

The Impact of Mandatory Managed Care for Medicaid Clients on the Delivery of Mental Health Services to Children and Adolescents in Rural Pennsylvania

**A report by
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March 2007

Executive Summary

This study compared the mental health outpatient services used by rural and urban children enrolled in Medical Assistance. Specifically, the research analyzed the authorization and utilization rates for children who live in rural and urban counties within the state's HealthChoices program areas as well as those who live in counties outside the HealthChoices program areas.

The HealthChoices program is a managed care program that began in the late 1990s. Pennsylvania Medical Assistance recipients were required to enroll in the program as it was rolled out to various counties. While the program was to be implemented statewide by 2005, budget constraints prevented the program from being fully implemented in every county.

The major findings from this study were that:

- Behavioral Health Rehabilitation Services (BHRS) are more likely to be used in a fee-for-service (FFS) system, regardless of whether the area is rural or urban. BHRS services, unlike many other mental-health-related services, are not delivered in a designated mental health facility but typically are delivered in the client's natural environment, such as the client's home or school. Therefore, service providers must travel to the client instead of the client traveling to the service provider.
- Counties with the HealthChoices program show higher rates of children's outpatient services than FFS counties. Furthermore, children in rural counties were somewhat less likely to receive outpatient services than children in urban counties; this disparity was amplified in FFS counties. Children's outpatient services are typically delivered in mental health clinics and require clients to come to the service provider.
- MA eligible children and adolescents in rural Pennsylvania are less likely to receive outpatient mental health services than children and adolescents living in urban counties. This difference cuts across regions and methods of reimbursement. For BHRS services, however, there was no difference in delivery rates.

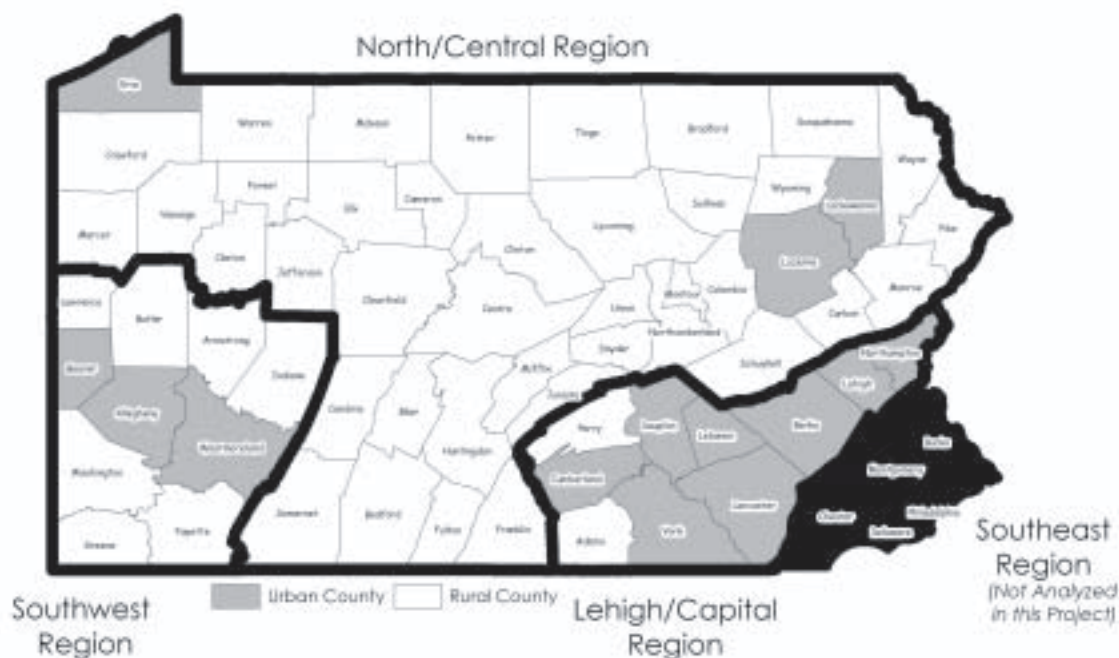
Introduction

In 1997, Pennsylvania began implementing mandatory managed care for Medical Assistance (MA) recipients. The program, HealthChoices, was first implemented in the southeast portion of Pennsylvania, consisting of five urban counties surrounding Philadelphia. In 1999, HealthChoices was expanded to a 10-county area surrounding Pittsburgh in the southwest region and, in 2001, was implemented in the 10-county area of the Lehigh Valley and Capital regions. The final stage of HealthChoices was to be implemented in the north/central region between 2003 and 2005, but was postponed due to state budget constraints.

This project was sponsored by a grant from the Center for Rural Pennsylvania, a legislative agency of the Pennsylvania General Assembly. The Center for Rural Pennsylvania is a bipartisan, bicameral legislative agency that serves as a resource for rural policy within the Pennsylvania General Assembly. It was created in 1987 under Act 16, the Rural Revitalization Act, to promote and sustain the vitality of Pennsylvania's rural and small communities.

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Pennsylvania Rural and Urban Counties and HealthChoices Regions



Mental Health Services and HealthChoices

Mental health services to MA recipients are provided through a behavioral health care component in HealthChoices. One goal of the HealthChoices program is to improve access to and the quality of health services for MA consumers. Another goal is to stabilize Pennsylvania's MA spending. MA spending is stabilized by transferring risk from the state to the managed care organization (MCO) through a capitation agreement in which the MCO is paid a fixed-fee, based on the number of enrolled MA consumers. The MCO, in return, is required to provide all medically necessary treatment. Simply put, the MCO makes money if the cost of the services it pays for is less than the amount of the capitation payment.

A number of concerns have been raised about the applicability of managed care solutions to health care delivery in rural areas. One concern is that commercial MCOs do not operate as efficiently in rural areas as they do in urban areas. This is because of the difference in economies of scale and the unique barriers to service access in rural areas. Several states, such as Colorado and Iowa, have developed incentives for their MA MCOs to enter rural service areas and maintain high utilization rates. Those incentives range from tax breaks to reduced regulatory requirements to partial capitation programs (National Rural Health Association, 1999). Currently, Pennsylvania has no incentives unique to rural areas. The absence of such incentives may inadvertently result in providing fewer treatment services to rural Pennsylvanians in contrast to services provided to urban Pennsylvanians.

Project Objectives and Methods

In order to evaluate whether rural residents are receiving less treatment services, this project looked at authorization and utilization rates for children and adolescents enrolled in the HealthChoices programs. The project had two components. The first was to analyze the authorization and utilization rates for mental health services provided to rural and urban children enrolled in the HealthChoices program. This was done by using the actual rates and risk-adjusted rates for two specific groups of child/adolescent mental health services: Behavioral Health Rehabilitation Services (BHRS) for children and adolescents, and outpatient services for children and adolescent. The second component was to compare the authorization rates for BHRS and child/adolescent outpatient treatment for counties with non-HealthChoices programs, such as fee-for-services (FFS). In addition to rural/urban comparisons, these data permitted a comparison between authorization rates in FFS and HealthChoices counties.

Data Sources

There were two primary data sources used in the analysis. The first was the Early Warning Monitoring Program (EWP), collected by the Pennsylvania Office of Mental Health and Substance Abuse Services. The EWP is a set of indicators that would allow an "early warning" detection of implementation problems with the HealthChoices program.

The second data source was information about BHRS and children's outpatient services in non-HealthChoices counties from the Office of Mental Assistance Program, Bureau of

Planning, Budget, and Policy. In those counties, mental health services for MA consumers are covered through an FFS program. These data were unduplicated counts of authorizations for each FFS county for all quarters from 1999 through 2003.

The analyses were based on estimated rates per 1,000 eligible MA recipients per county. Counties were considered rural if their population density was below the statewide average of 274 persons per square mile. All other counties were considered urban. The map above illustrates the HealthChoices regions and rural and urban counties.

For the study, authorization meant a HealthChoices participant was approved to receive a specific type of mental health service. Utilization meant the participant actually received the authorized service.

There are typically two types of non-hospital services that are provided to children and adolescents in the MA program: Outpatient treatment and BHRS. Outpatient treatment involves weekly sessions administered in a mental health clinic to children with less severe emotional or social problems. In contrast, the BHRS treatment, which is offered to those with more serious emotional or social problems, occurs in the client's natural environment, such as at school or home, several days a week, and requires providers to travel to the client. Because BHRS service providers must travel to geographically distant and dispersed locations, rural service delivery is more costly than urban service delivery.

Results

BHRS Services

Between 1999 and 2001, there was no statistically significant difference in the rural and urban BHRS authorization rates in the southwest region. The median rate for service authorization in rural counties was 18.7 per 1,000 eligible children and in urban counties was 17.0 per 1,000 eligible children.

In the southwest region, the BHRS utilization rates for both urban and rural counties showed a slight increase between the first quarter of 2001 and the first quarter of 2003. The median rate per 1,000 eligible children for rural counties was 21.4 and for the urban counties was 18.3.

When the utilization data for both the southwest and Lehigh/Capital regions were combined, a very different picture emerged. The median utilization rate for rural counties was 17.1, and is a marked contrast to the median urban rate of 32.9.

The north/central region funds its BHRS services through an FFS mechanism. The data collected for this group of 42 counties consists of authorization rates from the first quarter of 1999 through the fourth quarter of 2003. There is a consistent increase in utilization across the time period for both urban and rural counties. Furthermore, there is little

difference in the median utilization rate of 37.7 for the rural counties and 38.6 for the urban counties. Note, however, that the utilization rates in general are considerably higher for the north/central region than for the southwest and Lehigh/Capital regions, which operate under HealthChoices rather than an FFS program.

The difference in the impact of mandatory managed care in the utilization rates in urban and rural areas can be seen in the comparisons among the north/central, southwest and Lehigh/Capital regions. Within each of these regions, there were no urban/rural differences. However, the rates are significantly higher in the northern FFS counties. Both urban and rural counties in HealthChoices have lower rates, but there is a disparity between the urban and rural counties as noted earlier.

Children's Outpatient Services

Between 1999 and 2001, the rates of authorization for children's outpatient services in the southwest region were higher than those for BHRS services. The median rate for the rural counties was 36.7. This value was quite similar to the median urban authorization rate of 34.5 indicating that there was not a significant difference between the two.

For children's outpatient services, there were no differences in the utilization rates for the southwest rural counties (52.3) and urban counties (52.2). However, there does appear to be a change in the rates for urban and rural counties between the first year of utilization data and the last year. In rural counties, the rate decreased from 56.7 to 48.3, while in urban counties the rate increased from 52.7 to 57.3.

The utilization rates for the aggregated southwest and Lehigh/Capital regions showed a median rate of 46.5 for rural counties and 48.9 for urban counties. This difference was not statistically significant.

Rates of outpatient authorization for the north/central regions were much higher than the corresponding rates for HealthChoices counties and also showed a uniform and highly significant difference between urban and rural counties. Between 1999 and 2003, there was a consistent linear increase for all counties in the study, similar to the increase shown in BHRS services. The median children's outpatient authorization rate for rural counties was 60.2 and was significantly lower than the urban rate of 84.6.

Conclusions

BHRS Services

BHRS services, unlike many other mental health related services, are not delivered in a designated mental health facility, but typically are delivered in the natural environment, such as the client's home or school. This requires that service providers travel to the client rather than vice versa. According to the research, BHRS services are more likely to

be used in an FFS system, regardless of whether the area is rural or urban.

Children's outpatient services

Children's outpatient services are typically delivered in mental health clinics and require clients to come to the service provider. In contrast to the results for BHRS, the research found some effects of rurality on children's outpatient services. Specifically, counties with the HealthChoices program showed higher utilization rates for children's outpatient services than FFS counties. Furthermore, children in rural counties were somewhat less likely to receive outpatient services than children in urban counties; this disparity was amplified in FFS counties.

Urban/Rural Differences

Overall, MA eligible children and adolescents in rural Pennsylvania were less likely to receive outpatient mental health services than children and adolescents living in urban counties. This difference cuts across regions and methods of reimbursement. For BHRS services, there were no differences in delivery rates, perhaps because service providers travel to the client to deliver BHRS services while the client must travel to the provider for outpatient services.

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