



Secret Shopper Analysis Shows Getting Psychiatry Appointment in New York City is Well Kept Secret

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Abstract

Objective The Mental Health Parity and Addiction Equity Act prevents payors from imposing more stringent limitations on mental health and substance disorder benefits than medical and surgical benefits. In this study, we assess a New York City insurer's parity compliance based on the accuracy and validity of network-provided information and a consider legal framework to address this.

Methods A “secret shopper” analysis was performed, in which researchers attempted to contact the 192 psychiatrist providers listed in the 2019 online directory of United Healthcare psychiatry providers.

Results Only 3.1% of calls resulted in researchers booking an appointment. 50.5% of calls resulted in “no response”, 18.75% connected to psychiatrists not accepting new patients, and 8.8% of listed providers stated they were not in the United Healthcare network.

Conclusions Erroneous directory information exacerbates the issue of access to mental health treatment. Enforcement policy should hold insurers accountable for the reliability of their online directories.

Keywords Mental health access · Provider network · Health plans

Introduction

In order to remedy historical limits on insurance coverage for mental health and substance use services (“MH/SUD”), Congress enacted The Mental Health Parity and Addiction Equity Act (“MHPAEA”). Administered and enforced at the Federal level by the Departments of Labor, Health and Human Services, and Treasury, the law is intended to ensure payors treat MH/SUD coverage no more stringently than medical or surgical (“M/S”) coverage. Despite the passage of MHPAEA, a survey by the National Mental Health Alliance found that a third of participants who had searched for a new mental health provider between 2015 and 2016 reported

difficulty finding a provider who accepted their insurance, while only 9% had difficulty finding a primary care provider who accepted their insurance (Douglas et al., 2016). The continuing contraction in the workforce of U.S. psychiatrists will likely exacerbate this issue in the coming years, as, without intervention, the workforce of U.S. psychiatrists will continue to contract through 2024 (Satiani et al., 2018).

Studies to date have attributed the mixed compliance with MHPAEA to the burden of reporting being placed upon consumers and providers, as well as the limited regulatory enforcement structures (Bendat, 2014). Regulators in many state departments of insurance have imposed significant fines or settlements related to parity compliance, and federal regulators continue to identify instances of non-compliance in annual reports. Some state Departments of Insurance and Medicaid agencies have scaled-up enforcement of parity for Medicaid managed care organizations and commercial insurers (Mulvaney-Day et al., 2019). For instance, states like New York and California have developed their own enforcement protocols (Goodell, 2015). However, most states have left enforcement up to the Department of Health and Human Services (Goodell, 2015). Across all agencies, the tangible

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effects of enforcement actions have been limited (Horgan et al., 2016).

A recent study evaluated the adequacy of health plans operating in North Carolina, specifically the adequacy of providers available for mental health patients showed 66% of health plans did not disclose mental health provider ratios and would not list the number of mental health providers in network and 62% did not disclose average wait times for members (Akiyama et al., 2015). In Washington D.C., another study examined the availability of psychiatrists listed in insurance provider databases, 51% had working telephone numbers, 15% were accepting new patients, and only 7% were able to schedule appointments within the next two weeks (Blech et al., 2017). In a multi-city study, researchers called 360 psychiatrists in Boston, Chicago, or Houston and after two rounds of calling, 93 (26%) of the calls resulted in appointments booked with psychiatrists (Malowney et al., 2015).

Inaccurate information on network websites for provider access, and products offered is an ongoing issue specifically for mental and behavioral health networks. It adds an additional layer to bridging the gap between the demand for mental health services. Under MHPAEA, a health plan must be able to demonstrate that the factors, strategies, and evidentiary standards used in building a network of MH/SUD providers are comparable to, and applied no more stringently than, the factors and strategies that it uses in building a M/S provider network. However, MHPAEA does not stipulate a specific methodology for measuring or assessing comparability between MH/SUD and M/S provider networks. Most federal and state regulations set forth relatively crude minimum requirements for network adequacy, such as time and distance standards, that are generally based on the set of contracted providers without regard to appointment availability and that do not provide for direct comparisons between MH/SUD and M/S provider networks. As a step toward assessing the adequacy of existing provider network requirements and developing an effective comparative measure of network access to MH/SUD vs. M/S providers, this study was designed to evaluate actual access to MH/SUD services within a plan with a robust directory of MH/SUD providers based on the provider's availability for a new patient appointment.

Methods

This study was a "secret shopper" analysis based in New York City, in which researchers posed as potential patients seeking an appointment with the psychiatrist. "Secret shopper" analyses have been used to identify access to network psychiatrists in other regions of the country, as well as to assess consumer access to opioid use disorder

pharmacologic therapies (Blech et al., 2017; Presnall et al., 2022). Providers were selected from a 2019 online directory of United Healthcare (UHC) psychiatry providers. All selected providers were located within a 10-mile radius of New York City zip code 10010. Mental health providers were limited to psychiatrists, as they are the primary specialty that is able to pharmaceutically treat patients. Contact information including specialty, provider address, practice name and two office phone numbers, was compiled into a database. The final sample consisted of 192 psychiatrist providers. Calls were made to each provider phone number to try to gain an appointment for a new patient who had United Healthcare insurance. [Note: Appointments were not actually booked].

Calls were conducted between December 2019 and February 2020 during business hours and if there was no answer initially a second call was made on a different day. Researchers attempted to contact providers using the primary phone number and requested an appointment utilizing an unstructured discussion. Calls assessed: (a) the ability to speak to a provider or representative, (b) scheduling method, (c) contact information accuracy, and (d) the earliest available appointment.

In completion of the 192 phone call interviews, an independent researcher reviewed the notes from the interview calls and placed each into respective categories including, "not in provider network", "appointment booked", "referral needed", "in-patient only", "intake paperwork required", "no response", "not accepting new patients", and "specific patient type only". Another independent researcher then reviewed and validated a sample of 15 interviews to ensure validity of categorization. Microsoft® Excel® for Office 365 was used to summarize total number of responses. In accordance with similar secret shopper studies, no human subjects or patient records were utilized in the study, only organizational data therefore the study did not require Institutional Review Board Approval (Wu et al., 2022). Similarly, due to use of organizational data informed consent was not applicable.

Results

Of the 192 calls made to psychiatrists, 3.1% (n = 6) resulted in researchers having an opportunity to book an appointment. 50.5% of all calls made (n = 97) resulted in "no response". Even if patients were able to receive a response from the psychiatrist, there were additional obstacles to successfully "scheduling an appointment". 18.75% (n = 36) of all calls connected to psychiatrists who were not accepting any new patients. Additionally, a number of responses reported they were specific about the patient type that could be booked, including in-patient only 7.2% (n = 14),

and specific patient type (cancer, liver, etc.) 3.6% (n = 7). Although providers were in the UnitedHealthcare network provider list, 8.8% (n = 17) stated on the phone they were not in the UnitedHealthcare provider network. The remaining responses included referral needed at 3.6% (n = 7), and intake paperwork required at 4.1% (n = 8).

Discussion

The current study recognizes significant barriers for patients seeking access to mental health professionals, specifically psychiatrists within the United network. Of the 192 contacted health care providers, only 6 (3%) were available to book new appointments, a number consistent with similar secret shopper studies showing 7% and 26% respectively (Blech et al., 2017). This research contributes to a growing body of evidence that private plans' mental health provider networks contain inaccurate and inadequate information, indicating a need for greater regulatory enforcement.

Previous studies have similarly reviewed the adequacy and accuracy of network directories, and information in different cities, states, and specific healthcare networks (Haeder et al., 2016). As other researchers experienced, the accuracy of the available directories was unreliable. An insured individual relying on the information within these directories to seek out mental health care will likely be unable to reach the appropriate individuals. Therefore, the results of the research suggest the insured individuals have limited access to mental health care. This is yet another barrier to those seeking mental health care, even when accessing care through commercial insurance coverage.

At present, there is no legal standard for assessing the adequacy or accuracy of information that health plans share regarding their networks. Without an established legal standard, health providers cannot be held accountable for whether they are truly upholding the MHPAEA. When developing this essential legal measure, local or federal agencies should develop criteria that:

- Allow for a meaningful comparison between MH/SUD and M/S benefits. While Federal regulators have released clear guidance that parity does not require equal numbers of MH/SUD and M/S providers, any metric nonetheless provide a means of comparing the MH/SUD and M/S network.
- Allow for an efficient and consistent application to a wide variety of plan designs and types. In order to be effectively integrated into insurer/plan compliance operations, the measure must be relatively easy to use consistently and accurately.

- Are objective and easy to subject to third-party verification. Federal and state regulators as well as public interest groups involved in parity policy will insist that any measure of network adequacy that insurers/plans are applying internally be subjected to external audit/validation.

The findings of this study, as well as similar studies suggest serious implications for patients seeking mental health care. With networks providing erroneous information within directories, the availability of dependable information is restricted. A network, publicizing its services to the insured population should be held responsible for the information being provided. Policies around networks, as well as providers should require accountability for online directories, contact information and information regarding scopes of care. The inaccurate information is likely compounding the existing issue of access to mental health treatment.

Limitations to our study include limiting our study to evaluating the network of only one health insurance within a limited radius of a single zip code, conducting data collecting during the month of December—a common period for practitioners and offices to be on vacation, and not including psychiatric nurse practitioners as potential providers—despite their prescriptive authority. Our search was also restricted to in person visits, which was standard for mental health care prior to the COVID-19 pandemic, at the time of the calls were performed.

Further research should expand the scope of this study by considering a wider array of health insurances, zip codes, temporal periods, practitioners, and modes of healthcare delivery. Researchers interested in access to MH/SUD should also strive to identify novel methodologies to measure accuracy and adequacy of access to M/S and MH/SUD providers in a given health plan network that can be scaled by enforcement agencies. An appropriate, scalable methodology for evaluating MH/SUD and M/S provider networks would allow a legal standard for network adequacy and accuracy to developed, which would facilitate regulatory enforcement of health plan compliance with MHPAEA. This would be especially important in the context of the Department of Labor's pledge to focus its parity enforcement focus on the accuracy of provider network directories.

Declarations

Conflict of interest All authors certify there are no known conflicts of interest involving the study. Additionally, all authors certify responsibility for the manuscript.

Ethical Approval No human subjects were utilized in the study, only organizational data therefore the study did not require institutional Review Board Approval.

Informed Consent Similarly, due to use of organizational data informed consent was not applicable.

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