Crisis in Access to Care: Geriatric Psychiatry Services Unobtainable at Any Price

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Where are elders with difficult psychiatric illness to seek ambulatory care? These elders are patients with severe or recurrent major depression, bipolar disorders, schizoaffective disorders, behavioral complications of dementia, anxiety disorders, late life psychoses, substance abuse, and personality disorders.

A crisis in access to care for this group of patients has emerged in recent years. Its essential components are as follows:

SCARCITY OF EXPERTISE

There is a national paucity of practitioners with training and expertise in the more complicated geriatric affective and psychotic disorders. At present there are only 1,800 active members of the American Association of Geriatric Psychiatry, of whom just 820 are certified with "Added Qualifications in Geriatric Psychiatry" by the American Board of Psychiatry and Neurology. Of these, the overwhelming majority are found on either the west or east coasts of the United States, usually in resource-rich major metropolitan centers.[1] However, a geriatric psychosocial resource website for the New York Presbyterian Hospital network listed only 29 psychiatrists in New York City who accept geriatric patients; most of these did not have subspecialty certification.[2] New York City is the largest urban center in the United States, with seven medical schools as well as other tertiary medical centers; it is therefore likely that other areas of the country are even more grossly underserved.

Clinic-based care, the granting of prescriptive powers to nurse practitioners, psychiatric supervision of other mental health professionals, and legislation increasing the availability of medications to Medicare recipients—none of these has filled the gap. Clinics, whether public or university, have high institutional administrative costs; providing care to the community competes with their other missions, such as medical education, training, and research. Nurse practitioners and psychologists who specialize in geriatric mental health and who in some states have prescriptive powers may add to the pool of potential resources, but these individuals are few and do not practice independently.[3]

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Psychiatric supervision of mental health professionals who cannot prescribe medications may entail only cursory examination of the patients, a model which is not optimal for elders with complicated medical and psychiatric disorders. The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides for improvement in the availability of psychiatric medications to the elderly, but geropsychiatric expertise in the use of these medications is likely to remain out of reach for many.

CLINICAL COMPLEXITY

For clinical reasons, psychiatrically ill geriatric patients are often considered to be undesirable referrals. They require intensive management, including frequent communication with family members and caregivers as well as coordination of treatment with other physicians, such as internists and oncologists. The treatment of late life depression, for example, can be especially complex; even in expert hands, elderly patients frequently fail to achieve full remission of acute depression with the first trial of antidepressant medication and go on to require combinations of antidepressants, augmenting agents, or electroconvulsive therapy.[4] Managing elderly patients with major psychiatric disorders also involves considerable risk of adverse outcomes, including suicide, drug side effects and interactions, unanticipated shifts of polarity from depression to mania, delirium, and medical complications.[5]

FINANCIAL DISINCENTIVES

It has been our experience that elderly patients with severe psychiatric disorders are often rejected by clinicians for ambulatory care because of inadequate Medicare compensation. Old age and psychiatric illness have apparently become twin disadvantages. Under general Medicare rules, a fee is set for each physician; Medicare pays psychiatrists 50% of that fee, while most non-mental health physicians receive 80%. The Mental Health Parity Act of 1996 addresses the inequality between reimbursement for psychiatric and physical conditions—but only for supplemental insurance and then with many limitations and loopholes.[6] Younger adults with psychiatric coverage are more likely to have primary insurance which tends to cover a percentage of whatever fee is charged, rather than setting the fee itself, as does Medicare; this arrangement usually provides a fairer level of payment than Medicare, even if the percentage paid is still 50%. Moreover, younger patients not living on restricted retirement incomes are more likely than the elderly to be able to generate out-of-pocket funds to cover co-payments or deductibles. It is as yet unclear whether HMO-managed Medicare will offer any substantial advantages to the geriatric population in covering psychiatric treatment.

As an example, in 2005 one of the authors (RA) had a Medicare-established fee of $120.27 for a 45-minute combined psychotherapy and psychopharmacological management session (CPT 90807). Of this, Medicare paid half, or $60.14. For a briefer session confined to psychopharmacological management (CPT 90862), Medicare set a fee of 59.99, of which half ($29.95) was again paid. The medical school practice association then deducted approximately half of each of these balances, leaving $30.07 and $15.00, respectively. It was permissible to bill either the secondary insurance, if available, or the patient, for the half of each fee not paid by Medicare, but in many instances the secondary insurance refused payment or the patient was clearly unable to pay. In contrast, the same author recently billed a younger adult patient $250.00 for the equivalent of a 90807 session; for this the private primary insurer paid 50%, or $125.00.

Most geriatric psychiatrists are presently Medicare providers, although many not by choice. Full-time academicians, who comprise at least half of the psychiatrists with Added Qualifications in Geriatric Psychiatry,[1] are usually required to be Medicare providers because of their employment by hospital medical centers. Psychiatrists in the community who are Medicare providers often find the treatment of geriatric patients impractical considering the paltry economic returns for the risks and the time spent, while academicians find this clinical work both uneconomic and a distraction from other endeavors.

"But doctor, we are in a position to be able to pay a full fee for your trouble." Psychiatrists who are participants in the Medicare program cannot charge or accept fees other than those permitted by Medicare. Ironically, a situation has evolved in which expert psychiatric care for elderly patients has become unavailable even to the comparatively small group of individuals who are able and willing to pay "market rate" fees. Since the most highly qualified geriatric psychiatrists often work in settings that require Medicare participation, it has become difficult to find experts who are permitted to accept fees set by themselves. Of course, patients who cannot afford to pay privately will always constitute the majority of those in need, and these patients have the fewest options if they seek specialized care for the psychiatric problems of aging.

FURTHER CONSIDERATIONS

We have argued that the crisis in access to geriatric psychiatry services is contributed to by scarcity of expertise, clinical complexity, and financial disincentives. The numbers affected are not small. For depressive disorders alone, it has been estimated that 8%–15% of community-dwelling elderly have clinically significant symptoms, with considerably higher rates found among patients in primary care settings, general inpatient hospital units, and nursing homes.[7,8,9] Approximately 38% of elders 85 years or older have at least moderately severe cognitive impairment.[10] Rates of specific anxiety disorders among the elderly are low, but clinically significant subsyndromal anxiety symptoms have been reported in as many as 40% of patients treated in inpatient and outpatient geriatric medical settings.[11,12] It has been estimated that paranoid or other psychotic symptoms can be found in 11% of the elderly population.[13]

Among the consequences of lack of access to care are excess disability, increased medical burden, suicide, premature nursing home placement, vulnerability to elder abuse, and geriatric self-neglect.[14–19] In recent years, attention has also been directed toward the emotional toll taken by behavioral problems on caregivers of the elderly.[20] There is increasing recognition that the economic burden traceable to the unavailability of timely outpatient psychiatric intervention is merely deflected downstream, in the form of hospitalization and other more expensive interventions later on.[21] Thus, on a wider social level, it is the families and caregivers of the medically indigent—or merely middle-class individuals who rely on Medicare—who collectively bear the burden of the lack of access to geriatric psychiatry services.

It is most regrettable that many clinicians who find the challenging psychiatric work with the elderly to be professionally gratifying are dissuaded from taking on such patients for economic reasons. A small constructive step would be to allow academic or institutional geriatric psychiatrists to treat both Medicare-billed and privately-billed patients, in contrast to the present system, which requires an economically disadvantageous all-or-nothing choice with respect to Medicare participation. However, adjusting a few provider rules in this manner does nothing to relieve the plight of patients with limited resources, nor does it address other fundamental disparities.

What we have described here is a de facto crisis of access to geriatric psychiatric care, a situation in which the availability of a limited pool of experts is further reduced by geographic imbalances and inequities in reimbursement. Those most affected are the elderly or disabled who are also poor. Moreover, we assume the problem of access to specialty care to be more pervasive than that which has been our experience in a geropsychiatric corner of the world. We are given to understand that the present era of cost containment in healthcare unavoidably entails sacrifices. Nothing short of a national commitment, fueled by political will, will be needed to redistribute such sacrifices so that the axe falls less heavily on the growing segments of the population that rely on Medicare.

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