Position Statement on Carve-Outs and Discrimination

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"Policy documents are approved by the APA Assembly and Board of Trustees...These are...position statements that define APA official policy on specific subjects..." – APA Operations Manual.

Introduction

The separation of the funding and delivery of psychiatric and/or substance abuse* services (carve-outs) from general medical services is detrimental to providing high quality comprehensive care. The carve-out mechanism leads to stigmatization of psychiatric patients and the marginalization of psychiatric treatment. Only in highly specialized circumstances (most frequently in some sectors of public psychiatric care) can these problems caused by carve-outs be sufficiently mitigated to provide reasonable clinical care.

The advent of managed care has resulted in over 180 million individuals receiving psychiatric treatment through "Behavioral Health Carve-Outs." The American Psychiatric Association position is that the “carve-out” approach discriminates and selectively diminishes funding of psychiatric treatment in both the private and public sector. There is a crisis in the care of mentally ill patients. Patients are being refused treatment or are being subjected to severe limitations in treatment, hospitals are closing, psychiatrists are withdrawing from arrangements with third party payers and carve-outs and discrimination contribute to the reluctance of new physicians to enter the profession of psychiatry. In the academic setting, the survival of hospitals themselves is at stake, and the faculty within these settings no longer has adequate time to teach.

There has been a long history at the APA in the fight against discriminatory practices. Most recently, the APA Assembly has passed a series of action papers stating that carve-outs are discriminatory. The APA Joint Reference Committee (JRC) acting on these action items has established a work group to develop consensus and advise the APA Board of Trustees (BOT) as to a strategic position for the APA. The work group has met three times and the following paper is a product of this effort.

This document will (I) define the term carve-out; (II) review the political history of the APA and American Medical Association (AMA) position papers; (III) identify the core problems with carve-outs; (IV) establish principles of nondiscriminatory treatment and coverage, and (V) identify strategies for the APA to oppose carve-outs.

*Throughout this position paper we will refer at times to psychiatric illness or mental illness. When we do, we are including substance abuse within that broader category of illness.

I. Definitions

Managed Care

Managed care in its broadest definition is an organized system of care with some type of management in place to selectively deliver services to a defined population in order to contain cost. Managed care has grown so that over 180 million people are now enrolled in some form of Managed Care Organization (MCO), Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Administrative Services Only (ASO) arrangement, or Point of Service (POS) option.

Mental Health Carve-Outs

A mental health managed care carve-out is created when benefits and services for people experiencing mental illness are administered and managed entirely separate from their standard health benefit package covering medical/surgical illnesses. It occurs when a separate entity manages the psychiatric benefit apart from the medical/surgical illness. It can also occur within a health insurance program when different rules and regulations discriminate against people seeking psychiatric care.

The most frequent arrangement is when a Managed Behavioral Health Organization (MBHO) contracts to provide this carved-out psychiatric service. The primary purpose for a carve-out is to control health care costs. In such a system, mental health benefit packages for provider networks, payment systems, and program administration are separated from the general medical program.

There is a distinction between segregating the delivery of care for purposes of efficacy and focus, such as in surgical wings, medical wings, or psychiatric units in hospitals, from the total separation of funding and clinical treatments seen in carve-outs.

Integrated Mental Health and Substance Abuse Coverage

Mental health and substance abuse integration occurs when benefits and services for people with mental illness and substance abuse disorders are integrated, funded and administered no differently than for those people with other medical/surgical illnesses.

Access to Mental Health Care

Access is the ability of a person with a psychiatric illness to obtain diagnostic and treatment services by an appropriately trained and qualified professional. Access involves the ability to obtain the full range of services such as emergency care, inpatient, outpatient and/or partial hospital services in a variety of settings. Settings include office practices, clinics, and hospitals, special settings such
as jails and prisons, or community outreach. Access should be for all population groups, not varied by age (children, adolescents, adults, and the elderly), ethnicity, geographic area, or income.

**Stream of Funding for Carve-Outs**

In the private sector, funding is through premiums paid to insurance companies who contract with HMOs and MCOs. The premiums may be paid by individuals but more commonly are paid by employers with employee contributions as part of an employee benefit package.

In the public sector, funding for mental illness has been separated out from other funding for 170 years. States, in maintaining public mental hospitals and clinics, and the federal government, in the Community Mental Health Center Act of 1963, established separate funding to maintain a viable stream of funds for the mentally ill. States have usually maintained a separate Department of Mental Health through which funds for clinical services flowed. Public employees and mostly private, non-profit agencies under contract with public agencies have delivered the services. For the purposes of this policy, such separate public sector funding by the state is not considered a carve-out.

However, over the last decade many states have been permitted to contract out their mental health and substance abuse services primarily for their Medicaid populations. Under this arrangement, a number of states have established contracts using public funds between the state agencies and private for-profit MBHO carve-outs. In other states, the contracts are between the state and local county-based mental health systems. This paper recognizes that there are isolated examples where carve-outs, delivered under public auspices have led to increased funding and a broadening of services. To the extent that these are exceptions, these programs must be non-discriminatory and adhere to the criteria listed in section IV of this position statement.

**II. Political History at APA**

In May 2000, the Assembly passed Action Paper 12.N which asked that the APA advocate against carve-outs. APA.

In October 2000, the JRC stated that carve-outs have done more harm than good. The APA should vigorously seek ways to expose and challenge the discriminating characteristics of carve-outs while acknowledging that they have expanded and protected services to some groups who would not otherwise be covered.

In October 2000, the BOT approved the recommendation from the JRC that the APA strongly opposes discriminatory carve-outs.

In November 2000, the Assembly passed three action papers (14.B, 14.C, and 12.EE). Action Paper 14.B established principles for non-discriminatory insurance coverage (discussed in Section IV of this working paper). Action Paper 14.C opposed carve-outs in the private sector. This item noted that the APA’s opposition to discriminatory carve-outs is a redundancy since carve-outs are by their nature discriminatory. Action Paper 14.C notes that for the past 170 years public support for the indigent mentally ill has been necessary because of private discrimination and because social supports are essential for the care of the special population. Thus, it was suggested that the APA focus on the private sector.

Action Paper 12.EE recommended that the APA delegation to the AMA work with the Minnesota AMA delegation to achieve a strong statement on the opposition to carve-outs.

The AMA passed Resolution 702 "that our AMA oppose and work to eliminate mental health and chemical dependency carve-outs." Furthermore, the AMA reaffirmed policy H285.956 opposing the carving out of treatment for mental illness from health plans and carved out policies that discriminate against the mentally ill in health plans.

In December 2000, the BOT unanimously approved the Assembly recommendation to have the APA advocate against carve-outs in the private sector (Action Paper 14.C).

At the May 2001 Assembly meeting, Action Paper 12.C "Strategies to Oppose Carve-Outs” was passed (Discussed in Section V of this working paper). The Assembly asked the BOT to establish a new task force to develop a global strategy to oppose carve-outs.

The APA Assembly has passed five separate action papers regarding carve-outs. The focus has been on the private sector discriminatory nature of carve-outs, the need for principles, and the need for APA action. The JRC, at its June 2001, meeting supported the intent of Action Paper 12.C. It recommended in lieu of forming a new task force, that a meeting be held at the Fall (2001) Components Meeting to discuss the carve-out issue, paying particular attention to identifying the differences in defining carve-out and reconciling the differences within our organization on the definition.

**III. Core Problems with Carve-Outs**

Running throughout APA Assembly action papers and AMA resolutions are a series of identified problems with carve-outs.

**A. Mental health carve-outs reinforce stigmatization of psychiatric illness and separation of patients and their psychiatrists from other patients and their physicians.**
B. Carve-outs, by segregating and segmenting the care of a specific group of patients, are inherently discriminatory. It has been pointed out that prior to the integration of the races, segregationists would point out the good that Southern schools achieved with segregation. However, such discrimination was not good, regardless of the quality of the schools. The same segregation of the mentally ill, although claimed to be good for some patients, is inherently not good, and often stigmatizes the patient with mental illness.

C. Carve-outs frequently require patients to access mental health services initially by telephone. Non-physician mental health practitioners (screeners) typically answer calls. In other instances, the people who answer the APA phone have no formal education in mental health practice. Based on telephone interviews of highly confidential information, these screeners make referrals. Screeners have no professional liability risks if treatment is denied, inappropriate or inadequate. This system undermines the quality and availability of psychiatric care.

D. Coordination of health care is difficult with managed carve-outs because benefit packages, provider networks, payment systems, and administration are separate for the carve-out from general medical services. The additional layers result in increased administrative costs; in this regard carve-outs are not cost-efficient or cost-effective.

E. Carve-outs fail to integrate the delivery of mental health services and thus allow underlying psychiatric causes of medical conditions to be improperly diagnosed and treated. The offset costs of psychiatric care are not realized. Conversely, carve-outs fail to provide an adequate mechanism whereby psychiatric patients can receive coordinated medical care and referral to primary care physicians.

F. Carve-outs have been a vehicle for disproportionate reduction in resources allocated for mental illness and substance abuse treatment. In 1999, the Hay Group reported that the reduction has been from 6.1% of the health care dollar to 3.2%. In the same study it was estimated that the value of benefits for medical care was reduced by 11.5% and for mental health, the reduction was 54%. There is no evidence that this reduction was appropriate.

G. In traditional indemnity plans, 2-15% of the premium is allocated to overhead. Some audits of mental health carve-outs have found that up to 61.5% of the budget is allocated to overhead and profits (Report submitted to the Congressional Budget Office, J. Wrich & Associates, October 1997). These numbers should be compared to the 17% average profit and administrative load that represent general medical and surgical HMOs.

IV. Principles of Nondiscriminatory Treatment and Financing of Psychiatric Illness

In keeping with the APA’s opposition to discrimination in the delivery of care in mental health carve-outs, a set of underlying principles, which we believe can be applied to any health care plan, was proposed in Action Paper14.B in November 2000. The APA Committee on Universal Access to Health Care initially presented these principles. These principles, slightly modified, are as follows:

A. The pathway to receive psychiatric treatment should be the same as the pathway taken to seek other medical-surgical care. There should be no barrier imposed upon psychiatric treatment that differs from that imposed on any other kind of medical treatment.

B. Pre-certification requirements for psychiatric illness should be consistent with standards applied to other medical and surgical conditions. Utilization review procedures for patients receiving psychiatric treatment should not be any different in frequency or intensity from utilization review for patients receiving treatment from any other physician.

C. Revealing personal private information other than to a treating physician should never be a condition for accessing care.

D. There should be no barrier to the direct referral of patients between psychiatrists and other physicians.

E. Denial rates percent for psychiatric care should not differ from the percent of denial rates for medical/surgical care. The standard for medical necessity that gives access to care for patients should be reasonable and reflective of diagnostic criteria, APA practice guidelines and standards of care where they exist. Medical necessity is traditionally defined by the physician who knows the individual patient and who can determine, fairly, what is needed by the patient. The use of this term has been corrupted to justify the MBHO determinations.

F. Denials of care in mental health plans as measured by savings over fee-for-service plans must not be any greater than for other medical and surgical care.

G. The percent of total health care plan expenditures devoted to administrative costs and oversight in the psychiatric/mental health component of an insurance policy should not differ from the percent of total health care plan expenditures devoted to administer the medical and surgical aspects of the policy.

H. Incentives for denial of care must be illegal.

I. Treatment policies for patients with chronic mental illness must be the same as for those with a chronic medical or surgical disorder.

J. Payment scales based on RBRVS criteria should be consistent across specialties. There should be no
discrimination against the use of CPT- E & M codes by psychiatrists.

K. The names of psychiatric and other specialists in any aspect of the plan, whether carved-in or carved-out, must be published with other empanelled physician lists, and the lists must be available to other physicians and to the public. They must also be made available to prospective enrollees and updated annually in their publications and monthly on the Internet. There should be penalties incurred by the MBHOs if physicians who resign and who inform the company that they are not enrolled continue to be listed.

L. Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual patients and enrollees receiving psychiatric care to an independent appeals board; and the process must also be completely independent of the insurance plan. Appeals by either the patient or psychiatrist should be made without the fear of retaliation. Reviews delayed are reviews denied. There must be some requirement for appropriate speed of review.

M. Coordination of care between psychiatrists and any other physicians is paramount in quality treatment for patients and should not be impeded, regardless of the insurance arrangements or physician affiliations.

APA Policy

The APA adopts this paper as official APA policy and wholeheartedly endorses and will repeatedly emphasize at every opportunity that carve-outs of the mentally ill, including substance abuse, and discriminatory insurance coverage against the mentally ill must both come to an end. Only in highly specialized circumstances (most frequently in some sectors of public psychiatric care) can these problems caused by carve outs be sufficiently mitigated to provide reasonable clinical care.