery systems are centered around Community Mental Health Centers (CMHCs). Colorado's mental health carveout demonstration program, implemented in 1995, utilizes two models: in one, four CMHCs

have formed a consortium; in the other, three CMHCs have formed a partnership with Options, Inc., a national MBHO (Lambert.D., Hartley D., Bird D., Ralph R., Saucier P. 1998). Some states, such as Washington and Arizona, have organized regional service networks. Often, Medicaid is combined with state-sponsored services through agencies such as the state's Department of Mental Health, as in Massachusetts and Montana, as well as with county and local programs, as in Iowa.

In most states, the structure of services extends vertically — from state-level to county-level services, from counties to local mental health authorities to local providers — as well as laterally — across community mental health centers (CMHCs), consortia of local, traditional providers, local clinics and primary care providers. Most states require that providers be licensed by their professional or accrediting body. With behavioral managed care, providers may also be required to be credentialed by the managed care entity to meet industry standards as defined by the National Committee for Quality Assurance (NCQA), state and federal government, and/or other organizations. (See accompanying paper on best practices in credentialing.)

The expansion of Medicaid managed care, which is increasingly encompassing rural populations, has also necessitated the involvement of complementary agencies, such as welfare departments, schools, and criminal justice systems, and the development of linkage arrangements, such as enhanced communication mechanisms, case planning and coordination, and multiple funding streams, to assure that rural consumers receive a continuum of services to meet their needs.

BEST PRACTICE 1

Expanding and Diversifying Services through Reinvestment of Savings

Under managed behavioral health, services more cost-effective than inpatient care are being added as alternatives to serve the population of mentally ill children and adults. When Merit Behavioral Care of Iowa (MBCI) assumed that state's contract, its first goal was to expand the provider network to include a range of alternative as well as traditional services. As a result of its network development efforts, MBCI created a system which includes not only traditional inpatient, outpatient, partial hospitalization and day treatment, psychiatrist and psychologist services, but also alternative services including mobile crisis intervention, crisis stabilization, respite care, residential treatment, group homes, therapeutic foster families, and a range of community support services (Micali, P., Woods, C. 1996). Seven services not previously reimbursed under fee-for-service were developed, and preventive and early intervention services are also planned. According to Phil Micali, Chief Operating Officer of Merit Behavioral Health in Iowa (MBCI), "… specific services to be developed were targeted by the MBHO and the state, with input from consumer-provider-county round tables." Development of new services was funded through reinvestment of savings; yet, maintaining this infrastructure, even with MBCI's start-up support, remains a challenge."

Colorado Health Networks, an Options-CMHC partnership, plans to reinvest savings from managed care to strengthen emergency services, support client transportation, help develop telehealth, and support client scholarships for vocational training.

BEST PRACTICE 2

Building Capacity by Enhancing the Role of Primary Care Practitioners

Given that most rural areas lack sufficient mental health services and professionals, the delivery of behavioral health services often depends upon the capabilities of resident medical professionals. In most cases, primary care providers (PCPs) provide some mental health services. They may be affiliated with federally-funded community health centers, rural hospitals, public health departments or have their own private practices. Montana's Primary Care Association, for example, representing family practitioners, general practitioners, internists, OB/GYNs and pediatricians as PCPs, has played a major role in the implementation of that state's behavioral health carve-out. In most rural areas, physicians assistants and nurse practitioners supplement these medical specialties. Presbyterian Medical Services (PMS), a major primary care provider in the northern part of New Mexico, has used its network of federally-qualified health centers (FQHCs) to integrate mental health services by staffing physicians and psychiatrists in all sites (Enright 1998).

BEST PRACTICE 3

Addressing Lack of Essential Services and Personnel through Credentialing

Perhaps the most challenging issue for managed mental health delivery in rural areas appears to be having sufficient number and type of mental health providers in the network. Because industry standards for credentialing have been considered too stringent to meet in rural areas, some states have allowed credentialing of the organization or practice group rather than of the individual practitioner. In Iowa, MBCI modified its credentialing standards to fit utilization management guidelines for a broad array of clinical and psychological social service programs (Micali, P., Nardini, C.W. 1996). Best practices in credentialing are addressed in more detail in an accompanying paper in this series.

BEST PRACTICE 4

Integrating Primary care and Mental Health Services

Another trend in behavioral managed care is the integration of these services with medical services. This has been a long-standing challenge for managed care organizations as well as behavioral health organizations, partly because medical professionals have traditionally separated mind from body, and more recently because carve-outs of behavioral health reinforce this separation in the delivery of care. A recent recommendation of the National Advisory Committee on Rural Health stated that "This practice is not only inconsistent with holistic concepts of integrated health care, wellness, and prevention, but perpetuates the historic separation of care for persons with mental illness and addictive disorders."

(DHHS, 1998) In 1997, the National Committee on Quality Assurance (NCQA) set as a goal the coordination of behavioral health with medical care by “requiring evidence that individual practitioners and providers are coordinating a patient’s behavioral and medical care across delivery systems” (NCQA Standards for the Accreditation of Managed Behavioral Healthcare 1997).

Since primary care physicians are so active in the provision of mental health services in rural areas, it is not surprising that “a strategy increasingly used to bring mental health services to rural areas is the integration of mental health and general medical services in a unified clinic structure”(Geller et al. 1997). Successful integration of PCPs with mental health and substance abuse treatment programs was documented in a study by Bird, Lambert and Hartley in 1995. They found that over 50 percent of the integrated models were found in federally-funded CHCs, with the remainder occurring in rural hospitals, health departments, rural HMOs and rural private physician practices.

Nonetheless, the Maine Rural Health Research Center found that “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 …There appears to be more cooperation [between primary care providers and mental health centers] because of the need for rural providers to collaborate given limited resources in rural areas (Lambert et al. 1998).” This natural tendency can be reinforced, however, as in Colorado, where the legislature mandated that all mental health referrals go to the designated mental health contractor. While national standards (e.g. NCQA) and “urban carve-out” models also seek the integration of mental health and medical services as a goal, the infrastructure of rural communities — based on extensive reliance on primary care providers — naturally supports this approach. Behavioral managed care may provide the incentive to actually achieve this goal.

BEST PRACTICE 5

Increasing the Managed Care Expertise of Providers through Training

Since rural areas differ from urban areas in their mix of providers, most of whom have had limited exposure to managed care, training and technical support have become important components of provider relations functions within many MBHOs. Depending on the nature and levels of experience of local professionals, providers may require a range of education and training programs — from understanding how managed care works and how to use medical necessity criteria and case management, to how to use information systems—to effectively transition to a managed care environment. In Montana, continuing education programs on mental health issues were offered to enhance the skills of the primary care providers. In Iowa, Phil Micali (1997) recalls:

> “ Considerable MBHO effort went into showing providers what these reports meant, and how to use them to monitor their own practice patterns. Information management is the key to good clinical management as well as infrastructure development...this is a strength of managed care models that can help to empower rural areas and consumers...”

In Tennessee, a major intervention by a Management Services Organization (MSO), Psychiatric Management Resources (PMR), was necessary to assist community-based providers in meeting the demands of the TennCare Partners Program (TPP), which was managed by two MBHO - managed care organization partnerships, Tennessee Behavioral Healthcare (TBH) and Premier, since its inception in July, 1996. According to Womack and McCleery (1997):

> Mental Health Cooperative (MHC), the result of a major planning effort at the state and county levels, was established in 1993, as a not-for-profit, free-standing core service agency with a mission of providing integrated service delivery for SPMI adults in Davidson County, TN (Nashville area). With "limited capital resources, a lack of standardized service technologies and limited business management resources, there was no assurance that the agency would be able to reliably maintain and enhance the *capacity* to work effectively in a managed care environment."
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> …Entering into an agreement in 1995 with Psychiatric Management Resources (PMR), MHC obtained PMR services including "training in, and support for implementation of a specific, standardized service delivery technology called Collaborative Care; a financial model for case rate financing of case management services in a managed care environment; front-end, and ongoing capital support to enable workforce expansion, and investment in necessary technical infrastructure (e.g. MIS support); contract negotiations with MBHOs, and basic business, operations and evaluation systems."

To assist federally-funded community-based mental health and substance abuse providers in states with behavioral healthcare initiatives, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Managed Care Initiative plans to provide managed care readiness training on a variety of managed care topics, such as quality and utilization management, provider network issues, data management and MIS, and capitation and financing issues, for community-based providers becoming part of MBHO networks.

BEST PRACTICE 6

Coordinating Activities Among Governmental Agencies

While the state's Medicaid program often assumes responsibility for paying the managed care contractor — either a selected MBHO or other providers — it frequently partners with another state agency, such as the Mental Health and Developmental Disabilities agency (Oregon) and/or the Department of Health Services (Arizona) to monitor performance. Depending upon the state, different agencies spearhead managed behavioral health development. For example, in Massachusetts, the Medicaid Division has primary authority over decision-making, though it works with other state agencies, such as the Departments of Mental Health, Public Health and Social Services. In Montana, the Division of Addictions and Mental Disorders, under the newly-reorganized Department of Health and Human Services (DHHS), *manages* the contract because of its knowledge and relationships with service providers and the needs of its constituencies, while the Medicaid Division, also within DHHS, *monitors* it.

Colorado plans to tighten its requirements in the next round of contracts to include better coordination with the EPSDT program, as well as better coordination between Medicaid and the public mental health system in treating members of the same family with different program eligibility.

Understanding the working relationships between Medicaid and various state agencies overseeing mental health and substance abuse services is a key success factor in planning infrastructure which is efficient and of high quality. MBHOs can benefit from being informed about such issues as what needs have been assessed, whether resources are pooled, where policy and management decisions are made, and which agencies have politically active constituencies.

BEST PRACTICE 7

Making Optimal Use of Community Services and Resources

In order to augment existing professionally-trained providers, many alternative methods for providing mental health services have arisen using "natural helpers," paraprofessional, and self-help resources (Geller, J.M., Beeson, P., Rodenhiser, R. 1997). These natural helpers, defined as "those within the community people naturally turn to for help," may consist of clergy, the police and local sheriff, often playing the role of a social service agency (Geller et al. 1997). Linkages with this community-based support system are essential to developing a comprehensive continuum of care in rural areas. Often these services serve as connectors between health care consumers, providers and community services such as law enforcement, churches, and local physician practices (Witmer et al. 1995).

The Indian Health Service (IHS) has employed paraprofessional Community Health Representatives (CHRs) since 1968, linking Native American consumers with medical and mental health providers with IHS clinics and hospitals. These CHRs provide assistance with transportation, medication, appointment scheduling and problem identification — all of which can enhance the effectiveness of mental health services. Paraprofessionals have also been employed in Colorado staffing "crisis homes" to provide needed services and to keep rural persons out of state hospitals (Wackwitz & Wilson 1992).

BEST PRACTICE 8

Partnering with Community Mental Health Centers

In many rural areas, CMHCs are the foundation for mental health services delivery. Most managed behavioral healthcare organizations include CMHCs as part of their network, though both the level of understanding of managed care and management capabilities in these organizations vary widely, and their inclusion is sometimes controversial. Several CMHC directors in Colorado and Oregon cited the benefits of capitation when it comes to providing whatever services are needed, such as community rehabilitation services previously not reimbursed under fee-for-service (FFS) (Lambert et al.). In other cases, however, the information systems are very underdeveloped, hampering the ability to monitor the

utilization patterns of patients and providers, provide more integrated service delivery and effectively manage capitated providers and services.

In states where the existing infrastructure consists primarily of CMHCs, county mental health programs and other community-based providers, these organizations have either formed networks among themselves, as in Colorado, Oregon, Utah and Washington, or contracted with managed behavioral healthcare organizations, as in Iowa, Massachusetts and Nebraska. While providing a continuum of traditional services, some rural providers have either created or expanded services like 24-hour hot lines, using trained mental health paraprofessionals or 24-hour patient call-in lines staffed by emergency room psychiatric nurses in order to enhance access to hard-to-reach rural areas. In Iowa, according to Phil Micali, “the linkages between a CMHC and the state hospital [were so effective that they] provided the basis for collaboration over a multi-county area.”

BEST PRACTICE 9

Using Appropriate Telehealth Technologies to Reach Remote Consumers

Mental health services provided through telecommunication systems include continuing education and training, medication reviews, assessments, psychiatric supervision and case review, and involuntary commitment appraisals. Case conferences have been held between psychiatrists, primary care physicians, mental health professionals, and other allied health personnel. Administrative activities such as meetings, information transfer and utilization review are also supported. Consumers also make use of electronic communication, including the Internet “chat groups” for support groups and self-help. While controversial in some professional circles, these methods do meet real needs where few alternatives are available.

The use of telecommunications technology — ranging from telephone and fax to live interactive video — for providing mental health services is growing in rural areas. Walter La Mendola (1997), a member of the Frontier Mental Health Services Resource Network, summarized many of the projects currently underway, as follows:

> “...The Joint Working Group on Telemedicine (JWGT) identified 28 projects providing mental health services, six of which are found in Alaska, Colorado, Kansas, Montana, Nebraska, and South Dakota (JWGT, 1997).....A 1997 Abt Associates study found 159 non-federal rural hospitals and other providers using telemedicine, 31 percent of which was for telepsychiatry. Mid-Nebraska Telemedicine Network reported the largest single specialty usage for mental health consults in 1996. Greatest prevalence was found in the Rocky Mountain area. Interestingly, the Internet, a relatively low-cost approach has not been exploited for this purpose, possibly because service connections are just not available in these areas.”

RODEO Net (Rural Options for Development and Educational Opportunities Network), established in Eastern Oregon in 1991, represents a successful application of telemental health. It uses RODEO Net for training professionals and paraprofessionals, crisis response

through access to an on-call psychiatrist to help persons in extreme behavioral or emotional turmoil, medication consultations and management, interviews for pre-admission, pre-discharge and transfers, pre-commitment and psychiatric review board hearings (LaMendola 1997).

Telemedicine applications in behavioral health are not problem-free. Most telemedicine systems are now supported by federal government funding rather than by MBHOs and the effectiveness of these services in improving access and quality has not been sufficiently studied. Nonetheless, this innovation is being employed more and more by rural hospitals and other providers. As Geller et al. have pointed out (1997), "as managed care continues to penetrate rural markets, the use of telecommunications will dramatically increase," due to its efficiencies in time and distance — two significant cost factors if human resources, transportation and satellite clinics are the only alternatives for reaching rural populations.

BEST PRACTICE 10

Addressing Infrastructure Development Through Needs Assessment

States embarking on Medicaid behavioral healthcare approaches usually issue extensive Requests for Proposal (RFPs) with requirements for a needs assessment, procurement and contracting, reporting, and implementation. In response, most behavioral healthcare organizations conduct some form of needs assessment. Whether formal or informal, the purpose is to gain an understanding of the local populations-in-need and resources available and also to adequately respond to state RFPs. The needs assessment also serves as the basis for monitoring the performance of the system over time.

Sources of information may include community-based mental health and substance abuse providers, advocacy groups such as the Alliance for the Mentally Ill (AMI), and relevant state agencies. Data have been collected through various methods, including surveys, focus groups, as well as consultation with advisory groups of representatives developed to provide ongoing needs assessment.

In Iowa, for example, Merit Behavioral Care of Iowa (MBCI) coordinated with the state's Department of Human Services to conduct public meetings with consumers and professionals, and then put in place an Advisory Group of consumers and providers to offer ongoing input regarding access, availability and comprehensiveness of services. During the implementation of Iowa's MHAP, the Alliance for the Mentally Ill of Iowa received funding from its national parent organization to monitor the implementation from the family and consumer perspective. When the results pointed to inadequate services in specific areas, MBCI worked with AMI to fill the services gaps, and demonstrating a successful partnership between the MBHO, consumers and providers.

Conclusion

Montana's Kip Smith captures the essence of the rural experience with behavioral health care: "You cannot apply the urban model to rural areas," Smith reports. "Rural areas lack traditional mental health infrastructure; have tremendous geographic spaces (Montana has 2 urban counties of a total of 56), and do not have the "critical mass" that managed care requires."

As this review illustrates, building infrastructure for successful rural managed behavioral healthcare networks remains a challenge — as well as an opportunity with both promise and pitfalls to overcome.

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