MASSACHUSETTS MEDICAL SOCIETY REPORT
PSYCHIATRY AND MANAGED CARE CONTRACTS

Background

The House of Delegates at A-01 adopted as amended Report: 208, A-01 (B). In June 2001, the Board of Trustees referred Report: 208, A-01 (B) to the Task Force to Examine Quality of Care Related to Carve-Out Arrangements and Disease Management Programs for implementation.

Report: 208, A-01 (B) recommends:

1. That the Massachusetts Medical Society (MMS) does not support mental health carve-out arrangements for the provision of behavioral health services because of concerns regarding the impact of carve-out arrangements on patient access to high-quality health care. These concerns include fragmentation of the medical and mental health care systems; overly aggressive management techniques; serious threats to patient confidentiality; and the reduction in the role played by primary care physicians (PCPs) in diagnosing and treating mental illness and managing the patient's overall health.

2. That the MMS advocate that all insurers offering mental health services adhere to the following principles and that entities that evaluate such plans for the purposes of accreditation use these principles for evaluation (see appendix).

3. That the MMS reappoint the Task Force to Examine Quality of Care Related to Carve-Out Arrangements and Disease Management Programs to develop a model for presentation to the House of Delegates at A-02 for reintegration of behavioral health care into overall medical care.

Introduction

The Task Force agreed to continue its efforts on the largest of carve-out arrangements existing in the state at this time, mental health carve-outs. In the face of rising expenditures, health care organizations have developed population-based strategies to control costs and manage clinical care. The Task Force has been charged with developing the model for reintegration of behavioral health care into overall medical care. "Integration" in this context means that psychiatric and mental health/substance abuse care are part of the medical/surgical model. Such a model of integration is an alternative to the current model of "carving out" mental health care used by many Massachusetts health plans.

Organizations such as the MMS, the American Medical Association, the Massachusetts Psychiatric Society, and the American Psychiatric Association have stated that "carve-out" models of care for mental health services produce fragmented care, interfere with

access, and provide extra work for primary care physicians and psychiatrists. Concerns over these barriers to high-quality care and satisfactory care for our patients reinforces the need for a policy decision to reintegrate mental health services into the medical/surgical system. An integrated system will allow patients to be treated in a comprehensive fashion, without the stigma of being shifted into a separate health care system. This report strongly supports quality treatment of mentally ill children and adults by physicians in primary care, together with those in psychiatry, and in child and adolescent psychiatry, the only medical specialty and subspecialty dedicated to treating our mentally ill patients.

Massachusetts and several other states have enacted parity laws for mental health care services. These states consider it discriminatory to accord separate and inadequate coverage for mental health conditions or to provide insufficient resources to assist patients who suffer with these conditions. Parity laws ensure that psychiatric and mental disorders are covered by insurance plans in a manner commensurate with the coverage provided for medical conditions.

Massachusetts Parity

Massachusetts: Statute requirements for all plans issued or renewed in Massachusetts after January 1, 2001, includes (the following statute limitations do not apply to health plans that are exempt from state mandated benefit laws under ERISA pre-emption):

- Health plans cannot set any annual or lifetime financial or service limitations for the treatment of designated mental disorders that are less than financial or service limitations for physical disorders (i.e., “nondiscriminatory coverage”).
- Health plans must establish a minimum mental health benefit of 60 inpatient treatment days and 24 outpatient treatment sessions per 12-month period for the diagnosis and treatment of medically necessary mental health disorders.
- Health plan mental health benefits must include an appropriate mix of inpatient, intermediate, and outpatient treatment services.
- Health plans can only require disclosure of mental health treatment information to the same degree as disclosure of physical health treatment information.
- Coverage includes nondiscriminatory coverage for the diagnosis and treatment of biologically-based mental disorders (defined as schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, and any biologically based mental disorders appearing in the DSM that are scientifically recognized and approved by the Department of Mental Health); rape-related mental and emotional disorders; children and adolescents under the age of 19 for the diagnosis and treatment of nonbiologically based mental, behavioral, or emotional disorders; co-occurring mental illnesses; and addictive disorders.
- Health plans are not required to cover all treatment options, such as residential treatment services or intensive case-management services. However, if an insurer does choose to offer these benefits, they must provide service coverage equal to coverage offered for similar physician health treatments.

Since the parity laws view psychiatric and mental health/substance abuse conditions as they do other medical conditions, and since health care policy decision-making bodies suggest integration, it follows that psychiatric and mental health/substance abuse systems use the same "medical model" upon which medical/surgical care systems are based. A full discussion of the application of a "medical model" to psychiatry and mental health/substance abuse is complex and beyond the scope of the effort here. It is, however, important to recognize that the proposed system rests on this model and the assumptions and principles inherent to it.

MMS Position

The MMS adopted several principles regarding high-quality psychiatric care in Massachusetts. The Society hopes that insurers will adopt these principles and collaborate with mental health care providers to ensure that high-quality care is delivered to patients in need. It is also important to emphasize that local physicians and other local providers will help ensure the best outcomes, through improved ability to collaborate with all the caregivers involved with the patient during his or her illness.

Issues to Be Considered When Delivering Mental Health Care Services

1. Access to Personalized Mental Health Referrals: National carve-outs for mental health services apparently have not been successful in recruiting Massachusetts providers to their network and in maintaining provider lists. Such networks do not appear to be integrated with the local medical system. It should be noted that recruitment should be standardized and conform to commonly accepted quality criteria. In addition provider network lists should be accurate and updated frequently.
2. Local Management of Patient Care: Local management is beneficial to patients and is accomplished by local control centered around local medical groups. For the care of the seriously mentally ill, the psychiatrist should be the point of entry for the "behavioral health" team. For patients with mental health conditions that warrant the same manner of care as medical/surgical conditions, the psychiatrist should be the first mental health clinician consulted by the PCP. The psychiatrist should have the responsibility to determine what other, if any, psychotherapeutic or other services are needed. Calling psychiatrists "ancillary providers" or seeing psychiatrists as "back-up" to "primary" therapists only reinforces the marginalization of psychiatrists.
3. Compliance with the Principles of Parity: Many insurance companies carve out mental health care. Very few medical illnesses are carved out. By carving out mental health care, insurers feel they are containing costs. However, they are treating the mentally disabled differently from others who are ill, and by using distant providers and facilities and managers, they are not providing equal care. This violates the principles of parity.
4. Strict Confidentiality and Sensitivity to Stigmatization: Many mentally disabled patients do not complain about mental health insurance because of fears of stigmatization. They therefore become disenfranchised. Indeed, by having a different system for mental health care, a cause may be made that this in and of

itself is an institutionalized form of stigmatization. Lastly, by having out-of-date provider lists, distant inpatient facilities, and lack of local collaboration, these factors de facto contribute to stigmatization.

5. Streamlined Authorization and Clinical Review Procedures: Parity should apply to review procedures. Review procedures should be clinically based and appropriately tailored to the nature of the psychiatric condition. Reviewers should conform to locally accepted standards of care.
6. Availability of Intensive Services to the Seriously Psychiatrically Ill: The system is limited with regard to availability of intensive services. The lack of adequate hospital, partial hospital, substance abuse, and case management services is critical. National carve-outs, compared to local organizations, are much less likely able to assess and build the continuum of services needed by the seriously psychiatrically ill.
7. Ongoing and Annual Assessment: Insurers receive their assessment data through carve-outs. The insurers must be sure to assess themselves what is behind any information that they are given.
8. Recognition of the Value of Mental Health Services: While PCPs manage and will continue to manage many first line psychiatric situations, psychiatric specialists should be available to PCPs in the same fashion that other specialists are.

Fiscal Issues in an Integrated System:

It is assumed that health care resources are finite and that systems need to operate within budgets. At present most medical care systems are designed to use their finite resources to treat illness. Some systems also attempt to maintain health, for example by providing resources for disease screening. Most systems use "medical necessity" criteria to guide the process of apportioning resources. "medical necessity" is in itself a complex topic, and the application of "medical necessity" to psychiatric and mental health/substance abuse conditions has its own additional complexities. For purposes here, it will be assumed that "medical necessity" can be applied to psychiatric and mental health/substance conditions. The process is similar to that used in the medical/surgical arena and involves having health professionals establish a diagnosis supported by clinical evidence and provide treatment that is as appropriate and effective as evidence-based study, clinical judgment, and community standards allow.

It should be noted that research suggests that well-structured integrated care for common conditions such as depression and anxiety may improve the quality of care for patients as well as be cost effective compared to usual care or carve-out approaches. There is also work suggesting that a financial benefit accrues to society at large and employers in particular when workers with conditions such as depression are effectively treated. Any practical plan for reintegration requires the support of all involved parties (see appendix A for case discussion).

Conclusions

Mental health care services are currently facing a crisis with the shortage of inpatient beds, not enough staff to support these beds, and limited networks of psychiatrists to provide outpatient mental health services. In order to provide the appropriate degree of penetration, which means treating those patients who need psychiatric services, there must be a fair and high-quality system in place. Standards in mental health care services should emphasize access to care and a management system as in any other medical specialty. Fragmentation of care that can result from carve-out arrangements with any medical condition does not benefit the patient. Carve-outs also risk the possibility of cost shifting, where the HMO states the problem is in the area of the carve-out and denies payment. In the end this confusion only increases on the provider side. It is critical that all systems of care recognize that mental health care is a form of medical care and therefore to treat it separately from other forms of medical care would support stigmatization and devaluation of mental illness and the patients and clinicians who treat mental illness.

The Task Force concludes that, on the basis of the literature studied, it is clear that an integrated model for mental health care is better for patient outcomes and that a fiscally neutral model is possible.

Appendix A

Structural Elements of an Integrated System

Appropriate care begins with accurate diagnostic assessment so clinicians will obtain a complete evaluation for each patient. A clear treatment plan will be formulated at the final part of this evaluation. Care will be based on this plan. Treatment plans are re-evaluated as the case progresses or at regular intervals. Care plans rely on evidence-based medical studies but recognize that such information is applied to individual patients via clinical judgment. The goal of care is treatment of illness and to restore patients to prior levels of functioning.

1. The content and elements of the evaluation and treatment plan will utilize evidence-based material whenever possible.
   - A multi-axial (DSM IV) assessment is required.
   - In urgent or limited situations this may be completed during follow-up visits.

2. If UM review is required it will be done as soon as possible after evaluation.
   - Systems will develop resource-use guidelines and require UM only if the guidelines are expected to be or are actually exceeded. These guidelines will be evidence-based wherever possible.
   - Re-evaluation is conducted if clinicians, patients, or reviewers deem it necessary.
   - No resources are used unless medically necessary or appropriate.
   - Clinicians will share their opinions about diagnosis and treatment with patients to the full extent clinically possible and appropriate. This will discourage “gaming the system” and unnecessary adversarial reviews.

3. UM Review Process: UM is done by a multidisciplinary group led by physicians. The group may have a stable leader and core, but local clinicians are required to rotate onto this group in 6-month blocks. This group keeps written records and has an open procedure for patient and clinician appeals. The goal of UM is to make sure the care is as appropriate and effective as possible and is not biased toward any clinical approach. UM is not conducted to restrict resources but may set limits on ineffective or elective care.

4. Psychiatric Emergency and Inpatient Care: Psychiatric clinicians are required to be available for emergencies in the same way medical and surgical clinicians are—e.g., by page or coverage. Clinicians also are responsible for transmission of clinical information and in the creation of the treatment plan when their patients are hospitalized.

5. Medical Information: Core medical components of psychiatric diagnosis and treatment (such as multiaxial dx, medications, etc.) are part of the general medical record and are communicated to PCPs.

6. Management Information: Clinical, administrative, and UM leaders are provided with, and held accountable for, utilization and cost data. For example, MH/SA ALOS and readmission rates, outpatient utilization, and costs are reviewed monthly. Discussion among the UM group, individual clinicians, and management is used to factor in the higher utilization and costs of treatment of severe illness, so the goal is appropriateness and effectiveness rather than simply cost limitation.

7. High-cost patients and diseases require early intervention and personalized case management. Systems need to devote resources to developing programs to provide early identification of and intensive management for patients with selected disorders. Potential high-resource patients, such as those with eating disorders, substance abuse, etc., are identified at evaluation and moved to case management early in their course.

8. Interface with Medical/Surgical: Medical information is shared as above. Active CL service for medical and surgical inpatients is provided. Disease management systems for common disorders such as depression and anxiety are created and supported jointly by psychiatry and primary care.

Collaborative Approach

1. Payors: Integration of mental health services and general medical care should be done in a fashion that affects them equally in terms of cost. The case for how reintegration can help control costs, reduce waste, and improve patient satisfaction needs to be developed for this purpose. For example, the contribution of reintegration to the control of pharmacy costs, and the management and control of non-mental-inpatient LOS can be made.

2. Health Care Systems: Much like payors, many PCPs and health care administrators see mental health as different from the rest of health care. They fear it is a cost area that is hard to control and they do not see it as part of their core business. As above, the case for clinical quality, satisfaction, and cost-effectiveness with reintegration needs to be demonstrated for this sector. In addition to the above example, the demonstration of how reintegration can expand access to and effect collaboration with psychiatric and mental health clinicians can be made, as well as its impact on reducing medical practice assistant workload and patient complaints.

3. Employers: Most employers are pushing hard against the current premium increases and will not accept systems that add to such increases unless a very strong case for added value can be made. As above, the relative cost offset of providing effective treatment to employees with mental illness, in terms of reduced days lost from work and increased productivity, can be made.