Written Testimony

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Hearing: “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks”

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Chair Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee,

Thank you for the opportunity to testify today regarding ghost networks -- an issue that my organization and our affiliates have been working on for decades. We are so grateful for your leadership in recognizing that this is a problem that causes much suffering and can be addressed through legislative solutions.

My name is Mary Giliberti, and I lead the public policy efforts at Mental Health America (MHA), a national non-profit with approximately 150 affiliates in 38 states. We were founded over 100 years ago by Clifford Beers, who had a mental health condition and suffered abuse in mental health facilities. He spoke out about this injustice and over a hundred years later, MHA continues to address issues that harm people with mental health conditions and limit access to mental healthcare, such as ghost networks.

The Effect of Ghost Networks on Mental and Economic Health

Due to my work at MHA and, previously, at the National Alliance on Mental Illness, I am asked by friends, family, and people in my community for help finding mental health providers. Unfortunately, one of the first questions I ask is, "Do you need these services to be covered by insurance?" This is because I know that the time and effort it takes to receive the services they need will be reduced substantially if they are able to pay out-of-pocket. My colleagues who work in physical health care do not have to ask this question, and until those of us working in mental health care no longer have to ask it either, we will not know true parity between physical and mental health.

The nation's mental health needs and the continued effects of the COVID-19 pandemic make the issue of ghost networks particularly important to address. According to the Substance Abuse and Mental Health Administration, nearly 1 in 4 adults aged 18 and older and 1 in 3 adults aged 18 to 25 had a mental health condition in the previous year.[i] The pandemic has exacerbated mental health conditions in youth, with 2021 CDC data showing 40% of high school youth feeling persistently sad and 22% seriously considering attempting suicide.[ii]

I recently helped a young woman navigate the process of finding a psychiatrist after her symptoms deteriorated during the pandemic and her therapist recommended she consider medication. She called psychiatrists in her plan directory. Some did not call her back. Some turned out not to be in her network after all. What I remember most about that experience was how her symptoms got worse as she got more and more worried about finding help. The same symptoms that she, and many others with mental health conditions, needed help with– lack of motivation, anxiety, psychosis – make it very difficult, if not impossible, to call providers repeatedly to get a timely and affordable appointment. Fortunately for the young woman I was helping, someone at work mentioned an online telehealth solution available under her plan and she was eventually able to access the services she needed, but not before going through this very difficult and stressful period of delayed care.

Ghost networks can exacerbate mental health conditions, creating additional anxiety and feelings of hopelessness. They delay care and can even lead to individuals deciding to forego care altogether, due either to the difficulty of accessing services, the cost, or both. SAMHSA's data show that nearly half of adults with mental health needs do not receive treatment and the percentage of youth who received

treatment for major depression has remained at roughly 40% for the past six years, indicating that over half of youth with mental health needs are also not getting the help that they need.[iii]

Ghost networks also have a financial cost on individuals and distort the market for health insurance. Studies by Milliman,[iv] researchers from the Congressional Budget Office,[v] and NAMI[vi] indicate that people with mental health conditions are more likely to use out-of-network providers. This places a discriminatory financial burden on these individuals because of the high costs of such providers.

Ghost networks are particularly harmful to low-income people, those with disabilities, and women. As researchers have noted, people of color and individuals with disabilities are disproportionately represented in the Medicaid program and among low-income beneficiaries who are least able to afford the cost of out-of-network care.[vii] People with disabilities often have complex health needs that require finding multiple providers to treat them. Women are more likely to be responsible for family medical appointments and spend additional time, stress, and resources to secure timely care.[viii] This has become increasingly burdensome as children's mental health has worsened and providers for children and adolescents are even more difficult to access.

Inaccurate provider directories also distort the market for insurance plans and erode consumer choice.[ix] Individuals use provider directories to choose insurance plans, especially in Medicare, where individuals may be choosing among Medicare Advantage (MA) Plans or between MA and fee-for-service Medicare. Plans have an incentive to show broad provider directories, but when there are high percentages of inaccuracies, these directories misrepresent the value of a plan and undermine consumer choice.

Research Studies Indicate that Ghost Networks Are Widespread and the Problem Persists Despite Requirements for Provider Directory Accuracy

It is important to note that the individual stories of frustrating experiences with directories are not just anecdotes. They are examples of a widespread problem that has been studied in programs under the jurisdiction of this committee. One of the most telling is a recent study of the Oregon Medicaid program by Dr. Jane Zhu and colleagues.[x] They found that **67.4%** - more than 2/3 - of mental health prescribers and **59%** of other mental health professionals listed in the directories of Medicaid managed care organizations were phantoms. These providers had not submitted claims and billed for more than five unique individuals over a one-year period. I want to underscore that this study used claims data, which is information that every insurance company has access to if they want to verify their provider directories.

CMS has conducted audits of Medicare Advantage Organization (MAO) provider directories. They have looked at various providers, including cardiology, oncology, ophthalmology, and primary care providers and found high rates of inaccuracies with an average deficiency rate of over 40%.[xi] They have not, to my knowledge, audited specifically for behavioral health, but they should.

In addition to the high rate of deficiencies, there are three important conclusions from the CMS audits. First, it is possible to audit accuracies in directories and CMS has done this before and developed a composite measure of deficiencies based on how harmful the inaccuracies were to accessing care. Second, plans can improve the accuracy of their directories. The CMS audits showed significant variation with CMS highlighting two MA plans with deficiencies of less than 10% and two MA plans with deficiency rates above 90%. As CMS noted in its recommendations, "MAOs that take a reactionary approach by

relying solely on provider-based notification will not have valid provider directories. MAOs must proactively reach out to providers for updated information on a routine basis. They should actively use the data available to them, such as claims, to identify any provider inactivity that could prompt further investigation."

Finally, continuing to audit with no transparency or consequences was not very effective, as the average inaccuracy rate in 2018 was worse than the rate in 2016 despite CMS emphasizing the importance of this issue in several call letters and memos to plans. Despite its efforts to improve provider directory accuracy, CMS concluded that its 2018 review revealed significant errors that were likely to frustrate Medicare Advantage members.

An analysis of state laws confirms that having a requirement for accurate directories does not lead to compliance. Laws were passed in California, Louisiana and Maryland requiring accurate directories, but the problems continued despite the legislation. The researcher studying these efforts concluded that the lack of progress was directly related to weak enforcement mechanisms, minimal penalties, and the lack of critical tools to improve compliance.[xii]

MHA affiliates in Maryland and New Jersey conducted secret shopper surveys of psychiatrists in provider directories in 2014 and 2013. The Maryland study assessed provider directories for qualified health plans and found that only 43 % of listed psychiatrists were reachable, with many out-of-date phone numbers or addresses.[xiii] More than 10 % of providers who could be reached indicated that they were not even psychiatrists. Many of the doctors contacted had extremely long wait times. The New Jersey study found that one-third of the network entries for psychiatrists in HMO plans had incorrect phone numbers.[xiv] These studies show that inaccurate directories have been problematic for decades.

Legislative and Administrative Solutions:

Despite the longstanding problem, there are potential solutions. MHA recommends the following three policy changes:

First, the data must be verified using reliable methods such as audits and claims data. At all non-profit organizations, including Mental Health America, we cannot just submit financial data. We are required to have an independent audit. The Medicare Advantage Plans and Medicaid plans should have verified directories. This can be accomplished by a third-party independent audit or by CMS for MA plans. Last week, CMS issued a proposed Medicaid access rule requiring states to use secret shopper surveys by an independent entity for managed care plan directories for accuracy and wait time for appointments for outpatient mental health and substance use providers and several other categories of providers. The surveys would verify active network status, street address, phone number, and whether the provider is taking new patients.[xv] This policy should be finalized, and a similar policy enacted for Medicare Advantage.

Plans also should be required on an annual basis to reconcile their directories with claims data. If a provider has not billed in the previous year, then the insurer should have to remove them from the directory and the network unless they can prove that they will begin taking patients. Plans have full access to their claims data.

Second, the information should be transparent. In its audits of MA plans, CMS did not name the plans, referring to them as A, B, and C. In other areas of healthcare, CMS requires transparency – in Hospital

Compare and Star Ratings. This area also needs more sunlight. CMS has shown that it can develop a scoring system to distinguish among plans. This information on provider directory accuracy rates should be available to anyone choosing a plan. The proposed Medicaid rule requires the secret shopper information to be posted on a state website. This requirement should be finalized, and CMS should continue to work with states to ensure that the information is displayed in a manner that is easily understood by individuals choosing plans and by state and federal regulators.

CMS should ensure similar transparency for Medicare Advantage. A recent brief from the Kaiser Family Foundation concluded, "There is not much information on whether Medicare Advantage enrollees are experiencing barriers accessing mental health providers in their plan's network and the extent to which enrollees use in-network and out-of-network providers for these services."[xvi]

Third, and most importantly, plans must be fiscally incentivized to provide accurate directories. This would include weighing the deficiency rate heavily in overall quality measures, such as how many stars an MA plan receives or a composite quality score for Medicaid plans. This policy would affect the plan's competitiveness in the market and potential bonus payments and would have the advantage of rewarding plans that do a good job.

It is very important that plans that work hard to provide accurate directories and networks are rewarded for their efforts. The plan's reimbursement rates, and the ease and frequency of their prior authorization process, can also influence whether providers are willing to participate in-network and plans that improve these policies also should be rewarded for their efforts. Plans with consistent error rates over a benchmark set by CMS after a corrective action plan could be ineligible to participate or lose bonus payments.

For Medicaid plans, CMS could provide technical assistance and additional matching funds to incentivize states to pay for performance or withhold some percentage of Medicaid payment until plans meet reporting and accuracy requirements. States have withheld payment to Medicaid managed care organizations contingent on reporting accurate and timely data.

Congress could also look to effective enforcement legislation, such as the Health Insurance Portability and Accountability Act (HIPAA), which includes compliance reviews and civil monetary penalties for violations. Additional policies could provide financial protection and reduce administrative burdens on individuals. If a person relies upon an inaccurate directory, the individual should only be responsible for in-network cost sharing. Congress passed legislation applying this requirement to commercial plans and should extend it to all plans. California has passed a law requiring plans to "arrange coverage" of services when an individual cannot find a provider for mental health and substance use disorder services. The plan must find in-network providers who can provide timely care or provide out-of-network care with no more cost sharing than an in-network provider.[xvii]

Related Issues that Would Improve Directories, Networks, and Access to Care

Although this hearing is focused on inaccurate provider directories, there are four related issues for the Committee to consider for future legislation that would improve provider directory inaccuracies and, most importantly, access to behavioral healthcare: provider rates, telehealth, integrated care, and extension of parity requirements to Medicare Advantage Plans and Medicare and Medicaid fee-for-service programs.

A recent Government Accountability Office (GAO) report revealed that mental health stakeholders cited inadequate reimbursement rates for services as one of the main reasons providers do not participate in networks and individuals cannot access mental health care, even when they have insurance.[xviii] A study by the Kaiser Family Foundation found that only 1% of physicians have opted out of the Medicare program, but psychiatrists were disproportionally represented, making up 42% of those opting out, followed by physicians in family medicine (19%), internal medicine (12%), and obstetrics/gynecology (7%).[xix] Medicare's process for setting rates devalues cognitive work and fails to adjust for increased demand, relying only on supply factors. In addition, researchers found that commercial and Medicare Advantage plans paid an average of 13-14% less than fee-for-service reimbursement rates for in-network mental health services while paying up to 12% more when care was provided by physicians in other areas of healthcare.[xx]

Data clearly demonstrate that Medicaid programs in most states pay less than Medicare, with some states paying less than half of Medicare reimbursement rates for primary and maternity care.[xxi] Although this study did not analyze mental health rates, we can infer from studies of commercial plans that these disparities are equal or worse in behavioral healthcare.[xxii] The Senate Finance Committee Task Force on Workforce proposed a Medicaid state demonstration program with increased federal matching resources to improve rates and training of the behavioral health workforce. This policy change would significantly improve access if enacted and would complement recently proposed Medicaid access regulations which increase rate transparency for outpatient mental health and substance use services and compare these rates to Medicare fee-for-service reimbursement rates.

When I was helping the young woman access psychiatric services, she was finally able to get assistance from a telehealth platform and provider. Unlike dialing endlessly for help, the platform showed which providers were available and allowed her to make an appointment online. Some individuals prefer or need in-person care, so it is critical to maintain requirements for in-person networks. At the same time, allowing robust telehealth options streamlines the process for getting care quickly and efficiently. Congress extended the Medicare telehealth flexibilities and waived in-person requirements until 2024. Such changes should be permanent to provide greater access and Congress should incentivize states to make it easier for providers to practice across state lines.

Primary care providers are easily accessible, and many individuals already have an in-network primary care provider. Although strong models have been developed to integrate behavioral health into primary care for children and adults, there has been slow adoption due to low reimbursement rates, high startup costs, and cost-sharing barriers. The Senate Finance Task Force recommendations on integrated care and other legislative proposals would address these impediments and should also be enacted to increase access to services.

Finally, the exclusion of certain plans and programs from parity requirements is unfair to individuals with behavioral health conditions in those programs. There is no explanation for why Medicaid managed care plans are covered by parity requirements, but Medicare Advantage plans are not. People who get their care through Medicare are no less deserving of equal coverage of mental health and substance use services. In addition, both the Medicaid and Medicare fee-for-service programs are excluded. The rights of people in Medicaid should not depend on whether their state has chosen to use managed care plans. Similarly, people in Medicare should not have to factor in parity requirements when making their choices.

Conclusion:

There will always be some provider directory inaccuracies, but the high rates consistently revealed in recent studies and audits are not minimal errors. They are consumer and government deception misrepresenting the value of the plan and the breadth of its offerings. And this misrepresentation is particularly troubling because it causes great suffering for people who are already struggling. With the right verification of data, transparency requirements, and fiscal incentives, we can do better.

Thank you again for your attention to this issue.

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[viii] *Id.* citing Sharma N, Chakrabarti S, Grover S. Sharma N, Chakrabarti S, Grover S. "Gender differences in caregiving among family - caregivers of people with mental illnesses." *World J Psychiatry*. 2016 Mar 22 [explaining that women are more likely than men to be informal caregivers for people with mental illnesses]; Grigoryeva A., "When Gender Trumps Everything: The Division of Parent Care among Siblings." *Ctr. for the Study of Soc. Org., Working Paper No. 9.* 2014. [finding that women are twice as likely as men to act as caregivers for their parents.]

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