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Rural Mental Health Coverage Under Health Care Reform

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ABSTRACT: Efforts to integrate services and financing under health care reform hold benefits for provision of services to rural mentally ill persons. Remote areas pose a particular challenge as the unique characteristics of rural America are even more evident. The model for managed care in remote rural areas will differ from those used in urban and their adjacent rural areas. Universal coverage would remove the barriers to accessing care for this population, but does not assure availability of adequate mental health services or providers in rural areas. Characteristics of currently available rural mental health services are presented and obstacles to expanded delivery under health care reform are outlined.

INTRODUCTION

The unique characteristics of rural areas pose special challenges for health care reform. This is especially true when addressing the needs of the rural mentally ill. This paper examines the impact of current efforts toward health care reform upon the mentally ill within the context of rural America. The term "rural" is associated with areas of small and sparsely settled population and remote location. Two definitions of rural are commonly used for statistical and health program purposes (Hewitt, 1989). The Census Bureau definition is dependent upon settle-

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ment size and density and is more difficult to use. The Office of Management and Budget (OBM) definition is based upon county boundaries. With this definition, one or more counties form a statistical unit on the basis of population density and economic integration factors. A more detailed discussion can be found in a staff paper by Hewitt (1989) written for the Office of Technology Assessment. By either definition, approximately 15% of the US population live in rural areas (defined as communities with less than 2500 residents and/or in nonmetropolitan counties) (OTA, 1990). For the purposes of this paper, the term rural refers to nonmetropolitan areas as defined by OBM unless otherwise noted. For data presented, those states that have 50% or more of their population residing in nonmetropolitan areas are considered rural. Table 1 lists these fifteen states, their total population and percent of nonmetropolitan population.

The differences that exist between rural communities and urban ones have implications for development of rural mental health and health care systems. Population demographics reveal rural Americans to be slightly older, slightly less educated and more homogeneous in terms of

TABLE 1

States with More Than One-Half of Their Population Residing in Nonmetropolitan Areas

State	*Population (in 1,000s)*	*% of State*
Alaska	299	56.0
Arkansas	1,439	60.7
Idaho	809	80.7
Iowa	1,629	57.1
Kentucky	2,033	54.5
Maine	750	63.9
Mississippi	1,837	70.0
Montana	619	75.6
Nebraska	848	53.1
New Mexico	776	52.5
North Dakota	426	62.7
South Dakota	508	71.8
Vermont	416	76.9
West Virginia	1,217	63.4
Wyoming	361	71.2

race and ethnicity than metropolitan populations (National Mental Health Association, 1988). The population is sparse and distribution varies greatly between rural areas adjacent to urban centers and remote areas. Access to mental health services is limited by the geographic distances and compounded by the lack of public transportation and lack of outreach services (Human & Wasem, 1991). Reimbursement policies and regulations compound the limited accessibility through restrictions on the type of service and provider covered (OTA, 1992).

Health status indicators reveal that rural populations are similar to urban populations with the exception of a higher rate of chronic health problems (OTA, 1990). Higher rates of depression exist in rural versus urban areas and are thought to be intensified by the economic vulnerability of rural areas. Rural community studies suggest that approximately 10% of rural residents are in need of psychiatric care, but only 2–5% are treated (Flax, Wagenfeld, Ivens & Weiss, 1979).

Persistent poverty is characteristic of some rural settings. The unemployment rate is 50% higher, impacting the tax base and the chief means by which counties finance health, mental health and social services. Along with unemployment, rural people are less likely than their urban counterparts to have health insurance. The estimated rate for the uninsured is 15% higher for rural residents (National Association of Community Health Centers & National Rural Health Association, 1988). As working poor, they are also less likely to qualify for Medicaid. Similar to other uninsured groups, rural residents are likely to be more seriously ill when seeking treatment, receive less intensive services and receive services with greater variability in quality (OTA, 1992).

RURAL MENTAL HEALTH SERVICE DELIVERY

Recent information on mental health service delivery in rural areas is minimal (OTA, 1990). Based on survey data available, dramatic differences between rural and urban areas in the availability of local inpatient mental health services are noted. Sixty-three percent of urban counties had some kind of inpatient services in 1983 as compared to only 13% in rural counties (Wagenfeld, Goldsmith, & Stiles, 1988). In both rural and urban counties, general acute-care community hospitals are the most common providers of inpatient mental health care services. In rural areas, however, acute care community hospitals have fewer short-term psychiatric inpatient beds (avg. 1.5/hospital) than do urban community

hospitals (avg. 5.9/hospital) (OTA, 1987). This pattern holds true across every size hospital except for the very largest (Table 2), though variations by specific type of psychiatric service are noted.

Availability of comprehensive mental health services in rural areas is even more difficult to determine (OTA, 1990). Information available is limited and suggests that rural areas are less likely to have services. Where services are present, the range of services are narrow (Grusky & Tierney, 1989). Emergency services are particularly crucial in rural areas. As reflected in Table 2, rural community general hospitals provide more emergency psychiatric services than do their urban counterparts. Rural residents rely more heavily on crisis services than urban counterparts due to the lack of other alternative mental health services (Sommers, 1989). As with other mental health services, where crisis mental health services exist, they are more limited in scope than those found in urban areas (Miller 1982). Table 3 demonstrates the limited alternative services available in rural vs. urban states with a comparison of inpatient, outpatient and partial care treatment slots per 100,000 civilian population by different mental health organizations.

TABLE 2

Urban and Rural Community Hospitals Providing Psychiatric Services by Hospital Size 1987

	Rural				*Urban*			
# Beds:	*6–49*	*50–99*	*100–199*	*200–299*	*6–49*	*50–99*	*100–199*	*200–299*
Type Service								
child	.6	5.1	15.8	29.5	1.6	5.5	13.1	24.5
geriatric	.8	8.1	16.3	36.4	.8	5.8	17.7	33.6
emergency	11.9	14.7	27.9	53.8	4.9	12.7	32.8	50.1
education	1.1	6.0	17.1	37.1	6.1	9.9	18.8	36.4
consult	3.7	10.3	19.4	37.9	8.4	14.6	27.1	39.4
partial hospital	2.5	4.6	9.1	18.9	1.6	4.4	8.7	17.0
out-patient	2.5	4.5	9.9	24.2	2.0	5.8	12.7	22.6
substance abuse	2.3	8.5	14.6	73.5	5.7	11.0	20.3	29.1

TABLE 3

Comparison of Rural and Urban Treatment Beds per 100,000 Civilian Population by Type Mental Health Organization–1984, 1988

Type		*Rural (N=15)*		*Urban (N=36)*	
Organization/Service		*1984*	*1988*	*1984*	*1988*
State	inpt.	2.1	2.0	6.5	7.1
Hospital	outpt.	2.3	1.0	4.3	2.0
	partial	1.0	1.0	4.4	3.5
Private	inpt.	2.0	3.5	5.8	11.0
Hospital	outpt.	1.0	2.6	2.7	4.8
	partial	1.0	1.6	2.8	6.6
General	inpt.	8.2	9.1	31.5	35.6
Hospital	outpt.	2.7	2.8	13.4	12.3
	partial	2.1	2.6	9.8	9.2
VA Medical	inpt.	1.5	1.5	3.2	3.2
Center	outpt.	1.6	1.7	3.2	3.2
	partial	1.4	1.3	2.0	2.0
RTC	inpt.	2.4	3.2	8.4	11.0
	outpt.	1.2	1.5	2.4	4.4
	partial	1.7	1.9	3.2	5.4
MMHO	inpt.	7.7	4.8	16.3	12.7
	outpt.	9.2	10.2	26.5	27.9
	partial	9.8	10.0	27.7	29.9
Outpatient	inpt.	–	–	–	–
Clinic	outpt.	8.3	7.9	19.9	18.4
	partial	1.5	2.2	5.0	5.2

Source: DHHS, 1992

RURAL MANPOWER ISSUES

In rural areas, the availability of mental health professionals is limited. Seventy-three percent of all health manpower shortages are in rural areas (DeLeon et al., 1989). The number of full time staff employed in specialty mental health organizations increased 12% between 1984 and 1986, and 7% between 1986 and 1988 (Manderscheid & Sonnenschein, 1992). The most notable trend in rural states is the increased use of RN's in state psychiatric hospitals, general hospitals with psychiatric beds, private psychiatric hospitals and VA Medical

Centers. It is interesting to note that these same organizational types show decreases in FTE psychiatrists. This raises the question of whether RN substitution for lack of psychiatrists is occurring given their related roles in managing physicians orders, medications, supervision of treatment and advanced clinical nurse specialist practice.

Reasons for the limited number of mental health professionals in rural areas have also been attributed to professional isolation and low work satisfaction (Reed, 1992). Four of the rural states (Alaska, Idaho, Montana and Wyoming) have no psychiatric residency training sites and therefore, no trainees. Two of these states (Alaska and Idaho) have no clinical psychology trainees either. The distribution reflects that teaching hospitals and other training sites are frequently affiliated with medical schools and universities which tend to be located in or near population centers (Manderscheid & Sonnenschein, 1992). Rural mental health providers are often too distant to utilize university resources.

Reimbursement limitations also contribute to the limited number of rural mental health providers. The high rate of poverty and lack of insurance in rural populations results in dependency upon Medicaid and other public sources for reimbursement (Blendon, Donelan, Hill, Scheck, Carter, Beatrice & Altman, 1993). The lower rates of reimbursement from these programs limits the willingness of providers to accept these clients (NAMHC, 1993). Additionally, restrictions on reimbursement for type of service (community or in-home services compared to inpatient services) and type of provider (psychiatric clinical nurse specialists compared to psychiatrists) limits mental health providers as well as access to and availability of services (OTA, 1992).

RURAL UTILIZATION DATA

The most notable changes in both rural and urban states between 1984 and 1988 are seen in the growth of private psychiatric hospitals and general hospital psychiatric services. Freestanding psychiatric outpatient clinics show the greatest decline. Half the organizations providing mental health services in rural states show a decrease or no change in number of organizations while 87% of the organizations show increases in urban states. Availability of psychiatric services, as determined by number of mental health organizations, are greater in urban areas.

Utilization or occupancy rates for inpatient and residential beds varied as well. Nationally, the number of state psychiatric hospital beds

decreased as the occupancy rate increased (Manderscheid & Sonnenschein, 1992), indicating greater efficiency in the use of these beds. For the rural states however, both the number of beds and occupancy rate for state psychiatric hospitals increased between 1984 and 1988 (+ 15.4 beds per 100,000 and + 1% respectively) while urban states decreased beds (−10.6 beds per 100,000) and increased occupancy (+ 1.6%). This reflects the increased dependency upon state psychiatric beds by rural populations that in general have little or no insurance and few alternative services.

Private psychiatric hospital and general hospital psychiatric beds increased nationally as occupancy rates fell. This trend held in both rural and urban states. Rural states followed the national trend to increase VA and RTC (for emotionally disturbed children) psychiatric beds between 1984 and 1988, though occupancy rates decreased. A decrease in the number of multiservice mental health organizations (MMHO) was seen in rural states, while urban states showed a decline for both the VA and MMHO. This trend reflects privatization of inpatient services and emphasis on services that can be billed on a fee-for-service basis and are covered by third-party payers (Congressional Research Service, 1991).

Consumer preferences and provider referral patterns also influence delivery of rural mental health services. In a study of rural perceptions regarding mental health services, rural residents prefer to use their primary care givers for mental health problems, except in the case of serious mental illness (Flaskerud & Kviz, 1982). Estimates suggest that nearly half of mental health treatment is provided by general non-psychiatric physicians (Mechanic, 1993). Access to mental health services may be limited by this consumer preference as it has been shown that referral of mental health problems by general practitioners is rare, especially in rural areas (Verhaak, 1993).

The ability of rural areas to provide mental health services is limited within the current health care structure, and may be limited under the proposed health care reform plans as well (Shelton, Merwin & Fox, 1994). To include persons with mental illness in a health insurance framework, considerable capacity development is required. Mechanic (1993) suggests three basic alternatives for developing the capacity to manage disabling conditions (such as mental illness) in the general sector. First, existing programs can expand their services. However, the sparse population in rural areas makes it difficult to justify the development of new services and the hiring of new staff. Capitation can be designed to encourage coverage of rural mentally ill. Second, it may not

be worthwhile for providers to start-up and maintain mental health practices due to the sparse population of rural areas. Large managed care organizations can subcontract with the existing mental health providers. Inclusion of mental health benefits in a basic health insurance program would encourage programs to compete for contracts if they are to remain viable. A third option is to group clients that require intensive mental health services under a specialized mental health maintenance organization (MHMO) (Scheffler, Grogan, Cuffel, & Penner, 1993). Such organizations would receive an adjusted capitation and would be responsible to contract for all necessary general medical services (Mechanic, 1993). The MHMO would assume the responsibility to establish the necessary contract and manage the quality assurance and cost-control mechanisms. Current trends reveal a decline in the number of MMHO's in rural areas (Table 3), indicating some arrangement would have to be made to assure services were provided to rural areas.

MANAGED COMPETITION IN RURAL AREAS

Managed competition has been described as a change in the financial incentives for improving delivery and relies on capitation as a method to control the flow of funds from insurance pools to providers (Caper, 1993; Starr & Zelman, 1993). As a purchasing strategy, the rules of competition are used to reward those health plans that do best at improving quality and cutting costs with the most subscribers and revenues. Managed competition aims to divide providers in each community into competing economic units and to use market forces to motivate them to develop efficient services. Under managed competition, a sponsor contracts with various health plans to provide services to eligible persons (Patterson, 1990). Sponsors will vary, and include employers and Health Insurance Purchasing Cooperatives (HIPC). These sponsors would assume the responsibility to manage enrollment as well as create price elasticity through subsidies, information about quality of services and standardized benefit packages (Enthoven, 1993). Biased risk selection is a crucial issue for mentally ill persons under managed competition (Arons, Frank, Goldman, McGuire & Stephens, 1993). Thus far, insurers avoid coverage for severe mental illness due to the chronic nature and high cost of treatment (OTA, 1992). Under national health care reform, sponsors would have to be responsible to control for biased risk selection. Monitoring utilization and enrollment

patterns and use of risk adjusted capitation rates would compensate plans that provided coverage for mental illness, as well as other disabling diseases.

There is much debate as to whether or not rural areas can support competing health plans (Kronick, Goodman, Wennengerg & Wagner, 1991; Christianson & Moscovice, 1993). Enthoven (1993) suggests that competition "for the field" can exist where competition "in the field" cannot (p. 39). As suggested earlier, urban based plans may bid to establish and operate a network of satellite services. In areas where the population does not support its own doctor, several health plans could consolidate their purchasing power and recruit a physician from outside the community.

For rural areas adjacent to urban areas, the problem of providing services does not seem so formidable. A "trickle down" effect to these adjacent rural areas is easily envisioned. Health plans can then fill the gaps, for example, with either satellite clinics or provision of transportation to nearby urban centers, at some reasonable additional cost. Health plans serving rural areas will most likely contract with networks of local providers to provide services for enrollees through a free-choice-of-provider or preferred provider plans with regulated fee schedules (Christianson & Moscovice, 1993).

Remote rural areas pose a special challenge. Where the population is sparse and providers limited, costs have the potential to increase as health plans negotiate contracts. Providers in these remote areas are in these practices because of personal preferences making incentives to contract with health plans different than urban or even other rural providers. It has been suggested that these providers might form their own health plan (Christianson & Moscovice, 1993).

MENTAL HEALTH IN REFORM

The major thrust of health care reform is to provide basic care for all Americans, over the course of one's lifetime and without interruption. Under Clinton's plan, basic care includes health, mental health and substance abuse services reducing the need for a separate system for indigent care. Most importantly, by financing all care through the same system, coverage for at least basic mental health care can be improved immediately (Arons, Frank, Goldman, McGuire & Stephens, 1993).

Making the assumption that under health care reform, all necessary basic coverage including mental health services would be included, our attention turns to coverage for catastrophic illness. For those mental disorders of a more serious nature, how mental health services are defined will influence reimbursement for services. Restrictive reimbursement definitions have led to use of inpatient over outpatient care and medical over alternative psychosocial models. A broader definition allows flexibility, permitting substitution of services as client needs change. Under health care reform, the competition for reimbursement between types of care would be reduced, supporting development of alternative services. Addressing the needs of those persons with serious mental illness along with those persons with other long-term care needs (e.g. the elderly), shifts the focus toward managing all disabilities so as to maintain functioning and independence within the limits of individual capability. Health plans will need to balance between acute care and rehabilitative services.

More recent developments in mental health care hold promise for rural mentally ill individuals. Current efforts in development of comprehensive service systems have been found to be useful in caring for persons with serious mental disorders (Stein & Test, 1980). These service systems provide therapeutic (medication, counseling and education) as well as supportive services (housing and transportation). This approach wraps services around the individual with serious mental illness, utilizing a broad range of services, including existing natural support networks. Many problems associated with mental disorders are due to related social issues. Expanding coverage to include supportive services can only enhance the outcomes of care for mentally ill persons in rural areas. Affording the option to cover less intensive services may be less costly for those clients who in the past received more intensive treatment than needed because of coverage.

Case management services are gaining in popularity. Case managers assume responsibility and accountability for the full range of services provided to clients (Kanter, 1989). They assist clients in accessing services, and assure integration and continuity of services. Because case managers coordinate all services, they are in a key position to monitor utilization patterns and costs. As such, they would act as liaisons between mentally ill individuals and health plans.

The likelihood that these and other creative approaches to mental health services will develop under health reform will depend upon both clinician and consumer behavior. The misconceptions about mental illness and treatment present a challenge for development of treatment

alternatives and insurance benefits. Treatment outcomes and costs must be considered together as decisions of how to use the limited financial resources are made.

DISCUSSION

The three most important issues facing rural mental health under health care reform are inclusion of mental health benefits, avoiding biased risk selection under insurance plans and rural service availability. Mental health benefits can easily be set aside in favor of a more affordable basic package of services. Mental health benefits are seldom discussed in context of legislative discussions on health care reform. Similarly, rural health care is mentioned, but usually within the context of lack of clarity as to the direction to take in dealing with rural health care issues under a managed competition framework.

Insurance has assumed an important role in improving access and health in the U.S. The extent of coverage can potentially affect whether or not one accesses care and influences the manner in which care is provided (OTA, 1992). Biased risk selection presently limits mental health services, particularly for the seriously mentally ill. Mentally ill persons, like other individuals lacking health benefits, may delay or forgo care that has the potential to improve their health and functioning. Mental health benefits under health care reform can spread the "risk" and cost associated with these disorders across a larger pool of insured persons equalizing the effects with those of other chronic and persistent illnesses.

A variety of insurance-related and other financial incentives have been developed to either increase or decrease utilization, improve the process of care provided and to contain costs. There is difficulty in determining the impact of insurance coverage because providers and consumers face different incentives simultaneously. Due to the nature of emotional disorders, mentally ill persons function poorly as consumers. This suggests that the effectiveness of the incentives may be influenced more by family tolerance for the burden of care and the behavior of providers. Ignoring mental health benefits under health care reform would only shift the costs elsewhere (including nonmonetary costs such as social burden and costs of suffering), making them harder to contain. Further development of economic incentives are worthwhile. As an example, structuring reimbursement in a manner to encourage relatives to provide care for mentally ill persons (with assis-

tance). This would structure services so that the responsibility for care would be shared by professionals and the people who know the client best. Efforts to move in this direction are already in place in some states. Incentives like this address rural consumer acceptability, and would in part address some of the rural caregiver shortages.

CONCLUSION

Inclusion of mental health benefits under health care reform would clearly improve services for mentally ill persons in rural areas. Consolidating services under a basic benefit package reduces stigma and therefore, acceptability to rural populations. Further, consolidating services under an insurance plan would reduce the risk of having mental health services cut or persons with mental illness avoided. Addressing catastrophic and continuous coverage is perhaps the greatest benefit and greatest challenge. Flexible benefit coverage of serious mental illness will encourage families to retain their responsibilities for care of family members without fear of economic ruin. It can also encourage development and use of less restrictive, and potentially less costly supportive treatment alternatives. Consistent coverage will assist a more even maintenance of functional status, resulting over time in fewer crises and reduced costs through diminished use of expensive crisis services.

Managed competition, as a vehicle to improve care, can work in rural areas with consideration for local culture. Successful managed care efforts will be cooperative efforts that grow out of local institutions and network with existing rural providers (James et al., 1993). Building upon the strengths of rural areas promotes a sense of control and less unrealistic fear. This moves the health care system from a reactive mode to one of managing resources. Through efforts to manage health care, we have begun to deal with the realities of our limited resources. The transition to a new system for health care has already begun. Consumers, providers and legislators have to adjust to a new approach to providing mental health and health care.

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