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Access to Outpatient Psychiatric Care: One Patient's Story and a Call to Action

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In Massachusetts, where I live, over 50% of patients must wait longer than 1 month to access a psychiatrist (1). Almost half (46%) of Massachusetts adults with any mental health disorder did not receive mental health care in 2013 (2). Further, 59% of Massachusetts youth who experienced a major depressive episode in the same year failed to receive mental health services (2). The Commonwealth has made great strides toward improving access to psychiatric care for children through the Massachusetts Child Psychiatry Access Program, which offers pediatricians free access to psychiatric consults (3). Yet significant gaps in access exist, particularly for adults, despite Massachusetts's high density of behavioral health providers relative to other states (4). A 2017 report by the Massachusetts nonprofit Health Care For All (HCFA) asserts that "while nationally the number of psychiatrists who accept commercial insurance is greater than the number who accept Medicaid, indirect evidence indicates that the largest cohort of psychiatrists in the Commonwealth are those who accept no insurance coverage at all" (5). In fact, Massachusetts has the highest percentage of psychiatrists of any state in the country at 42 psychiatrists per 100 000 population (2). Yet nationwide, only 55% of psychiatrists accept any insurance, and even fewer (43%) accept both private and public insurance (6). Of those psychiatrists who accept private insurance, the lowest rates of acceptance are in Northeast (48%) compared to other areas of the United States (6).

I experienced the problem firsthand, when I had an episode of major depressive disorder (MDD) in the summer of 2014. At the time, I was living in the Greater Boston area and working full time on public health-related research projects for a consulting firm. Over the course of about 3 months, I became inexplicably irritable, had decreased energy and motivation, had significant difficulty concentrating, felt hopeless about the future, and eventually developed near constant suicidal ideation. My living, work, and social environments had all been relatively unchanged for several years. Therefore, the only potential triggering situation that I can identify is that I had just returned from my first trip abroad when the symptoms started. I hypothesized that perhaps "vacation let-down," having to go back to the daily routine, simply hit me harder than a typical person would experience. Throughout this time, I was seeing a clinical psychologist for psychotherapy. Yet because I was not seeing any improvement through psychotherapy alone, I decided to consult with a psychiatrist about medication.

Through my job, I had a preferred provider organization health insurance plan that was arguably, as one physician would later inform me, "the best in the Commonwealth." A coworker provided me with a referral to her own psychiatrist, of whom she spoke very highly. Yet the psychiatrist did not accept insurance, and his fee was about $200 per visit. I knew that it would take a handful of appointments to evaluate me and provide a reasonable amount of follow-up over the next few months. This was a significant financial investment for me at the time, and so I turned to Internet searches to find a psychiatrist who would accept my insurance.

Mark et al investigated why psychiatrists have a low participation rate in commercial insurance networks through an analysis of the 2014 paid private insurance claims data across the United States. When providing in-network services to individuals with a primary mental health diagnosis, psychiatrists are reimbursed between 13% and 20% less than other physicians serving this same population (7). Clearly, psychiatrists have a financial incentive to accept only out-of-network or private pay patients as opposed to joining commercial insurance networks.

The reasons that only about half of psychiatrists accept insurance are not limited to low reimbursement rates alone; clinicians face administrative burden in billing to insurance

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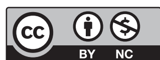
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that may not be offset by a higher reimbursement rate (8). In a large, nationally representative survey of US physicians, psychiatrists reported spending the highest percentage of time on administration (9). The survey further revealed that factors associated with greater time spent on administration include employment in a large practice, the implementation of electronic medical records, and financial risk sharing in the form of bundled payment programs (9). Psychiatrists may circumvent these burdens by going into private practice and accepting only a few insurance plans or no insurance at all.

When I was able to find a psychiatrist in private practice who did take insurance, the online profile often indicated, "No meds unless in therapy with me." I had already received psychotherapy weekly for several months without an improvement in symptoms. Despite the progressive worsening of my symptoms, I had invested time into the current therapist getting to know me. Rather than begin with a new therapist, I preferred to maintain the continuity of care with my current therapist during a medication trial. A patient may have an established and productive relationship with a psychotherapist who cannot prescribe medication, for example, a psychologist, social worker, or marriage and family counselor. When this patient is forced to switch to a new psychotherapist for the purposes of receiving medication to supplement therapy, the patient's progress is therapy may be significantly disrupted. Further, evidence indicates that participation in psychotherapy is unnecessary to safely prescribe antidepressants and that a pharmacological approach alone may be the treatment of choice, depending on the individual patient's circumstances (10).

In my case, this barrier existed even in the psychiatry department of the health care system in which I was an established patient for primary care. Within this large health care system, all insurance types were accepted, which addressed my difficulty in finding a psychiatrist in private practice. However, the unfortunate consequence of this "take all comers" policy is often a wait for psychiatric care that does not meet established standards for timely access to care (4). Further, the system in which I was an established patient required an intake appointment with a psychotherapist at the clinic, who would then make a recommendation of whether the patient was referred to one of the prescribers in the department. Again, I would be required to meet with a therapist other than the one who had known me for several months in order to access medication.

Ultimately, after several weeks of continued suffering while I tried to find a psychiatric prescriber, I accessed psychiatric medication through my primary care provider (PCP). Typically, I saw my PCP only for physical health concerns and preventive care. It would not have occurred to me to make an appointment with her for a mental health concern. In fact, I would have been surprised at the time to learn that PCPs prescribe 79% of antidepressants in the United States (11). My best friend, a physician, encouraged me to see my PCP after I admitted that I was having intrusive thoughts of suicide and could not complete any work. I saw the PCP within 48 hours of calling her office and walked out with a prescription for the medication that stopped the MDD episode. Why did I not take this step 3 weeks sooner? Because I simply did not know that a PCP would prescribe a psychiatric medication. I was privately insured, middle class, living in a metropolitan area cluttered with some of the best ranked hospitals in the country, and had a master's degree in public health. If I failed to access psychiatric care, how can we expect nearly anyone else in the country to secure it?

Opportunities for Policy Change

My story highlights several barriers to care that should be a focus of future policy change. These include low reimbursement rates for psychiatric services, insurers' influence on clinical decisions, and the opportunity to address psychiatric diagnoses in primary care when appropriate.

Low Reimbursement Rates for Psychiatric Services

As discussed earlier, average reimbursement rates for psychiatrists are significantly lower compared to other physicians. This finding applies to both private and public insurance plans (5,7). While many factors contribute to the problem of psychiatrists' reluctance to accept insurance, the issue of low reimbursement rates is a primary concern, as financial disincentives are particularly difficult barriers to overcome. States may consider enacting legislation to establish an independent commission to set reimbursement rates for providers in the private insurance market, as California has proposed through the Health Care Price Relief Act (12). A higher reimbursement rate may result in more psychiatrists willing to accept private insurance. This would in turn reduce the current burden on large health care systems that are financially able to accept all insurance types.

Psychiatrists consistently rank among the lowest paid of the medical specialties (13), and this ranking reflects the value—or lack thereof—that Americans place on psychiatric care. Significant strides have been made in the United States toward mental health parity, particularly with the passage of the Patient Protection and Affordable Care Act of 2010, which extended the number of health insurance plans subject to federal parity requirements and mandated that all qualified health plans cover treatment for mental health and substance abuse conditions (14). However, the existing parity laws do not account for remaining inequities faced by psychiatric patients. For example, insurers may require a copayment for outpatient behavioral health visits without violating the parity requirement, as long as the copayment for all specialty care is the same. Yet mental health care often requires a greater number of visits as compared to other forms of specialty care, resulting in a significantly higher annual cost of care for the patient (5). In addition, it is not

a violation of parity laws for a psychiatrist to refuse to accept insurance, despite the resulting disparity in access to psychiatric care as opposed to other medical care (5).

Further, the lack of consistent enforcement of federal parity regulations provides evidence that the value placed on behavioral health by government is perhaps lower than the value placed on physical health. In a public comment to the US Department of Health and Human Services, the Massachusetts Association for Mental Health responded to a call for strategies to improve parity with the statement,

> The single most important objective for the Federal government should be vigorous enforcement and oversight of parity laws. The federal government should encourage rigorous State enforcement and should step in when the State cannot or will not enforce the parity law (15).

The Massachusetts Association for Mental Health further explains that even when comprehensive parity laws exist at the state level, which in the case of Massachusetts extend parity far further than the federal legislation, the laws are not being enforced consistently (15). Consumers are unaware of these violations because insurance policies often use complex language that is difficult for the layperson to understand, and the appeals process for a denial of coverage is similarly difficult to navigate (15).

Insurers' Influence on Clinical Decisions

One Massachusetts provider, speaking as a key informant, stated that providers have yet another disincentive to participate in commercial insurance panels when they face an "onerous" process to obtaining approval for continued care (5). This provider further explained that "there is a lack of transparency surrounding the criteria to prove medical necessity" (5). Without these clear criteria, insurers are free to approve or reject providers' requests for more sessions, effectively limiting access to care for patients who rely on insurance to cover the cost of their treatment (5). In addition, when a privately insured patient truly cannot find a provider in-network within a reasonable distance from home, insurance companies are often reluctant to approve coverage for an out-of-network provider (5).

Addressing Behavioral Health in Primary Care

The Collaborative Care Model (CoCM) is an evidence-based approach that allows for certain less severe psychiatric disorders, such as mild-to-moderate MDD or generalized anxiety disorder, to be managed in primary care. The model allows patients to more easily—and often, more quickly—access specialty psychiatric care through a care manager, often a social worker (16). The care manager reviews the patient's case with a psychiatrist, who provides a recommendation to the patient's PCP to prescribe. In the CoCM, a psychiatrist may review and provide recommendations for perhaps 8 patients in an hour, whereas a psychiatric intake with each patient would have taken between 45 and 60 minutes. Despite the benefits to patients, the CoCM has been slow to expand nationwide, and the lack of reimbursement for the psychiatrist's consultation time has contributed to this slow uptake (16). Massachusetts has an opportunity to expand access to psychiatric care for its residents by providing reimbursement for care coordination through MassHealth. If the consultation between the care manager and psychiatrist was reimbursable, more health systems may be incentivized to adopt the model. This policy has previously been enacted in Washington and New York states (16).

When I was struggling with depression, I assumed that my PCP would respond compassionately but ultimately refer me elsewhere to see a psychiatrist, as there were none colocated at the group practice where I receive my primary care. So, I figured I would not waste a copay on a trip to see the PCP. If I did not have a physician friend who strongly recommended that I see the PCP for depression, the thought of seeking help in primary care would not have occurred to me, even as a health-literate patient who regularly accessed preventive care.

Even without an embedded behavioral health clinician in the practice, PCPs may routinely utilize depression screening tools such as the Patient Health Questionnaire-9 to begin a conversation about mental health with their patients. In my case, if behavioral health topics had been a regular part of every interaction with my PCP, I may have gone to her first and saved myself weeks of suffering. Access to primary care in Massachusetts is not universal, though a greater proportion of the population does report access to primary care than report access to needed psychiatric care (2).

Conclusion

Numerous challenges exist in ensuring access to psychiatrists and other psychiatric prescribers in the United States. Even for patients with health insurance, a main barrier to accessing care is the few number of psychiatrists in Massachusetts who accept either MassHealth or private insurance. Several factors contribute to this problem, such as low reimbursement rates, administrative burden, and time spent on unbillable tasks such as consultation and documentation. Underlying these factors are social, economic, and political values that do not encourage policy solutions.

My story had a positive outcome, but we have a long way to go to ensure that everyone who needs medication to manage depression has access to the right prescriber at the right time.

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