The ‘Quiet’ Crisis In Mental Health Services

Adequate reimbursement to providers of mental health services is the key to sustaining a viable care system.

by Paul S. Appelbaum

ABSTRACT: The failure of insurers and managed care organizations to reimburse providers of mental health services for the costs of care has led to a crisis in access to these services. Using the situation in Massachusetts as a case example, this paper explores the impact of this defunding. Unable to sustain continued losses, hospitals are closing psychiatric units, and outpatient services are contracting or closing altogether. The situation has been compounded by the withdrawal of many practitioners from managed care networks and cuts in public-sector mental health services. Unless purchasers demand effective coverage of mental health treatment, mental health services will likely continue to wither away.

What was the precise meaning of the President’s New Freedom Commission on Mental Health declaration in the fall of 2002 that the mental health system was “fragmented and in disarray” and in need of “dramatic reform”? As chair of a large academic department of psychiatry, I found no mystery in the commission’s pronouncement. Over a little more than a decade, I have witnessed the progressive and systematic defunding of psychiatric services in Massachusetts and—despite some regional variation—in the United States as a whole. As a result, provision of mental health treatment in organized settings such as hospitals and clinics has often become a money-losing proposition. With inpatient units and outpatient clinics driven by the inexorable economics of the situation to downsize or close, people in need of treatment are finding it more difficult, if not impossible, to get care. The situation is compounded by the flight of private practitioners from managed care networks, leaving insured patients struggling to find clinicians who will accept their coverage, and by the continuing retreat of the states from their historical role as providers of last resort for psychiatric care.

I am generally cautious in my use of the word “crisis,” but as best I can tell, the current situation in the mental health system qualifies for that label. When I talk to colleagues and mental health professionals around the country, I find that they agree. Rather than attempting here to review the situation in the entire country, I
present a case example of the current crisis from Massachusetts, with some evidence to suggest that by no means does it stand alone in confronting this serious situation. I conclude that unless steps are taken to remedy the current “disarray,” we are likely to witness the slow implosion of mental health services in many parts of the United States.

Organized Mental Health Care In Massachusetts

To understand this account, one needs to know a bit about the organization of mental health care in Massachusetts. Almost all insurance coverage for mental health treatment in the state is administered by managed behavioral health care organizations (MBHOs) or directly by a health maintenance organization (HMO); except for most Medicare patients, traditional indemnity coverage is all but nonexistent. Outpatient care is provided by a mix of private practitioners, clinics (both for-profit and nonprofit), community mental health centers (CMHCs, mostly private nonprofit, although a few state-operated centers remain), and general hospital outpatient departments. The primary payer for indigent patients is Medicaid, with the state’s Department of Mental Health providing almost no direct support for outpatient services. Hence, there has been a major effort to enroll all qualified indigent patients in Medicaid. Except for the minority of patients who are enrolled in Medicaid HMOs, all Medicaid mental health benefits are provided through a contract with a large, for-profit MBHO in a “carve-out” arrangement. There is no payer of last resort for uninsured patients; the costs are assumed by the general hospitals and CMHCs where the care is provided.

Acute inpatient care in Massachusetts, except for the few state-run CMHCs, is provided entirely in the private sector. State hospitals no longer have any acute inpatient units. As with outpatient care, Medicaid is the payer for most indigent patients who require hospital admission. Uninsured patients who are not on the Medicaid rolls, either because they do not qualify for the program (a group that has been increasing in number as the eligibility criteria have been tightened) or because they simply have never enrolled, must be admitted by any hospital unit that has a Medicaid contract as a condition of participation in the program. Essentially, the costs of hospitalizing the uninsured have been shifted to the hospitals; a fraction of the Medicaid day rate may be reimbursed to hospitals through a state-run free-care pool, but the bulk of the funds available in the pool come from contributions by those same hospitals.

Continuing care for patients who cannot be discharged to the community after an acute hospitalization is still provided in a dwindling number of state hospitals. (One state hospital closed in the past year, and another was threatened with closure this year.) Beds for these patients are scarce, however, and patients can wait up to several months to be admitted to the state hospital after applying for transfer. Once such application is made, private payers consider patients awaiting transfer as no longer in need of acute care and thus pay the hospital and physicians...
nothing, although the patients continue to occupy beds on acute units. The Medicaid carve-out plan reimburses their care at an “administrative day” rate—one-third less than the usual inpatient rate. Most residential and community support services are funded by state contracts with providers, largely nonprofit entities.

The Nature Of The Current Crisis: Outpatient Treatment

Trying to cover the costs of care. When managed care entered Massachusetts in the early 1990s, contracts were negotiated with practitioners and facilities to provide care at rates 30–50 percent below the prevailing rate of payment. In retrospect, one can question the wisdom of providers’ entering into such contracts. At the time, however, there was a sense that retaining market share was an important survival mechanism and that as the weaker providers fell by the wayside, the survivors would be able to demand higher reimbursement. Beyond strategic considerations, however, providers—whether private practitioners or facilities—did not relish the thought of losing a substantial segment (sometimes 20 or 30 percent) of their patients by virtue of refusing to agree to any company’s proffered terms. Although the particulars of their rates differed, the managed care companies that were flocking into the state all demanded substantial discounts from the prevailing payment levels, leaving most providers with no option but to agree to their terms.

In the decade or so since, the rates paid by most payers have edged up only marginally, as costs have continued to rise. Shortage professions, such as nursing, command premium salaries (in some cases exceeding those paid to physicians), and most other salaries have risen as well. In addition, the introduction of managed care itself resulted in an increase in costs, as clinical time was diverted and additional clerical personnel hired to obtain advance authorizations, collect copayments, monitor the number of authorized sessions, negotiate approval for additional sessions, meet increased documentation requirements for billing, and track and resubmit the growing numbers of bills denied—often for what seemed to be trivial reasons (such as an incorrect middle initial for a patient whose other identifying information was all correct).

As a result, outpatient clinics, whether based in general hospitals or CMHCs, receive payment at rates that do not come close to covering the costs of care. To personalize the situation, every time we see a patient at our university medical center–based outpatient clinic, we lose money. If patients are seen instead at the CMHC that is part of our system, the loss is less, but even this tightly run operation loses money on every outpatient visit. There is nothing unusual about our programs; the same is true at comparable programs throughout the state. As a result, clinics have been closing or scaling back services to the point where demand far exceeds supply. Early this year a major academic medical center in the western part of the state announced the closure of its psychiatric outpatient clinic. 2 At our clinic, which receives approximately 48,000 visits per year, we have largely restricted our flow of new patients to referrals from clinicians at our medical center.
“Some patients who are unable to obtain timely outpatient care deteriorate to the point where urgent intervention is required.”

When other clinicians or patients call us directly, we make every effort to refer them somewhere else; we cannot justify the increased losses that would result from hiring additional clinical staff to meet the demand. If clinicians leave our system, we encourage them to take their patients with them—behavior that once would have been considered idiosyncratic but that is now adaptive.

**Impact on access.** Of course, since the situation is the same in the rest of the state, the patients we cannot treat have an extremely difficult time gaining access to care anywhere else—unless, of course, they are able and willing to seek treatment from one of the growing number of practitioners who limit their practices to people who pay directly for their care. There was a time when patients who could not find treatment anywhere else could go to a CMHC. I trained in such a facility in the late 1970s, when we were the locus of care for all who were excluded from every other system. Direct state support of the center allowed such treatment to be provided. Today, however, the state provides no funding to CMHCs for outpatient care, so no funds are available to pay for treatment of the uninsured. As a result, CMHCs are turning away uninsured patients, since even they have to limit the losses incurred in rendering outpatient treatment. As a member of the board of our CMHC for more than a decade, I have experienced repeated agonizing discussions about how much longer we can afford to operate an outpatient service altogether, at the risk of dragging the entire center down. Even limiting outpatient care, our CMHC projects a margin of less than one-third of 1 percent of its budget, an amount that could easily be wiped out by unexpectedly high costs for snow removal.

**Sicker adults and children.** The consequences of this situation in the outpatient setting are not difficult to imagine. Some number of patients who are unable to obtain timely outpatient care deteriorate to the point where urgent intervention is required. Emergency rooms are seeing a steady increase in the number of patients coming in for psychiatric evaluations. Clinicians in those settings have the impression that the increase in numbers is paralleled by a rise in the level of psychopathology and degree of acuity. As bad as the situation is for adults, it appears to be even worse for children. They cost more to treat, since clinicians have to spend unreimbursed collateral time meeting with parents, teachers, and others as part of the evaluation and treatment process. Our emergency room is seeing children in numbers we have never seen before: From the last six months of 2001 to the first six months of 2002, the number of children coming to our emergency service rose 30 percent.

**The situation elsewhere.** Were this only a Massachusetts problem, its implications would be dire but of limited extent. However, there is every reason to believe that the situation I have described reaches much beyond the borders of our state. The *Washington Post*, reporting on the gap between the costs of outpatient care and
the rates at which it is reimbursed, noted that in Montgomery County, Maryland, private insurers pay $52 for an hour of psychotherapy that costs a clinic $83 to provide. Similar discrepancies exist for other outpatient services. Hence, it was no surprise when the Post subsequently featured a story about a mother in Maryland who called thirty clinicians to set up an appointment for her teenage daughter and found no one who would accept the fees paid by the MBHO that was managing her mental health insurance benefit.

A report by the Minnesota Psychiatric Society noted that one organization in the state closed six of its nine outpatient clinics because of inadequate payments and that waits for initial appointments can be as long as six months. It could be that this is a problem that only affects states beginning with the letter “M,” but I don’t think so.

The Nature Of The Current Crisis: Inpatient Treatment

- Private hospitals. The situation is equally bad, perhaps even worse, when it comes to acute inpatient treatment. In Massachusetts our public and private payers typically cover about 50–60 percent of the total costs (direct and indirect) of a day of inpatient care in a general hospital unit (which account for the vast majority of hospital days). These rates dropped by roughly half at the time of managed care’s initial penetration of the state, and they have only inched up marginally since. Costs continue to rise, as health care inflation exceeds the general rate of inflation, and units need to hire special staff just to deal with the demands of managed care companies, which puts these units into a progressively deeper deficit. As long as the units cover their direct costs and make some incremental contribution to the margin, there is some economic basis for their retention. But as hospitals’ overall economic situation deteriorates (two-thirds of hospitals in Massachusetts lost money on operations in 2002), units that do not come close to covering their full cost allocations look like prime targets for replacement by more profitable services.

Consequently, the number of acute psychiatric inpatient beds in the state has decreased steadily over the past decade. Indeed, as more Medicaid cuts were announced recently, the Boston Globe reported, “Hospitals said they are considering hiring freezes, layoffs, and closures of money-losing programs such as psychiatric and addiction treatment services.”

The response has become almost reflexive; no other area is targeted as automatically. And the results are predictable. Patients requiring admission back up in our emergency rooms as staff spend hours trying to find facilities that can and will accept them. Some unlucky patients are kept in holding beds in the emergency room for days while beds are sought. When a bed becomes available, many patients and their families must travel halfway across the state to reach it.

- The situation elsewhere. Once more, Massachusetts is more typical than atypical of other states, and I am not even sure that it is among those most drastically affected. Psychiatrists in Lansing, Michigan, report that closures of hospital
units force child and adolescent patients to travel an hour or more to the nearest inpatient units. The major general hospital in Columbia, South Carolina, has thirteen to fifteen psychiatric patients in its emergency room at any point in time, simply waiting for an inpatient bed. Psychiatric beds in the Twin Cities area in Minnesota are in such short supply that patients are often forced to travel out of state for hospital care. Why don’t hospitals build new units to meet the demand? A St. Cloud, Minnesota, hospital that built a new adolescent unit in 1998 in response to community concerns reported four years later that it expected to lose nearly $6 million on mental health services. In an informal survey, members of the American Psychiatric Association (APA) reported bed shortages in sixteen states.

- Public facilities. In the public sector, where continuing care beds and residential and support services are funded, the current state budget crisis in Massachusetts has led to cuts in an already inadequate state budget. With patients already waiting up to several months for transfer to chronic care units in state hospitals, another state hospital is being readied for closure. The inevitable result will be to increase the bed squeeze and the fiscal pressure on acute care units, where patients in need of chronic care beds will back up. Meanwhile, at residential programs in the community, many staff members are paid only $20,000 a year for their work with extremely difficult patients. It is not uncommon for such workers to leave their jobs to take employment at fast-food outlets so they can earn something closer to a living wage. As with private hospitals, this situation is echoed around the country, as states from California to Florida continue to close state hospital beds despite the effects of such closures on the rest of the mental health care system.

Where Do We Go From Here?

As I traveled the country talking about these issues in my role as APA president, I found that I was not bringing any news to people working in the mental health system. They were well aware of the situation I have described and of the forces that have brought it about. But I found little awareness of the severity of the problem on the part of political leaders, public administrators, insurers, business leaders, and others who could actually bring about some of the needed changes. In part, I think this is attributable to the slowly progressive nature of the problem. Instead of a sudden cataclysm, the mental health system has undergone steady attrition of available services and a corresponding diminution in access for people needing care. Such a situation does not lend itself to the dramatic media coverage that seems to be essential to mobilizing support for major policy changes. Even the mental health services research community seems largely not to be paying attention to the crisis, perhaps because the aggregate data on which so many of their analyses depend have not yet caught up to the present dilemma, or perhaps because the variables on which they have focused are not those that would reveal the nature of the current problem.

The shape of a solution to the slow starvation of the mental health system is not
obscure. Adequate funding needs to be made available to cover the costs of care. Whatever gains can be achieved by greater efficiencies were obtained several years ago. In many parts of the country, Massachusetts being one, the care system is dominated by not-for-profit entities. They are not looking to return sizable funds to their shareholders; they have no shareholders. Rather, they are looking for the costs of providing mental health care to be covered. The greatest leverage in accomplishing that goal probably rests with the real purchasers of care: employers and the states. These purchasers believe that they are providing effective insurance coverage for mental health services to their employees and indigent citizens. But when the MBHOS to which they have carved out mental health care pay rates below the costs of delivering care, these purchasers are being shortchanged. The people they believe they are covering are often unable to get access to care, and the structure of the current system guarantees that the situation will only become worse. Purchasers must learn to demand adequate payment rates, sufficiently large networks to ensure access to care when needed, and an end to the petty harassment that has driven so many practitioners away from dealing with the managed care industry.

The U.S. surgeon general’s report on mental health resulted in widespread attention to data from the National Comorbidity Survey, which indicated that only 20 percent of Americans with mental disorders—and fewer than half of people with severe mental disorders—receive any treatment for their conditions in a given year. It is difficult to imagine the situation getting much worse than that. But barring effective intervention by those in a position to demand that things change, we are likely to witness an even more unpleasant reality for people with mental illness.

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