Medicaid Acceptance by Psychiatrists Before and After Medicaid Expansion

Medicaid is the principal payer of behavioral health services in the United States and has been expected to play an increasing role in financing behavioral health services after states’ implementation of Medicaid expansions.1,2 Little is known about recent trends in psychiatrists’ acceptance of Medicaid, including before and after 2014, when most Medicaid expansions under the Affordable Care Act went into effect. Without adequate participation in Medicaid among psychiatrists, Medicaid enrollees with behavioral health needs may be unable to find a local psychiatrist who accepts new patients with Medicaid or have to wait a long time for an intake appointment.3,4

Methods | We used the 2010-2015 National Ambulatory Medical Care Survey (NAMCS), a nationally representative survey of physicians who were not federally employed, were based in offices, and were primarily engaged in direct patient care.5 Medicaid acceptance was created based on 2 questions. The NAMCS first asked, “Are you currently accepting new patients into your practice?” and then asked, “From those new patients, which of the following types of payment do you accept?” (with answer choices of payment via private insurance, Medicare, Medicaid or the Children’s Health Insurance Program, worker’s compensation, self-payment, and/or no charge/charity care). We limited the study sample to physicians who reported accepting new patients.

We compared the trend differences in physician acceptance of new patients with Medicaid across 2-year spans (2010-2011, 2012-2013, and 2014-2015) by physician specialty, grouping physician specialties into 3 broad categories: (1) psychiatry; (2) primary care, including general and family practice, internal medicine, and pediatrics; and (3) other nonpsychiatry specialties. We also examined differences in Medicaid acceptance before and after expansion between expansion and nonexpansion states by physician specialty, which is analogous to a stratified difference-in-differences analysis. Geographic identifiers that allowed for the classification of Medicaid expansion were only available after 2012 and for 18 large states (Arizona, California, Florida, Georgia, Illinois, Indiana, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin), which collectively represented 60% of the physician sample (or 73%, weighted) between 2012 and 2015. For most expansion states and all nonexpansion states, the preexpansion period was 2012 through 2013 and the postexpansion period was 2014 through 2015; exceptions were Indiana and Pennsylvania, for which the preexpansion data were for 2012 through 2014 and the postexpansion period was 2015. Analyses were weighted using NAMCS national weights. The trend analysis from 2010 through 2015 was adjusted for individual-level covariates, including ownership status, practice size, practice region, and metropolitan statistical area status. The difference-in-differences analysis from 2012 to 2015 was also adjusted for state-level managed care penetration rate, unemployment rate, poverty rate, and median household income, as well as 2-way fixed effects for state and year. Standard errors were clustered at the state level.

This study used deidentified data from publicly available sources, which removed the need to implement an informed consent procedure. It was deemed an exempt human research study by the University of Kentucky institutional review board.

Data analysis occurred from July 2018 to September 2018 using Stata/SE version 15 (StataCorp). Statistical significance was assessed with significance set at P < .05, using 2-sided tests.

Results | A total of 11 521 NAMCS respondents (95% of the total sample) reported seeing new patients, including 584 psychiatrists, 4400 primary care physicians, and 6537 other specialists. During each period we examined, psychiatrists were less likely than primary care physicians and other specialists to accept new patients with Medicaid (psychiatrists: 2010-2011, 47.93% [95% CI, 40.81%-55.05%]; 2012-2013, 44.94% [95% CI, 37.63%-52.24%]; 2014-2015, 35.43% [95% CI, 27.26%-43.59%]; primary care physicians: 2010-2011, 75.78% [95% CI, 72.11%-79.45%]; 2012-2013, 71.73% [95% CI, 69.11%-74.35%]; 2014-2015, 71.29% [95% CI, 67.53%-75.05%]; other specialists: 2010-2011, 76.99% [95% CI, 73.94%-80.04%]; 2012-2013, 73.22% [95% CI, 69.75%-76.69%]; 2014-2015, 73.33% [95% CI, 71.11%-75.55%]; all comparisons, P < .001; Figure 1). Furthermore, there was a significant decline in the likelihood of psychiatrists accepting new patients with Medicaid. The likelihood of psychiatrists accepting Medicaid declined from 47.9% from 2010 through 2011 to 44.9% from 2012 through 2013 (Figure 1; P = .04) and to 35.4% in 2014 through 2015 (P = .01). In contrast with these declines, no significant change in Medicaid acceptance was found among primary care physicians or other specialists.

The adjusted difference-in-differences estimates suggest Medicaid expansion was not associated with a discernable change in the likelihood of accepting new patients with Medicaid among psychiatrists (Figure 2; −7.89% [95% CI, −40.03 to 24.24%]; P = .63). Furthermore, Medicaid expansion was associated with an increase in Medicaid acceptance among other specialists (14.0% [95% CI, 7.12-20.89]; P < .001) but not with a change in Medicaid acceptance among primary care physicians (−1.82% [95% CI, −13.38 to 9.74%]; P = .76).
Discussion | Owing to declines in psychiatrist participation in Medicaid, patient gains in insurance coverage under Medicaid expansion may not translate into meaningful improvements in access to office-based treatment by psychiatrists. This study was limited by the relatively small physician sample size in the NAMCS and only 2 years’ postexpansion data in most expansion states. Furthermore, low Medicaid participation among primary care physicians has been attributed to low Medicaid physician fees, reimbursement delays, and administrative burden.6 However, we lacked data to explore the relative importance of these potential factors in psychiatrists’ decision to accept Medicaid patients.

This topic merits future study. The patterns we observed in Medicaid acceptance among psychiatrists over time suggest that factors other than Medicaid expansion must account for these findings. Future research is also needed to identify interventions, such as team-based care coordination approaches, to increase Medicaid capacity to care for patients with behavioral health care needs.

Hefei Wen, PhD
Adam S. Wilk, PhD
Benjamin G. Druss, MD, MPH
Janet R. Cummings, PhD

Author Affiliations: Department of Health Management and Policy, University of Kentucky College of Public Health, Lexington (Wen); Department of Health Policy and Management, Emory University Rollins School of Public Health, Atlanta, Georgia (Wilk, Druss, Cummings).

Accepted for Publication: March 17, 2019.
Corresponding Author: Hefei Wen, PhD, Department of Health Management and Policy, University of Kentucky College of Public Health, 111 Washington Ave, Lexington, KY 40536 (hefei.wen@uky.edu).

Published Online: June 5, 2019. doi:10.1001/jamapsychiatry.2019.0958
COMMENT & RESPONSE

Pharmacological Management of Delirium

To the Editor JAMA Psychiatry published a network meta-analysis on pharmacological interventions for delirium in which the authors conclude that “…haloperidol plus lorazepam seems to be a superior therapeutic choice in patients with delirium.” As delirium is an important health care problem, initiatives for improvement are applauded. However, we would like to point out some concerns arising from the conclusions from this study.

First, lorazepam and haloperidol are not disease-modifying drugs, and sedation is not treatment for delirium. The solitary study on which the conclusions rest assesses the combined effect of lorazepam and haloperidol in delirium treatment of agitated patients near the end of life (median survival, 73 hours). Patients receiving lorazepam in addition to haloperidol on average were lightly to moderately sedated, compared with the placebo group who were alert, calm, or drowsy. This treatment likely masked hyperactive delirium symptoms through sedation, leading the patients in a hypoactive delirium state. No therapeutic effect on attention was observed. Thus, the generalizability of these findings to most patients with delirium is highly questionable.

Second, the mean age in the reported studies is younger than 70 years, but medical inpatients with delirium tend to be older, and many are frail and have cognitive impairment or dementia. The studies included in the network meta-analysis by Wu et al were devoid of relevant safety outcomes for the average patient with delirium.

Third, delirium is highly prevalent and is associated with distress, high caregiver burden, and multiple complications. This syndromic diagnosis is not etiological and no final common pathway has been established, to our knowledge. Current consensus is that delirium likely involves multiple mechanisms. Hence, a one-size-fits-all pharmacologic treatment is unlikely to be of much use. Indeed, the most recent evidence-based guidelines, published in March 2019, recommend the prioritization of multicomponent, nonpharmacological approaches for the prevention and treatment of delirium. The most important actions for clinicians are to identify and correct the underlying causes and apply symptomatic treatment of behavioral symptoms and distress. It is only considered appropriate to use psychotropic drugs if there is intractable patient distress or substantial safety concerns. In these cases, there is always a trade-off, as benzodiazepines and antipsychotics have well-known severe adverse effects (eg, decreased level of consciousness, falls).

We are very concerned that this article will wrongly encourage health care professionals to prescribe lorazepam and haloperidol to patients highly vulnerable to these adverse effects and cause further harms.

Bjørn Erik Neerland, MD, PhD
Karin J. Neufeld, MD, MPH
Arjen J. C. Slooter, MD, PhD

Author Affiliations: Oslo Delirium Research Group, Department of Geriatric Medicine, Oslo University Hospital, Oslo, Norway (Neerland); American Delirium Society, Milwaukee, Wisconsin (Neufeld); Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, Maryland (Neufeld); European Delirium Association (Slooter); UMC Utrecht Brain Center, Department of Intensive Care Medicine, University Medical Center Utrecht, Utrecht University, Utrecht, the Netherlands (Slooter).

Corresponding Author: Bjørn Erik Neerland, MD, PhD, Oslo Delirium Research Group, Department of Geriatric Medicine, Oslo University Hospital, P.B. 4956 Nydalen, N-0424 Oslo, Norway (bjørn.ekirik.neerland.net).

Published Online: July 3, 2019. doi:10.1001/jamapsychiatry.2019.1513

Conflict of Interest Disclosures: Dr Neufeld reports grants from Hitachi and personal fees from Merck & Co outside the submitted work. No other disclosures were reported.


In Reply We read with great interest the letter by Neerland et al and fully agree with the opinions about delirium management that: (1) the most important actions are to identify and correct the underlying causes and apply symptomatic treatment of behavioral symptoms and distress and (2) there...