# A Proposal for Mental Health Care in a Single Payer National Health Program

## Introduction

Mental health disorders are a leading cause of disability in the U.S. An estimated 1 in 5 U.S. adults have a mental illness, yet less than 40 percent of affected adults received any mental health services (Murray et al, 2013 and Moitra et al, 2022) The cost of mental illness to the economy is high, with major depression alone estimated to cost $210 billion in 2010. (Greenberg et al, 2015). Inadequate treatment contributes to individual and family suffering, homelessness, lost productivity, suicide, and spillover costs to other parts of the health system, and significantly, to the prison system. Because patients with mental illness also suffer high rates of poverty, they are at risk for un- and under-insurance, exacerbating financial barriers to care.

Children fare no better. Four million children and adolescents in the US suffer from a serious mental disorder that impairs their functioning at home, at school, or with peers (National Research Council and Institute of Medicine, 2009). In any given year, only a fifth of children with mental disorders are identified and receive mental health services (U.S. Public Health Service, 2000). In youth, untreated disorders can have life-long effects. The annual cost of mental illness in young people amounts to $247 billion, including costs for treatment, lost productivity, and crime (National Research Council and Institute of Medicine, 2009).

Despite expanding coverage, the Affordable Care Act has done little to lower barriers to appropriate psychiatric care or change the practices of insurers that single out psychiatric patients for special scrutiny and restrictions on access to care. Most of the

Medicaid expansion has been implemented through private Medicaid managed care organizations that aggressively "manage" mental health care, requiring prior authorization for psychiatric treatment more frequently than for any other medical specialty care. (Funkenstein et al, 2013)). Insurers also stringently limit their networks of providers and publicize lists of in-network providers that are replete with wrong numbers and/or providers who are not accepting patients, making it difficult for patients to access needed care (Malowney et al, 2014). Most insurers also impose deductibles, co-pays, and co-insurance for services and medications. These barriers are particularly problematic for those with serious mental illness.

Reimbursement for psychiatric care is often lower than for other types of services. Acute care hospitals that offer psychiatric care generally lose money by doing so. As a result, health care facilities, not just insurers, frequently obstruct access to outpatient psychiatric care and limit the number of inpatient psychiatric beds they maintain.

By 2014 over half of U.S. psychiatrists had stopped accepting any insurance at all (Bishop et al, 2014) a trend that has undoubtedly gotten worse since then. Psychiatrists are often in solo practice with no employees and unable to deal with the computer systems required and administrative costs and burdens of billing and collections from insurance, dealing with prior authorizations and claims denials, and the data reporting demands of the 2015 MACRA and MIPS laws (Qi et al, 2022). Furthermore, the nationwide shortage of psychiatrists means those in practice often have little difficulty filling their practices with cash-paying patients. As a result, many simply stopped accepting insurance of any kind. And psychiatrists who do not accept insurance are

significantly less likely to care for the seriously mentally ill than those still accepting insurance (Busch et al, 2019).

Not surprisingly, demand for psychiatric services outstrips supply (Weiss et al, 2012) and our nation's emergency rooms have become *de facto* psychiatric wards; 70% of emergency physicians reported that on their last shift they had boarded psychiatric patients for whom a psychiatric bed could not be found, sometimes for days (American College of Emergency Physicians, 2017). In Hawaii, the state Medicaid Department converted the Aged Blind Disabled population, which includes most of the seriously mentally ill, to private managed care organizations in 2009 and cut back state-provided mental health services at the same time. Prior to privatization through Medicaid Managed Care Organizations almost all Hawaii psychiatrists accepted Medicaid, but by 2013 almost none of them were still accepting new Medicaid patients, and mental health emergency room and hospital costs shot up 30% in those four years (Consillio, 2013)

Although the Affordable Care Act has increased access to health insurance, 7.7% (26 million) of Americans remained uninsured in 2023 (US Dept of Health & Human Services Report, 2023). Another 34% (115 million) of Americans had gaps in coverage during the year or were underinsured in 2022 (Collins et al. 2022), and even those with seemingly "good" insurance often face substantial barriers to mental health care.

In what follows we offer a proposal for greatly improved mental health care within a not-for-profit single-payer national healthcare program (NHP). Our proposal would eliminate financial and bureaucratic barriers to care and put treatment decisions in the hands of doctors and patients.

## Single payer health care financing

Physician organizations have made several proposals over the years for a publicly financed single-payer National Health Program (NHP) covering all Americans for all their healthcare needs. Most recently, a proposal put forward by Gaffney and others—and endorsed by Physicians for a National Health Program--outlines a comprehensive health care plan that would provide universal coverage without deductibles or copayments (Gaffney et. al., 2016).

Despite the U.S. spending far more per capita than countries with universal coverage, many Americans have no health insurance or have insurance that does not prevent bankruptcy in the event of serious illness (Pollitz et al, 2014). A large proportion of U.S. health care spending is currently wasted on bureaucratic expenses, with about a third of total U.S. health care spending currently going to administrative costs borne by both insurers and providers of care. (Woolhandler, Campbell, Himmelstein, NEJM 2003). U.S. private insurers' overhead is around 18 percent, depending on definitions of "overhead," compared to about 2% in traditional Medicare. By eliminating private insurance, an NHP would slash administrative overhead, saving over $375 billion annually, enough to cover all the uninsured and eliminate cost-sharing for everyone else (Jiwani, Himmelstein, Woolhandler, et al 2014).

In light of the large unmet need for mental health care, some of the administrative savings from implementing an NHP should be devoted to improving the mental health care system. This system must be redesigned to be accountable to the needs of the community, and to be as cost-effective as possible.

In what follows, we take as our starting point the Gaffney proposal for an NHP.

Its key elements include:  Coverage of all physical and mental health care, as well as long-term care, rehabilitation, and dental care, without copayments or deductibles; funding of hospitals through global lump sum budgets that cover all operating expenses, including payments to salaried physicians; and accommodation of both simplified fee-for-service and salaried practice for physicians.

**A Proposal for Organizing and Funding Mental Health Care in a Single-Payer National Healthcare Program**

## I. Coverage and benefits

*A single payer NHP would cover all medically necessary care including mental health care, with no arbitrary coverage limits, whether inpatient or outpatient, and without co-payments or deductibles.*

This means that all inpatient hospitalization and all medically necessary outpatient treatment would be covered in full. Psychiatric medications on the NHP formulary would also be covered without co-pays or deductibles.

Under the NHP, formularies for all drugs, including psychiatric drugs, would be determined by Formulary and Therapeutics Committees composed of practicing physicians from the relevant specialties who have no ties to the pharmaceutical industry, along with pharmacists and patient advocates, and reviewed at least annually. Psychiatric formularies should be broad enough to assure options for those with trouble tolerating certain medications. Serious side effects from psychiatric medications are common, especially for antipsychotics, and often require discontinuation or switching to another drug. One study, for example, found that no matter which antipsychotic drug was chosen first, 75% of patients will have to be switched to at least one other drug before finding one the patient will take long enough and in an adequate dose for it to be effective (Lieberman, J. A., Stroup, T. S., McEvoy, et al, 2005).

Although a broad formulary is desirable, new drugs with no clear advantage over established drugs would not automatically be added to the formulary, since widespread

promotion and use of such "me too" drugs both raises costs and diverts pharmaceutical research resources onto "me too" drugs and away from real innovation. Prior authorization requirements would apply only to those drugs found to be prone to inappropriate use for reasons other than medical necessity. The NHP would control pharmaceutical prices through bulk purchasing and price negotiations with the pharmaceutical companies, not by arbitrary formulary restrictions and excessive reliance on prior authorizations. (See Gaffney et al, 2018. PNHP proposal for reform of the pharmaceutical industry.)

**II. Payment for mental health care**

*To assure a cost-effective, fair, and transparent payment system while sharply limiting opportunities for fraud and abuse, we advocate the following principles for payment of psychiatrists and other mental health professionals:*

1. *Providers of care must be paid directly by the single-payer program with no profit-seeking fiscal intermediaries.*

2. *Payment should be based on paying for physician and other mental health professional time and expertise based on training, and not on a system for assigning a "value" to each procedure instead of to the time and expertise of the professional performing the procedure.*

The Resource Based Relative Value System (RBRVS) fee-determination system attempts to calculate a relative "value" for each of thousands of procedures. This has enabled devaluation of physician expertise and substitution of mid-level practitioners with far less training than physicians because "value" has been placed on the

procedures rather than on the training and expertise of the professional performing the procedure. The RBRVS has also left a large portion of physician work time unreimbursed, especially for primary care specialties (Sinsky et al. 2016).

3. *Restoration of physician autonomy in clinical decision-making.*

   For cognitive services, physicians and their patients should have control over time allocated for care of each individual patient, and payment should cover everything a physician does on behalf of a patient with no unreimbursed patient-care time. Payment must include required time spent on documentation, care coordination, letter-writing, long phone calls, telehealth in a pandemic, etc.

4. *Payment of providers of care must be disconnected from diagnostic coding except to justify medical necessity.*

   This can be accomplished either with salaries for physicians and other mental health professionals included in institutional global budgets or with fee-for-service for independent providers that does not involve shifting insurance risk onto providers. Risk adjustment first became necessary when Medicare started paying fiscal intermediary Medicare Advantage plans with capitation, because holding providers or capitated health plans accountable for the outcomes and cost of care creates an incentive to avoid treating sicker and costlier patients and populations. Risk adjustment attempts to correct for this but is too inaccurate to be an effective deterrent to "cherry picking" the capitated population to secure a favorable risk pool. Medicare introduced the Hierarchical Conditions Categories risk adjuster in 2004 in an effort to improve the accuracy of risk adjustment, which tied payment to diagnosis for the first time and created an incentive to "up-code" diagnoses to game the risk adjustment formula. The

need for risk adjustment has been expanded with all forms of "value-based payment" including bundled payments, pay-for-performance or outcomes, capitation of primary care physicians, and the push for capitated ACOs, ACO REACH, etc. As a result, up-coding has become a pervasive form of gaming the payment system, often to the point of fraud (Abelson & Sanger-Katz, 2022).

5. *The EHR must be re-focused on patient care priorities, optimizing physician work-flow, and quality improvement instead of on meeting the demands (and gaming) of the payment system.*

6. *Prior authorizations should be severely limited and applied only for services and pharmaceuticals prone to mis-use and/or abuse.*

7. *Billing and collections must be vastly simplified and transparent, eliminating the need for specialized billers, coders, revenue-cycle management companies, collection agencies, etc.*

Standardization of fees, equal benefits and a uniform payment system care of everyone regardless of their economic circumstances, elimination of unreimbursed care and patient cost-sharing, assuring payment for all time required for patient-care related activities, eliminating unnecessary prior authorizations, and disconnecting payment from diagnoses would all help achieve this goal.

Eliminating capitated payment, either through fiscal intermediaries and/or direct capitation of physicians, would also help achieve this goal. Capitated payment introduces incentives to avoid sicker and costlier members to secure a favorable risk pool and rewards skimping on care. These perverse incentives require administratively costly and burdensome risk adjustment, which is both ineffective at preventing risk

pool gaming and creates a new incentive for up-coding that requires further counter-incentives. Capitation also requires pay-for-performance to deter skimping on care, but attempts to measure quality are woefully inadequate and costly and burdensome to administer.

8. *Collective negotiation of fees and salaries for payment of physicians and other independent professional practitioners.*

Administrative simplification and savings in a single-payer system will depend on standardization of the payment system, but unilateral control of fees by government will inevitably lead (as it has in other countries) to inadequate payment for physicians and other professionals over time. Collective bargaining, as with physicians in Canada, is necessary to keep fees and salaries reasonable for both physicians and for the single-payer and the taxpayers who fund it. Collective negotiation of physician fees and salaries will also be necessary to secure physician buy-in for a single-payer program.

All of these principles could be satisfied with either physician and other professional salaries included in institutional global budgets (with no capitated fiscal intermediaries) or with replacing the RBRVS with a fee-for-service payment system that pays for the value of professional time and training instead of a system for assigning a “value" to each procedure. A well designed, cost-effective, and physician-friendly system could be built with a mix of both payment systems depending on whether physicians were employed by institutions or in independent practice. For a detailed proposal for physician payment based on time and training, see Kemble and Kahn, “Optimizing physician payment for a

single-payer healthcare program." (Kemble & Kahn, 2023)

Clinics, hospitals, and specialized programs for substance abuse and the seriously mentally ill would receive global operating budgets, with clinicians working in these settings paid salaries. Budgets would be based on institutional cost of operations plus professional salaries, not capitation of fiscal intermediaries. Mental health professionals in independent practice would be paid on a simplified fee-for-time basis designed to be as incentive-neutral as possible.

The current fee-for-service system based on Evaluation and Management (E/M) codes plus psychotherapy add-on codes under the CPT coding system is overly complex and encourages excessive documentation to meet criteria for more highly reimbursed codes. The NHP would instead pay fee-for-service practitioners based on time scheduled with the patient plus time needed for documentation and care coordination, similar to the time-based mental health procedure codes in use prior to 2013, after which psychiatrists were switched to much more complex Evaluation/Management procedure coding. Payment with either salaries for employed practitioners working for globally budgeted institutions or with time-based fee-for-service for those in independent practice does not involve shifting insurance risk onto providers, so these forms of payment have no need for risk adjustment based on diagnosis, severity of illness, or complexity of services, and no need to pay more for procedures versus cognitive services. Thus, the NHP would remove financial incentives to do certain "procedures" compared to others, so that therapeutic choices would be based only on the best interest of the patient instead of incentives favoring procedures over cognitive services. Documentation based on clinical priorities instead of "pay-for-documentation" would save time and money for both mental

health professionals and for claims administration. Time-based billing plus the ability to monitor total time billed per practitioner would greatly reduce opportunities for fraud and abuse.

We expect that most services would be covered by four codes - an initial evaluation code expected to be scheduled for an hour; a 15 minute visit for medication or brief check-ins with stable patients; a 30 minute visit; and a 45-50 minute visit, all including both psychotherapy and medication management. The clinician and patient could decide on visit length based on the patient's situation. For crisis services or complex services such as family psychotherapy, practitioners could bill for actual time spent, with documentation supporting the time billed.

Given both the extra training required by child and adolescent psychiatrists as well as the extra work conferring with parents, teachers, and other interested parties often required when treating children and adolescents, payment rates for child psychiatrists would be higher than the base rate for adult psychiatrists, and procedure codes would include non-face-to-face care coordination time. When psychiatrists with subspecialty training in child and adolescent psychiatry see adult patients, however, they would not be paid at this higher rate.

Pay differentials between types of providers (e.g. psychiatrists, psychologists, social workers, or clinical nurse specialists), would be based on the years of training required to practice each discipline or discipline subspecialty. For prescribers such as psychiatrists and advanced practice nurse specialists, within a given discipline there should be no differential in pay between psychotherapy, medication management, or a combination of the two, assuring incentive-neutrality.

Care funded by the NHP would require documentation and justification for treatment based on medical necessity, including a biopsychosocial assessment, mental status exam, relevant laboratory test results, a diagnosis and assessment, and a treatment plan that is plausibly expected to benefit the patient's identified problems. Medical necessity criteria would be set by an Office of Quality Control under the NHP, similar to current regional Medicare Carrier Advisory Committees. Fee schedules would be negotiated between the NHP and professional organizations representing practitioners, with adjustments for regional cost-of-living and to correct for sub-specialty and regional shortages. Individual practitioners would be able to submit a patient name, diagnosis, and time-based service code electronically or via mail, and receive reimbursement from the NHP for their services. Simplified billing and uniform payment regardless of practice location would enable mental health providers to enter and sustain small scale practices anywhere, including in rural and under-served areas, and to care for complex patients without undue administrative barriers.

To encourage mental health care clinicians to work in underserved areas, the NHP would provide dedicated funding for hospitals to provide and expand mental health care, based on community need. The cost-effectiveness of mental health care would be enhanced by interdisciplinary collaboration and teamwork among psychiatrists and other mental health practitioners. This includes funding for psychiatrists and other disciplines, including psychologists, clinical social workers, psychiatric nurses, marriage and family therapists, care managers, and substance abuse counselors, to work collaboratively on a salaried basis in globally budgeted specialized programs for the seriously mentally ill and for substance abusers, and for consultation to primary care practices and other general

medical settings.

**III. Improving Care for the Seriously Mentally Ill**

In the U.S., the trend toward cash-only practices and refusal of insurance has resulted in many mental health providers gravitating to treating minimally ill individuals. The NHP would introduce several features that would encourage improved focus on treatment for the seriously mentally ill (SMI). An NHP that eliminated disparities in access to care based on insurance status would in itself enhance access to mental health care for the seriously mentally ill. Education and training for mental health professionals would focus primarily on this population. Training programs for all mental health related disciplines would prioritize placing trainees in specialized programs for the seriously mentally ill and substance abuse, and in collaborative care programs supporting management of mental health problems in primary care and general medical settings. Simplified billing and administration and a uniform payment system that did not discriminate against poorer and sicker patients would remove administrative and financial barriers to practice in underserved areas where those with SMI often live. The NHP would eliminate for-profit hospitals and establish more incentive-neutral payment systems, including global budgeting for hospitals and clinics and time-based reimbursement for independent practitioners, markedly reducing incentives for unnecessary care and minimizing the need for burdensome managed care restrictions. With providers paid with either fee-for-service or salaries and elimination of payment schemes such as capitation, bundled payments, and pay-for-outcomes that shift insurance risk onto providers, there would be no financial incentive to “cherry pick” healthier patients and avoid the sick.

## IV. Community-Based Resources to Improve Care of Mental Disorders

### a) Expanded Community-based Services for those with Serious Mental Illness (SMI)

*Under the NHP, care for those with SMI would be prioritized. Specialized services for the seriously mentally ill would be funded through institutions with global operating budgets and would be available to all patients in a community based on need.*

Under the NHP, patients with SMI would have access to specialized services, including crisis intervention, case management, psychosocial rehabilitation, Assertive Community Treatment programs, day programs, intensive out-patient programs, residential programs, clubhouse model programs, short-term hospitalization for acute psychiatric problems, and dual-diagnosis programs for those with both SMI and substance abuse problems. For those who need it, long-term psychiatric hospitalization would also be provided.

Services would be delivered by local government entities or by contracting with non-profit entities paid global operating budgets. Continuity of caregivers is a priority in treatment of those with SMI and changes in service providers are to be minimized, so contracts with non-profit entities should be for at least 5 years, with preference for continuity in the absence of egregious contractor failure. All inpatient and residential facilities would be subject to unannounced inspections by outside assessors.

Independent psychiatrists, other mental health practitioners, and primary care practices with patients who need specialized services would be assisted by case managers employed by these specialized programs, who would help develop individualized service

plans that address complex patients' needs. Specialized programs for those with SMI should emphasize interdisciplinary care, working as teams that meet regularly to go over individual patients and fine-tune their treatment plans. This additional support would enable independent mental health practitioners and primary care practices to take on difficult patients whose problems cannot be fully managed in the office setting.

**b) Substance Abuse Treatment**

*Treatment for substance use disorders would be covered along with all other forms of psychiatric care.*

Drug and alcohol abuse are common, often co-occur with serious psychiatric problems, and often lead to other health problems and criminal behavior. Effective substance abuse treatment has been shown to reduce spending on other health problems and for society at large (Holder, 1998).

The NHP would provide the full range of substance abuse services as community based, globally budgeted programs. Funded services would include inpatient detoxification, both long-term and short-term residential substance abuse treatment, dual diagnosis programs, intensive out patient services including group treatment programs, and evidence based pharmacological treatment for those with substance use disorders.

**c) Integration with Primary Care**

*Collaborative care, with psychiatrists and care managers consulting to primary care settings, would be a priority in the NHP, to ensure timely, high quality mental health care for those who need it.*

Embedding mental health practitioners in primary care practices has been shown to improve outcomes and efficacy of care, and this would be an option for larger clinics

and group practices (Patel et al, 2015). For smaller practices, it is more cost-effective to provide Collaborative Care Model consultations as a community resource (Tice et al, ICER Report, 2015), and at least one study found that Collaborative Care achieved better treatment results than "co-located" care with a mental health practitioner embedded in a primary care practice (Blackman & Carleton, 2018). In the Collaborative Care Model psychiatrists are paired with care managers (usually clinical social workers or advanced practice psychiatric nurses) consulting to primary care practices to augment the ability of primary care practitioners to manage most psychiatric patients themselves. (See AIMS Center, Evidence Base for Collaborative Care. U. of Washington. 2023.) The model has been shown to enable psychiatrists to reach a much larger population than with direct care, and it enables prompt and high-quality response to requests by primary care practices for help with their patients with mental illness, improving access to mental health services and overall health. The Collaborative Care team also functions as a triage and quality assurance service. In a minority of cases, when a full psycho-social assessment by the team determines that direct care by a community psychiatrist or psychotherapist is medically necessary, the team can facilitate such referrals. The NHP will establish funding for the Collaborative Care Model using globally budgeted community-based programs with both psychiatrists and interdisciplinary staff paid with salaries, and services made available to all primary care practices and clinics without cost to the practice, based on patient need.

**d) Training programs in psychology and psychiatry**

*The NHP would pay for health professional education, including tuition and post-graduate training.* Educational debt should not dissuade individuals from going into

psychiatry and mental health disciplines. The NHP would expect mental health training programs to focus on the needs and treatment of SMI patients in order to ensure that those in training learn to care for the sickest psychiatric patients while they have support, teaching, and supervision. Training focused on the SMI population, together with augmented community-based specialized support programs and payment that did not discriminate based on patients' socio-economic status, mean that trainees would be more likely to continue working with SMI patients after finishing their training.

**e) Innovation in Mental Health Care**

*The NHP would provide funding for innovation and pilot programs for alternative services, including expanding community-based services for those with SMI.*

The NHP would support innovation and pilot programs testing alternative service models, including expanded community-based services for those with SMI. Funding priorities for these programs would be determined by a panel of psychiatrists, psychologists, and community representatives of SMI patients and their families. These panels would specifically exclude members with ties to the health insurance, medical device, or pharmaceutical industries.

## Conclusion

Although a single payer reform would rectify many of the ills in our current health care system, in-and-of-itself it would not fully address the glaring deficiencies in care, or current disparities based on socioeconomic status and other factors (Steele et al, 2006). Savings on administration through the simplification of the payment system would free up the resources needed for these new and expanded programs, and for first dollar coverage of existing care. Meeting mental illness and substance abuse needs will require new specialized programs to assure adequate treatment for those with the most serious problems, and to encourage collaboration between mental health professionals and primary care physicians.

The NHP would eliminate the abuses of managed care, make payment incentive-neutral, and rely as much as possible on professional training and ethics to target care appropriately and maximize cost-effectiveness, markedly reducing the bureaucratic management now imposed by health insurers and government agencies. It would equalize payment regardless of patient socio-economic status or location and simplify billing, making independent practice viable in any location where services are needed. Training and community-based support services would be designed to support and encourage psychiatrists to manage treatment of the most seriously ill patients.

Under our proposal, mental health professionals would be able to practice either independently or as employees in hospitals and other institutions, including programs offering specialized community-based services for those with serious mental illness and/or substance abuse problems, and for Collaborative Care consultations to support management of mental health problems in primary care.

Our proposal would greatly improve the morale of psychiatrists and other mental health professionals and make a career in psychiatry more attractive to physicians in training. Canadian child psychiatrists working under their single-payer system are significantly more satisfied with the quality of services for both inpatients and outpatients than their U.S. counterparts. They are less likely to think third-party payers affect their clinical decision-making and spend less of their time on billing-related paperwork (Morra et al, 2011).

We believe that access to health care, including the full range of mental health services, is a fundamental human right. Our patients deserve respect and should not be stigmatized or singled out by special rules and restrictions on their care. The NHP we have outlined above would assure necessary care for all who need it in a cost-effective manner and through a structure that is responsive and accountable to community needs. The need for such a system is most urgent for those suffering from serious mental illness and substance abuse.

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