



STATEMENT

of

Jack Resneck, Jr., MD

President

American Medical Association

U.S. Senate Committee on Finance

**Re: Barriers to Mental Health Care: Improving Provider
Directory Accuracy to Reduce the Prevalence of Ghost Networks**

May 3, 2023

**Division of Legislative Counsel
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I appreciate the opportunity on behalf of the American Medical Association (AMA) to provide testimony to the U.S. Senate Committee on Finance as part of the hearing entitled, “Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks.” In addition to my position as President of the AMA, I am a practicing dermatologist and the Chair of the Department of Dermatology at the University of California, San Francisco.

As the President of the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, I am acutely aware that provider directories are critically important tools to help patients find a physician when they need one. Directories allow patients to search and view information about in-network providers, including the practice location, phone number, specialty, hospital affiliations, whether they are accepting new patients, and other details. Some directories also provide information on health equity and accessibility issues, such as public transportation options, languages spoken, experience with specific patient populations, and the ability to provide specific services.

Directories can help physicians make referrals for their patients, serving as a primary source of network information for patients’ health plans. Directories also serve as a representation of a plan network and the network’s adequacy for regulators.

Importantly, directories can help patients purchase the health insurance product that is right for them. A patient with psoriatic arthritis may select a product that appears to have their rheumatologist and dermatologist in the network. A family without a car may select a product because the pediatrician down the street is in-network. A 26-year-old may not choose to put money in her flexible savings account this year because all of her physicians appear to be contracted under her new plan. And patients being treated for opioid use disorder may pick a product because it appears that the mental and behavioral health care services they require are available through the plan’s network providers.

Therefore, when directory information is incorrect, the results can be complicated, irritating, expensive, and potentially devastating, especially to patients. Inaccurate directories shift the responsibility onto patients to locate a plan's network or pay for out-of-network care. Patients are financially impacted and may be prevented from receiving timely care.

Moreover, in the long run, continuing to allow inaccuracies makes it easier for plans to fail to build networks that are adequate and responsive to enrollees' needs. Accurate directories are a basic function and responsibility of health plans offering network products. It should be noted that directory accuracy seems of particular importance in the immediate term, as we face the end of the Medicaid continuous enrollment provision, and many Medicaid recipients begin to transition off Medicaid and onto private health insurance plans. It is critical that directories provide accurate information for individuals who are entering the private market, especially those who may have chronic conditions or significant health care needs and are looking to ensure that their physicians and other health care providers are in-network.

I. Scope of the problem

There have been dozens of studies over the last 10 years looking at the scope of the provider directory problem and nearly all of them point to serious inaccuracies with physicians' locations, as well as inaccurate physicians' network status, physicians' availability to accept new enrollees, physicians' specialties, or all of the above.

In October 2014, I published a study with several colleagues in the *Journal of the American Medical Association Dermatology*.¹ We specifically studied Medicare Advantage (MA) plan directories of participating dermatologists and the appointment availability of those dermatologists listed. Our "secret-shopper" research first found that about 45 percent of the listings included duplicates—multiple office listings at different addresses for the same physician, or the same physicians at the same addresses with slightly different versions of their names. This, of course, created the appearance of more robust networks than were in place.

After accounting for those duplicates, we found that they were unable to contact nearly 18 percent of physicians either because the numbers were wrong, or the office had never heard of that physician. Furthermore, 8.5 percent reported that the listed physicians had died, retired, or moved out of the area.

After that, we found that 8.5 percent of those physicians were not accepting new patients, and more than 10 percent were not the right type of physician to address the condition for which we were seeking care (an itchy rash)—e.g., they were subspecialists, dermatologic surgeons, pediatric dermatologists, etc. In the end, we found that about 26.6 percent of the individual directory listings were unique, accepting the patient's insurance, and offering a

¹ J. Resneck, A. Quiggle, M. Liu, D. Brewster, "The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks;" *JAMA Dermatology* (October 24, 2014).

medical dermatology appointment. However, the average wait time to get that appointment was 45.5 days.

Since I published that study, I fear that the situation has not improved. In 2018, the Centers for Medicare & Medicaid Services (CMS), in a review of 52 MA organizations (MAOs) (approximately one-third of MAOs at the time), found that nearly 49 percent of the provider directory locations listed had at least one inaccuracy.² Specifically, providers should not have been listed at 33 percent of the locations because the provider did not work at the location or because the provider did not accept the plan at the location. CMS also found a high number of instances where phone numbers were wrong or disconnected and incorrect addresses were listed. Similarly, CMS reported cases where the provider was found not to be accepting new patients, although the directory indicated that the provider was accepting new patients.

Errors in location and contact information can lead to patient frustration and, in many cases, delays in accessing care. It can also result in higher costs for patients. The AMA fielded a survey between 2017 and 2018 where 52 percent of physicians reported that their patients encountered coverage issues due to inaccurate information in provider directories at least once per month.³ And a 2020 study in the *Journal of General Internal Medicine* found that, of patients receiving unexpected bills, 30 percent noted errors in their health plan's provider directory.⁴

Imagine selecting a health plan and paying health insurance premiums only to find out that you relied on erroneous information. Imagine the sense of helplessness and frustration amongst patients when they cannot access the care on which they were counting.

Directory inaccuracy issues do not seem to be specific to any type of physician specialist or patient care, but **in a moment where we are facing a mental health crisis, it is imperative that health plans offer adequate networks that are accurately reflected in their directories so that patients can access timely mental and behavioral health care.**

Unfortunately, this does not seem to be happening. For example, a March 2022 Government Accountability Office (GAO) report to this Committee⁵ highlighted patient challenges with accessing mental health care. Stakeholders reported that inaccurate or out-of-date information on mental health providers in a health plan's network contributes to ongoing access issues for consumers and may lead consumers to obtain out-of-network care at higher costs.

Similarly, a 2020 *Health Affairs* study found that 44 percent of the patients surveyed had used a mental health provider directory and 53 percent of those had encountered directory

² "Online Provider Directory Review Report", CMS, November 28, 2018, https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.

³ "What Physicians are Saying About Directories" Powerpoint summary, American Medical Association, 2018.

⁴ K.A. Kyanko, S.H Busch, "Surprise Bills from Outpatient Providers: A National Survey." *J Gen Intern Med* 36, 846– 848 (2021). <https://doi.org/10.1007/s11606-020-06024-5>.

⁵ Mental health care: Access Challenges for Covered Consumers and Relevant Federal Efforts, GAO, March 2022. <https://www.gao.gov/assets/gao-22-104597.pdf>.

inaccuracies.⁶ Those who encountered at least one directory inaccuracy were four times more likely to have an out-of-network bill for the care.

In 2022, another study published in *Health Affairs* looked at mental health care directories in Oregon Medicaid managed care organizations.⁷ The study found that 58.2 percent of network directory listings were “phantom” providers who did not see Medicaid patients, including 67.4 percent of mental health prescribers, 59.0 percent of mental health non-prescribers, and 54.0 percent of primary care providers.

II. Identifying the problems without pointing fingers

I am not here to try and convince you that achieving provider directory accuracy is easy, and I acknowledge that physicians and practices have a role to play in achieving accuracy. That is why in 2021 the AMA collaborated with CAQH to examine the pain points for both physicians and health plans in achieving directory accuracy and published a white paper⁸ with the hopes of identifying how insurers and physicians can work together to improve the data collection and directory updating processes.

Physicians have a responsibility to notify health plans when a physician leaves a group, is no longer practicing at a certain location, and when contact information changes. However, it is important to recognize the burden on practices that comes with these obligations. Practices on average contract with more than 20 plans, and even more products per plan, and can be inundated with requests for updates through phone calls, emails, or health plan-specific portals. And even when new information is provided, practices report that the updates do not always appear in the directories.

Additionally, many practices separate their credentialing information (about the clinician) from contracting information (about practice locations and health plan participation) and appointment scheduling data (on availability). When information is siloed, a practice may struggle to bring the disparate data together accurately and make it available to health plans and other parties.

Finally, because the relationship between a plan and a physician practice is a financial one, and because some plans contract and adjudicate claims by location, practices may list all clinicians at every location when, in fact, each clinician primarily practices at only one or two. Practices may do this in the event a clinician provides care or coverage at a location other than his or her primary site(s). While this approach may help avoid claim denials and payment delays, it has the unintended consequence of contributing to directory inaccuracy.

⁶ S.H. Busch, K.A. Kyanko, “Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills.” *Health Affairs* Vol. 39 No. 6, June 2020, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501>.

⁷ J.M. Zhu; C. Charlesworth; D. Polsky, K.J. McConnell; “Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid,” *Health Affairs* Vol 41 No. 7, July 2022. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00052>.

⁸ “Improving Health Plan Provider Directories And the Need for Health Plan-Practice Alignment, Automation and Streamlined Workflows,” AMA, CAQH; <https://www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf> (2021).

With ever decreasing reimbursement rates plaguing practices, a reality exacerbated by the COVID-19 pandemic, physicians are often forced to take certain actions to ensure timely payment.

For health plans, the provider directory is the most public-facing data that health plans provide, and patients are dependent on accurate directories to access care. Likewise, being listed correctly in a directory is a fundamental component of a practice-health plan contract. As a result, most directory regulation and legislation appropriately identify health plans as the party accountable for provider directory accuracy. Consequently, many plans have devoted resources to comply.

While the contract between the health plan and practice is the authoritative source on which clinicians may see patients in certain plans and products, plans also maintain claims data that provide a variety of other insights into the practice, care provided to patients, and billing activities. While pockets of high-quality data exist, the industry has yet to converge upon a widely recognized “source-of-truth” and the proliferation of data collection channels and correction methods has made it more difficult for an authoritative source to emerge.

Similarly, while some health plans have worked towards establishing an internal source of truth, many face their own internal data silos that result in delayed updates and inaccurate data overwriting good data. This internal misalignment of data requires health plans to take additional steps to re-validate information, which places an additional burden on physician practices and can dilute the effect of data quality improvements.

In addition to siloed data sources, adjacent regulatory requirements also affect improvement efforts. Regulators like CMS have established requirements for both network adequacy and directory accuracy for health plans. While these requirements go hand-in-hand, efforts to improve directory accuracy and network adequacy can impact each other. The confluence of industry data silos and misalignment between health plans and practices on roles, responsibilities, and compliance with regulatory requirements has created barriers to improvements in provider directory accuracy.

III. Working toward solutions

In its research with CAQH, the AMA identified a number of solutions aimed at simplifying and standardizing the data, the data requests, and the data systems with the goal of a solid foundation of basic provider directory information. For example, the AMA suggests that practices should identify the best sources for directory data, make timely and accurate updates when offices move or physicians leave the practice, and establish the right processes so that their teams and vendors can deliver the best data possible for provider directories. Likewise, health plans should similarly make timely updates, streamline processes for practices to submit the data, permit practices to report all locations associated with a physician to enable coverage when necessary while accurately indicating the practice locations that should appear in the directories, and leverage interoperability and automation where possible so that updates are made as quickly as possible.

In a recent response to a CMS Request for Information (RFI) seeking public input on the concept of CMS creating a directory with information on health care providers and services or a “National Directory of Healthcare Providers and Services” (NDH), the AMA doubled down on its call for increased data standardization and highlighted a lack of data reporting standards as a barrier to accuracy. For example, each payer’s directory requires that physicians provide different types of data, similar data but named differently, or requires that physicians report their information using different data formats. Policymakers, including CMS and state regulators, should consider standardizing physician data elements with the most impact on accuracy and standardizing reporting formats in all common business transactions.

It is also critical that policymakers and health plans take meaningful steps to reduce other administrative burdens on physician practices, especially those that directly impact patient care and coverage and, thus, are likely prioritized over the directory burden by practices. The clearest example of such a burden is prior authorization. Practices are completing 45 prior authorizations per week per physician, adding up to two business days per week spent on prior authorization alone.⁹ With hours spent on the phone with insurance companies, endless paperwork for initial reviews and appeals, and constant updating of requirements and repeat submissions just to get patients the care they need, is it any wonder that added administrative burdens on practices may not be getting the attention they should?

Last Congress, the House of Representatives sought to address the burden of prior authorization with the passage of the “Improving Seniors’ Timely Access to Care Act.” In fact, key members of the Finance Committee, including Senators Sherrod Brown (D-OH) and John Thune (R-SD), worked together to introduce this important legislation in the Senate. While the bill ultimately failed to pass both chambers, this legislation sought to simplify, streamline, and standardize prior authorization processes in the MA program to help ease the burden on physicians and ensure no patient is inappropriately denied medically appropriate services. CMS has subsequently taken action toward ensuring timely access to health care by proposing rules similar to the aforementioned legislation to streamline prior authorization protocols for individuals enrolled in federally sponsored health insurance programs, including MA plans. The AMA is urging CMS to promptly finalize and implement these changes to increase transparency and improve the prior authorization process for patients, providers, and health plans. It is also urging CMS to expand on these proposed rules by: (1) establishing a mechanism for real-time electronic prior authorization (e-PA) decisions for routinely approved items and services; (2) requiring that plans respond to prior authorization requests within 24 hours for urgently needed care; and (3) requiring detailed transparency metrics. I applaud CMS’ recent finalization of regulations that will ensure a sound clinical basis and improved transparency for criteria used in MA prior authorization programs, as well as protect continuity of ongoing care for patients changing between plans.

Finally, a new approach to regulation and enforcement that includes proactive solutions is needed. Most enforcement currently is reliant on patient reporting, which is inconsistent and

⁹ 2022 AMA prior authorization (PA) physician survey, <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>.

likely underestimates the scope of the issue. For example, the 2020 study in *Health Affairs* mentioned above found that, among those patients who encountered inaccuracies in the mental health directories, only three percent reported that they had filed a complaint with a government agency and only nine percent said that they had submitted a grievance or complaint form to their insurer. Sixteen percent said they had complained to their insurer by phone. Ultimately, we have no way of knowing how frequently a plan is contacted by a patient who is unable to find the right physician using the directory, or how often a physician refers a patient to another physician who appeared in-network under the directory but was ultimately not, or how often a patient pays the out-of-network rate because they relied on erroneous directory information. Secret shopper studies and CMS reports published on the scope of the problem are important, but they are not fixing the deficiency for any individual patient who is in need of in-network care.

Given the limitations of the current complaint-based system, I urge all organizations charged with regulating health plans—whether it be CMS, state departments of insurance, or the Department of Labor—to take a more active role in regularly reviewing and assessing the accuracy of directories. For example, regulators should: require health plans to submit accurate network directories every year prior to the open enrollment period and whenever there is a significant change to the status of the physicians included in the network; audit directory accuracy more frequently for plans that have had deficiencies; take enforcement action against plans that fail to either maintain complete and accurate directories or have a sufficient number of in-network physician practices open and accepting new patients; encourage stakeholders to develop a common system to update physician information in their directories; and require plans to immediately remove from network directories physicians who no longer participate in their network. This enhanced oversight will drive the needed improvement in directories to ensure that patients have access to current, accurate information about in-network physicians.

IV. Conclusion

Implementing solutions to provider directory inaccuracies is a critical component of improving patient access to timely, convenient, and affordable care. Policymakers and other stakeholders must take action to improve the data, standardize the data collection and maintenance, reduce burden on physician practices, and protect patients from errors in real time.

However, in order to truly address the real harms, it is also critical that we address the network and access issues that directory inaccuracies may mask. For example, a bloated provider directory may be hiding a network that is wholly inadequate to serve the needs of the plan's enrollees. Requiring and enforcing adherence to quantitative network adequacy standards, including wait-time requirements, is critical. Additionally, updating directories when there is a change to the network is essential, but that should be followed by a notification to regulators if the change is material, continuity of care protections for patients to continue with the provider if they wish, and a reevaluation of the network's ability to continue providing timely and convenient access to care. I am glad to see that CMS, generally, is more recently making progress on network adequacy requirements for MA plans, as well as Qualified Health Plans (QHPs). For example, just recently CMS finalized

stronger behavioral health network requirements in MA plans and codified standards for appointment wait times for primary care and behavioral health services in these plans. And for the 2024 plan year, CMS will begin evaluating QHPs for compliance with appointment wait time standards, in addition to time and distance standards. However, these requirements are only as good as their enforcement, and right now there is simply not enough. States and federal regulators should work together to ensure that health plans are meeting minimum quantitative requirements before they go to market and tough penalties are assessed when violations are found. Patients must be getting value for their premiums paid by being able to access the care they need—when they need it—within their networks.

Given recent reports of ghost mental health networks in provider directories, network evaluation is also important in the context of mental health parity compliance. Behind these misleading mental and behavioral health directories are potential plan processes that have more restrictive strategies and standards, or lower payment for behavioral health providers in their networks compared with physical health providers. I am gravely concerned by the findings of the 2022 Mental Health Parity and Addiction Equity Act (MHPAEA) Report to Congress, which found that insurers' parity violations have continued and become worse since the MHPAEA was enacted in 2008, and it is important that policymakers continue to focus attention on mental health parity enforcement.

Finally, network deficiencies cannot be discussed without highlighting the growing physician shortage and the need for investment in our workforce. Lawmakers have a clear opportunity to help increase the total number of physicians by enacting S. 1302/H.R. 2389, the "Resident Physician Shortage Reduction Act," which will increase the number of Medicare-supported residency slots by 14,000 over seven years, build upon the investment Congress has made over the last few years to improve Graduate Medical Education, including the 1,000 new Medicare-supported residency slots included in the Consolidated Appropriations Act of 2021, and the 200 new physician residency positions funded by Medicare to teaching hospitals for training new physicians in psychiatry and psychiatry subspecialties included in the Consolidated Appropriations Act, 2023.

Thank you for considering my comments. My goal, and the goal of the AMA, is to improve patient access to timely, affordable, and convenient care. Addressing the ability of patients to locate such care through accurate provider directories is a critical component of this goal and of great importance to physicians and the patients we serve.