

**CHALLENGES IN SERVING RURAL CHILDREN AND ADOLESCENTS  
UNDER MEDICAID MANAGED BEHAVIORAL HEALTH CARE**

**Presented by David Lambert, Ph.D.**

The State of Maine began an initiative, the Maine Dual Diagnosis Demonstration Project, on co-occurring disorders 6 or 7 years ago. The Cumberland County Diagnosis Collaborative began during that period of time and has continued since then. Often these projects and grants come and go, so it is unusual that the Collaborative has continued to flourish and is sponsoring a conference like this today, 6 years after its conception. It is very heartening because it is often very hard to put in practice these wonderful ideas with all the other competing interests that happen in health services today.

**BACKGROUND**

***GROWTH OF MEDICAID MANAGED BEHAVIORAL HEALTH (“MMBH”) IN RURAL AREAS***

One of two major areas of concentration at the Maine Rural Health Research Center at the Muskie School of Public Service is mental health. Over the last 3 or 4 years, the center has been looking closely at what has been happening nationally under Medicaid managed health care and specifically the mental health and behavioral health care that have been brought under it. A vast majority of the states have undertaken Medicaid managed care initiatives in contrast to Maine, which has not gone forward with managed care for behavioral health. These managed care initiatives almost always include and target children and adolescents. The experiences, however, are relevant to Maine because (1) Medicaid managed care will come to Maine, although there is a good chance that by the time it comes here, it will look different; and (2) the issues other states have wrestled with are similar to the issues that face Maine.

Thirty-five states have implemented Medicaid managed behavioral health and in 22 of those states there is a large rural area being served. That list includes states such as Maryland, Connecticut, Vermont, Washington and Wisconsin. Medicaid managed care typically includes different populations, a primary care population and special populations. The primary care population typically is the AFDC/TANF population. The benefit for mental health and

behavioral health care is usually modest, around 20 visits, and includes children for an initial intake or assessment. For the special populations under Medicaid managed care there usually is a triggering mechanism to determine Medicaid eligibility. The criteria vary from state to state but generally include children with serious emotional disturbances, adults with serious mental illness, and, increasingly, older persons who are dually eligible for Medicare and Medicaid. These varied populations are important because it means that under managed care the states are responsible for serving these various groups, which have a lot of competing demands. And everyone says “Yes, we can do it,” but they start and then run into difficulties. They then have to re-bid the contracts, usually with less money available in the second bidding cycle.

### ***CONCURRENT INITIATIVES/TRENDS AFFECTING SERVING CHILDREN UNDER MMBH***

There are also a number of concurrent initiatives occurring across the states that affect the services for children and adolescents under Medicaid managed care. A number of states are moving to increased management of child welfare services through welfare reform. In addition, the Family Preservation Act passed in the mid-90's poured a lot of money into states at the same time as they were going to managed care. Moreover, the so-called CHIP Programs (child health insurance programs) also have enabled states to use more money for covering children who otherwise do not have insurance. Some states are only beginning to realize fully this source of revenue. These various revenue streams have caused access and utilization to actually increase. However, at the same time, in-patient facilities for children have closed, so the services have shifted from in-patient settings to the community with the managed care company or the state Medicaid program managing the financial risk. Consequently, the additional dollars and the political backing may look good in the short term but from a longer-term perspective many of these states now have run into difficulties.

### **CHALLENGES**

#### ***EXCLUSION/LACK OF COORDINATION WITH SUBSTANCE ABUSE UNDER MMBH***

The challenge to serving children as well as adults under Medicaid managed care is that often there is an exclusion of a lack of coordination with substance abuse services. The progress that had happened in many states has taken a step backwards under managed care. Because of all

the challenges involved with integration under managed care, substance abuse benefits typically were left under the physical health benefit while separate programs were created for mental health or behavioral health. This has made coordination even more challenging. This separation is particularly serious for rural care where there is already a limited infrastructure of all types of services: transportation, facilities, specialized services, etc. Managing care across systems of health, behavioral health, juvenile justice and education becomes more complex with additional system boundaries.

### ***DIVERSE FUNDING STREAMS***

Under diverse funding streams from separate systems, the substance abuse benefit often pays less than the mental health benefit. As a consequence, the incentive is to just keep billing on the mental health side and ignore the substance abuse issues. Sometimes you get the consult and sometimes you do not. If you do get the consult, how do you bill for the collateral contact? These double binds are not new but they have not been solved by managed care either. The actual practice of blending the funding streams has been limited in actual practice.

### **PROMISING PRACTICE AREAS**

#### ***ENHANCING ACCESS***

In rural areas there are few specialty mental health providers. The front line workers often are not credentialed or licensed. This is an issue for managed care programs because they typically create a list or panel of approved providers with specific qualifications. The managed care companies are under a lot of pressure with quality assurance to monitor and be responsible for the panels so they tend to be more, rather than less, restrictive. That is a problem in rural areas where there is a scarcity of licensed providers. A good example of this is in New Mexico, where new social workers cannot be reimbursed under the Medicaid managed care system until they have had two years of supervision. It becomes a “Catch-22” problem to get them licensed because you need the licensed provider for the supervision, but if you had enough licensed providers you would be able to provide the service in the first place. Some states have been successful in getting waivers around those rules.

Although treatment facilities are closing there is still a need for some limited beds. The

question becomes how many. Practice standards about medicating children and the reimbursement mechanisms for community medication regimens often change and therefore it has been very difficult to determine the actual hospital need. Avenues that managed care companies are exploring in rural mental health to increase the access and manage utilization are the emerging fields of telemedicine and physician extenders for prescription practices.

## ***MANAGING CARE ACROSS SYSTEMS***

### **Flexible financing**

Flexible financing is one mechanism to pay for what is needed rather than just for existing programs. This problem has been around for a long time and one would expect that it could be solved under managed care. Medicaid managed care has done away with fixed fee schedules and in most states, even though they do have approved lists of services, it has actually increased the number of services that can be reimbursed. Sometimes very important services that were not reimbursed under a typical Medicaid fee schedule, such as family counseling, anger management, and group therapies, are now reimbursable. There is more freedom to create flexible financing. But having said that, the problem is how do you really do that and how do you maintain it where there are different people and competing interests that want different priorities.

### **Important Venues & Inter-Organizational Issues**

Very important venues or settings must be included in managed care if children and adolescents are really going to be served better across the continuum. Treatment and linkage must be established among the human services, the juvenile justice systems and the schools. Again, the question is how do you open up the venues while maintaining control and assurance of quality of care. Issues around the lines of authority, how to determine eligibility, coordinating multiple case managers, exchanging records and information all need to be clarified and put into place.

## ***REDUCING STIGMA***

Stigma to mental illness is a significant issue across the nation. For children and adolescents it can be seen when someone is first referred or even when there is a hint that there

might be a problem. Family issues and problems the person is facing compound the stigma. And then add, particularly in rural areas, the attitude to "mind one's own business" and the layers of nested problems become immense.

## ***PROMISING PRACTICES***

### **New Mexico**

I want to give you a quick snapshot of two states, New Mexico and Oregon. Both have well established managed care programs, and have taken children and adolescents health care very seriously. In New Mexico, the general Medicaid Managed Care model is a carve-in model. They do not have separate mental health programs under Medicaid Managed Care. They have 3 large Managed Care Organizations ("MCO") that collectively serve the whole state and provide choice. They are very different programs, with each one responsible for partnering or sub-contracting out to a behavioral health organization that specializes in managing behavioral health care in the regions they serve. There is more integration between mental health and primary care in this model and yet you still have the specialists that come in and help you. The largest MCO is Presbyterian Medical Services. It is well established and is a very sophisticated health network. They are primarily located in the Santa Fe area and serve all the way up to northern New Mexico. Another MCO is in the middle of the state, and a third MCO in the southern border area, which is actually a collaborative of all the community mental health centers that existed before managed care. This southern border area is a very Hispanic area, and the local providers basically pooled together. As a local group it is able to meet the cultural needs of the area that might not have happened with an outside group coming into the area. New Mexico is very rural and poor. The southern part of the state has more people of Mexican origin; the northern part of the state has people of more Spanish descent, going back centuries. There are a lot of distinctions between these groups that is very much reflected in the service networks.

Serving children has been very challenging in New Mexico because of several things. There is a tremendous level of need with limited resources. Almost all the treatment facilities in the state were closed prior to managed care or concurrent with managed care, which has shifted care into the community. The infrastructure in the communities was not there and managed care reduced reimbursement for both in-patient and outpatient care. And then, with the limitations

imposed by the provider panels, providing care was difficult. New Mexico is slowly addressing some of these issues. There is some movement toward getting more reimbursement to the service level and they have been able to work with the state toward relaxing some of the requirements of who can be reimbursed.

## **Oregon**

Oregon has a very ambitious approach to managed behavioral health, the Oregon Health Plan. They have been much more willing to allow for experimentation. In a nutshell, what Oregon has been trying to do is allow more local input into what happens in service delivery. They have allowed different models that range from fully capitated managed health plans to mental health organizations that are usually a collaboration of local providers. In Oregon, as in New Mexico, there is a lot of high need among the children and adolescents in terms of assessments, alcoholism and drug abuse. Again the experience in Oregon, as it has been elsewhere, has been that the substance abuse treatment has been very difficult to integrate. Substance abuse continues to be a separate service under managed care with different reimbursement rates. Two rural areas in the State have worked hard to make the system work. An area of 5 counties spanning from the coast to the central part of the state, called the Accountable Behavioral Health Alliance, report that they have been able to take advantage of the flexibility under managed care to offer services tailored to adolescents and children that were not previously offered. They also have been able to gain relief from the credential guidelines of the provider pool through an appeal process. Another area, Josephine County, which is in the southern part of the state, on the California border, is an area that has been bypassed by any economic boom. The young adults leave the area and the young and elderly are left. They have created a system for wrap-around services but have not been able to do much about coordinating across venues yet. The successes under Medicaid managed care are only just emerging on a state-by-state or region-by-region basis. The work still happens by person to person and by agency to agency.

## **MAINE CONTEXT**

Maine does have an extensive telemedicine capacity, however, it is has been difficult to get mental health providers to fully utilize the resource. Maine, as elsewhere, has found that

there is a lot of resistance to utilizing telemedicine without first having established trust and relationships. Some of the proposals here in Maine and across the nation involve developing and training teams before taking it out into the field. And even with this, telemedicine does not work well for on-call schedules or emergencies. An example of its use for physical health is when someone has been hospitalized and they go home to a rural area where access is difficult, especially during winter months. They can take home a unit that can take all their vital signs through a health on-line and transmit back to the doctor's office to determine if they need to be seen.

As to Maine's use of physician extenders, we are probably under-utilizing our ability to do this. Oregon and a few other states have allowed non-physicians to prescribe medications pretty openly. It usually entails supervision and a consult back with the psychiatrist. Again, to make this work, it requires developing a prior relationship.

Also, another thing that can happen under Medicaid managed care with children and adolescents is cost shifting. The cases that are high utilizers under capitated-managed care are shifted back to child welfare with its fee for service. Some states have made explicit criteria to stop this.

In Maine and Washington, Regional Children's Cabinets have been established that have brought together the various state departments that serve children to assist with cross-system coordination. Their various initiatives are making changes in care, however, the questions are whether their activities are going to be officially endorsed by the government as a public document, whether they have the "hammer" to make them work, or whether they will need managed care. The Children's Cabinets provide a needed function for coordination, however, the question will be how will the Children's Cabinets be integrated into managed care when it comes and how can they can continue to keep the heat and incentives on integration.

## Reference

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**About the Presenter**

David Lambert, Ph.D., is an Assistant Research Professor of Health Policy and Management at the Muskie School and Research Associate in the Maine Rural Health Research Center, funded by the Federal Office of Rural Health Policy, DHHS. Dr. Lambert was the Principal Investigator of Maine's Dual Diagnosis Demonstration Project (a random-assignment longitudinal study of person with co-occurring mental health and substance abuse issues). He has directed several studies tracking the implementation, effects and best practices in delivering Medicaid Managed Behavioral Health in rural areas. Dr. Lambert was co-chairperson (1991 – 1994) of the Bingham Mental Health Research Study group, which sought to foster collaboration among researchers, providers, consumers, and state policymakers. Dr. Lambert currently serves on the Board of the National Association for Rural Mental Health (NARMH) and was conference chairperson of the 1998 NARMH Annual Conference held in Portland, Maine.

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