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BARRIERS TO MENTAL HEALTH CARE: IMPROVING PROVIDER DIRECTORY ACCURACY TO REDUCE THE PREVALENCE OF GHOST NETWORKS

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BARRIERS TO MENTAL HEALTH CARE: IMPROVING PROVIDER DIRECTORY ACCURACY TO REDUCE THE PREVALENCE OF GHOST NETWORKS

WEDNESDAY, MAY 3, 2023

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, Warner, Whitehouse, Hassan, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Thune, Cassidy, Lankford, Johnson, Tillis, and Blackburn.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Eva DuGoff, Senior Health Advisor; and Joshua Sheinkman, Staff Director. Republican staff: Gable Brady, Senior Health Policy Advisor; Kellie McConnell, Health Policy Director; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The Finance Committee will come to order.

Today across America, insurance companies are selling mental health coverage to our people worried about their mental health or that of their loved ones. Unfortunately, too often, after these insurers take big premiums from our people, they let them down.

The providers they advertise are not available. They cannot get appointments. The firm basically says, "We are not taking new patients," which of course was not represented to them initially in that way. The fact is, these Americans are being ripped off by what the Government Accountability Office has described as a "ghost network." Not my language, the language of the Government Accountability Office.

Now to me, what a ghost network is all about is essentially selling health coverage under false pretenses, because the providers who have been advertised are not picking up the phone, they are not picking up patients. And in any other business, if a product or service does not meet expectations, consumers get a refund.

In my view, it is a breach of contract for insurance companies to sell their plans worth thousands of dollars each month, while their product is unusable—unusable due to a ghost network. So I am

going to work with all of my colleagues here on both sides, Democratic and Republican, to get some real accountability for these patients who pay good money for mental health coverage and then find that there is very little "there" there.

And in a moment of national crisis about mental health, with the problem growing at such a rapid rate, the widespread existence of ghost networks is unacceptable. When somebody is worried about their mental health or the mental health of a loved one, it is hard to work up the courage, hard to work up the courage to step up and try to coordinate their care.

And if they cannot get help, the last thing they need from a big insurance company is a symphony of "please hold" music when they call, and nonworking numbers, and rejection. I think we can all imagine, because we are all hearing from our constituents—I am looking at my Republican colleagues. I have talked to almost all of them personally about this mental health challenge, and we have been working on it together.

But what I have described is not a hypothetical matter. Last month, my staff conducted a secret shopper study. They made over 100 calls to make an appointment with a mental health provider for a family member with depression, and they looked at 12 Medicare Advantage insurance plans in six States. The results were clear. Our secret shoppers could get an appointment—now this is after people had paid vast sums—they could get an appointment only 18 percent of the time.

That means more than 8 in 10 mental health providers listed in these insurance company materials were inaccurate or were not taking appointments. A third of the time the phone number they called was a dead end completely. In one instance, staff trying to reach a mental health provider was connected to a high school student health center. And Senator Cassidy is a real pro at all this, all this health issue. I think both of us have probably said we laughed, but we really feel like crying for the patients, and I think it is kind of representative of it.

By the way, in my home State—I am not very proud of what our investigators found there too. My staff did not find that we could make one successful appointment. Other secret shopper studies looking at commercial health insurance found the same thing. In 2017, researchers posing as parents seeking care for a child with depression got an appointment 17 percent of the time. In 2015, pretty much the same results.

Ghost networks are an ongoing, persistent problem. The Finance Committee has been looking closely at this issue, and we put a lot of sweat equity into developing legislation to improve mental health care for all Americans, from telehealth to youth mental health to workforce care, integration, and parity.

I can look down the row starting with Senator Crapo and my Republican colleagues, because we have been working on this on a bipartisan basis, and we've got plenty more to do, as Senator Crapo and I talk about in our weekly conversations.

Finally, just looking at the ghost network issue—to wrap up—it is a three-legged approach. We have to have more oversight, great transparency, and serious consequences for insurance companies that are fleecing American consumers. I believe, certainly, greater

transparency, for example, ought to be an easy one for members of this committee to get around.

I do not know anything about the accountability you get with transparency being a partisan issue. So I want to work with my colleagues on that issue, on the accountability questions, and I want to look at this across the board, not just with respect to Medicare and Medicaid. And many of my colleagues have expressed interest in applying policies to commercial insurance like employer-sponsored plans.

We have a lot of work to do. There is not going to be anything partisan about it, and let me yield to my friend, Senator Crapo.

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Senator Wyden. And you know, it is no secret to anybody that you and I have prioritized mental health delivery in America. In the last Congress, we got a number of major initiatives through and signed into law, but there are a number of major initiatives, such as this one, that we still have work to do on, and I appreciate the opportunity to work with you on it.

The last Congress, as I said, we came together to enact dozens of bipartisan policies to expand access to mental health-care services. These reforms will increase the number of providers participating in Medicare, and allow patients to receive care in more convenient locations, including through telehealth.

However, in order for these improvements to achieve their potential, patients need accurate and up-to-date information on their health-care options. I have long championed Medicare Advantage for its ability to offer patients choice and control over their health care. Through robust competition and innovative benefit offerings, Medicare Advantage provides consumer-focused health coverage to millions of Americans.

As enrollment continues to grow, improving the accuracy of provider directories could further strengthen Medicare Advantage. The patient-provider relationship is the foundation of the health-care system. Whether a patient is suffering a mental health crisis or just received a troubling diagnosis, directories should serve as crucial tools to help seniors across the country.

While we work to better align incentives to improve provider directory accuracy, we must also do so without increasing burdensome requirements that will only weaken our mental health workforce. Regulatory red tape and reimbursement strain, among others, can also decrease patient access, exacerbating physician shortages, compounding burnout, and eroding health-care access and quality.

Congress should build on their targeted relief measures like the ones we advanced last year, including temporary physician fee schedule support and Medicare telehealth expansion, to address these issues on a bipartisan and sustainable basis. Physician payment stabilization and telehealth coverage for seniors have received strong support from members of both parties in both chambers.

As we look to enhance Medicare, we should prioritize these and other bipartisan goals, and we must do so in a fiscally responsible manner. I look forward to hearing from our witnesses today about the opportunities to streamline and improve provider reporting requirements, empower patients, and give them accurate information to advance a more transparent health-care system.

Thank you.

[The prepared statement of Senator Crapo appears in the appendix.]

The CHAIRMAN. Thank you, Senator Crapo, and you have certainly laid out a number of areas where we can continue our bipartisan cooperation. I look forward to pursuing it with you and with all our colleagues.

Let me introduce our witnesses briefly. Keris Myrick is vice president of partnerships at Inseparable, a nonprofit organization working to improve mental health care. We welcome you, ma'am, and I know you are a leading mental health advocate and executive.

Dr. Jack Resneck is here. He is the president of the American Medical Association. Good to see you again, Dr. Resneck. I know you are a professor and chair of the Department of Dermatology at the University of California at San Francisco, and you and I have been in health-care discussions a number of times over the years, and we are glad you can be here.

Robert Trestman, Ph.D., M.D., comes to us at the recommendation of the American Psychiatric Association organization, and is at the forefront of mental health parity and provider health accuracy. We welcome you, Dr. Trestman. We have a long relationship with the American Psychiatric Association.

Mary Giliberti, J.D., serves as chief public policy officer for Mental Health America. She is also author of an important blog series called "Designed to Fail," looking at how these powerful special interests determine the quality and accessibility of so much of mental health care in America.

And then we are glad to have Dr. Jeff Rideout, the president and CEO of the Integrated Healthcare Association. He is recognized for his work in provider data management utility. That is a mouthful, but in plain, old English, it makes sure that there is a focus on, particularly now, when there is so much content out, making sure it is presented in an intelligible way, and we appreciate it. Glad you are here.

Let us begin with you, Ms. Myrick.

STATEMENT OF KERIS JÄN MYRICK, M.S., M.B.A., VICE PRESIDENT OF PARTNERSHIPS, INSEPARABLE, WASHINGTON, DC

Ms. MYRICK. Thank you, Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee. Thank you for conducting this hearing today, and providing me the honor of testifying regarding ghost networks and provider directories.

My name is Keris Myrick, and I am vice president of partnerships for Inseparable, a nonprofit working to advance policy that reflects the belief that the health of our minds and our bodies is inseparable. I am also a mental health advocate and survivor, with lived experience of ghost networks in health plans.

I am here today to share my story and bring attention to this very critical issue. Ghost networks erect invisible, unexpected barriers within our health systems, preventing people from accessing the care and support that they need. They are particularly damaging for those of us who are living with serious mental health conditions like me, as they can result in delayed or inadequate treatment, or even going without, any of which can be devastating and have devastating consequences.

My first experience with ghost networks occurred when I had to change my health insurance due to a new position with the Federal Government in 2014. Navigating the Blue Cross/Blue Shield for Federal Employees provider directory to find a psychiatrist in the DC or Maryland area turned into one rejection after another.

Call after call resulted in the following types of responses: "Who? Hmm. She does not work here. No, I do not know where they are." "Who? I do not know who that is. I am not sure they ever worked here. Hold please." Dial tone. Or a recorded message: "Dr. (fill in the blank) is no longer accepting new patients. If this is an emergency, hang up and dial 911."

I spent countless days and hours scouring the networks and finally found a psychiatrist who was taking new patients. Success, though, was short-lived. In a call to set up an appointment, I was asked about my diagnosis, and I responded without any hesitation "schizophrenia."

A pause, a long silence, and then the response "Oh, I do not take patients with schizophrenia." I asked if they had any suggestions or referrals to help me find a doctor who does, and the answer was "check the provider directory." Going back to the directory was like looking for a needle in a haystack—lots of hay, very few needles, and none that can stitch together the needs of my schizophrenia garment.

Finally, I contacted my psychiatrist back in California and asked if and how he could remain my doctor. I ended up flying regularly to Los Angeles at my own expense for over a 4-year period, to ensure that I could be and stay well. I also paid high out-of-network copays, but at least I had a provider.

On the same plan, when I needed a doctor for what turned out to be thyroid cancer, I was able to find an endocrinologist the very same day. But for mental health, it was a very different story, a story that continued throughout my career. In 2018, I began working for the Los Angeles County Department of Mental Health.

My L.A.-based psychiatrist now was my colleague, so I had to find another psychiatrist. I searched the provider directory with trepidation and received dead-end responses. In 2020 and 2022, I dealt with new insurance plans and new provider directories. Each time, it felt like the movie "Groundhog Day"—with the all-too-familiar responses: there is no provider here; no one by that name; oh, they are retired or they are not taking new patients; there is literally no "there" there.

Unfortunately, my story is not unique. Many of my peers with mental health diagnoses face similar challenges, regardless of whether they are covered by Medicare, Medicaid, or private insurance. Even today, despite having health insurance that is otherwise considered excellent, I have no regular psychiatrist.

This leaves me with ongoing anxiety about what will happen if I should need more intensive or ongoing care. I have experienced being unhoused, unemployed, having interactions with the criminal justice system, and involuntary hospitalizations. I do not ever want to go through those traumatizing experiences again, just because I was not able to find a provider through my health plan's directory and get the help I need to stay well.

I do not have to worry about this for my thyroid condition; I have a specialist, an endocrinologist readily available under every insurance plan. Why then do I not have the same for my mental health?

Senator Wyden, you had said, "Too often Americans who need affordable mental health care hit a dead end when they try to find a provider that is covered by their insurance. Ghost networks mean that the lists of mental health providers in insurance company directories are almost useless"; never a truer word. As a survivor with lived experience of ghost networks in health plans, I urge the committee to act on this critical issue through policies, and I have three recommendations.

One, provide the oversight, enforcement, and incentives necessary to result in highly accurate provider directories. Two, require the inclusion of psychiatric subspecialties in directories. And three, implement a federally operated mechanism like an online reporting system or dedicated 1–800 number for consumers and plan members to report their experiences of ghost networks, and use that information to enforce policy and inform policy and enforcement actions.

So, thank you again for the opportunity to share my story today. Mr. Chair and members of the committee, I would be happy to answer any questions that you may have for me at this time.

[The prepared statement of Ms. Myrick appears in the appendix.]

The CHAIRMAN. I think it is very clear you are going to get plenty of questions, Ms. Myrick, and we thank you very much for being here.

Let's go to Dr. Resneck.

STATEMENT OF JACK RESNECK, JR., M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL

Dr. RESNECK. Chairman Wyden, Ranking Member Crapo, thank you for the invitation to participate in this hearing. I am Jack Resneck, president of the American Medical Association. I am a practicing physician and chair of the Department of Dermatology at the University of California, San Francisco.

As you said, physician provider directories are critically important tools. They help patients shop for and select insurance products that cover physicians who are already part of their health-care team, and find in-network care that they need once they are covered. They help physicians make referrals for our patients, and they serve as a representation of a plan's network adequacy for regulators. So, when directory information is incorrect, the results are costly and devastating for patients, as you heard from Ms. Myrick and her lived experience.

You know, at a time when our Nation is fighting a mental and behavioral health crisis, inaccurate directories are not only an absolutely infuriating barrier for patients and families already in

great periods of stress—who must waste time calling practice after practice to find one that is actually in-network and accepting new patients—but they help mask the fact that insurers consistently and, frankly, egregiously fail to provide adequate networks and comply with parity laws, causing harm to millions of Americans. The problem is not limited to mental health.

You know, not only have I read the many studies showing the scope of problems with provider directories, but I conducted one of these studies myself, so this hearing is of particular interest to me. A few years ago, I had med students call every dermatologist listed in directories for many of the largest Medicare Advantage plans in a dozen U.S. metropolitan areas.

They sought appointments for a fictitious patient with a severe rash, and the results were dismal. Of 4,754 listings, almost half represented duplicates. Among the remaining listings, many of those practices did not exist, had never heard of the listed physician, or reported that they had died, retired, or moved away. Others were not accepting new patients or were the wrong subspecialty altogether.

So in the end, just 27 percent of listings were unique, accepted the listed plan, and offered an appointment. And sadly, more recent studies, including your own, Mr. Chairman, demonstrate that these problems persist and maybe even are worsening. Achieving directory accuracy is not simple, and I acknowledge that physician practices do have a role to play. But the responsibility of directory accuracy ultimately lies with the plans.

Being listed correctly in the directory is a fundamental component of a physician health plan contract, and health plans are not making it easy for physicians to help. I work at a pretty big academic medical center. You would think our big staff devoted to this work would equate to more accurate listings.

But health plans are typically taking 6 to 8 months to add or delete physicians after we notify them of changes. They do not use standardized formats, so we have to send different rosters with different formatting to each and every one. For big and small practices—typically contracting with 20 or more plans—this amounts to a costly and just demoralizing administrative burden.

It is happening at a time when the physician workforce, emerging from the pandemic with skyrocketing levels of burnout, is facing a web of growing and wasteful obstacles from these same health plans, obstacles like prior authorization.

My physician colleagues, they need to be freed up to spend time doing what drew us all to medicine in the first place: taking great care of our patients. So what are some solutions? Well first, in 2021, the AMA collaborated with CAQH to examine the pain points for both physicians and health plans in achieving directory accuracy, and I am here to urge all organizations charged with regulating health plans 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 directories every year—that is what patients deserve; audit directory accuracy more frequently; take enforcement action against plans that fail to maintain complete and accurate directories, with monetary penalties; encourage stakeholders to develop

common standards for updating physician information in their directories so practices like mine do not have 20 different methods; and require plans to immediately remove physicians who no longer participate in their network.

My study was in 2014, and here we are today. Enough is enough. We can fix this. Moreover, I urge policymakers to continue examining issues that phantom networks and inaccurate directories may be masking, problems like overall workforce shortages, a lack of network adequacy, and plans' rampant failures to adhere to mental health parity laws.

Thank you so much for considering my comments. I am happy to take questions, and I am looking forward to the discussion later. Thank you.

[The prepared statement of Dr. Resneck appears in the appendix.]

The CHAIRMAN. Great.

Dr. Trestman?

STATEMENT OF ROBERT L. TRESTMAN, Ph.D., M.D., CHAIR AND PROFESSOR, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE, CARILION CLINIC, VIRGINIA TECH CARILION SCHOOL OF MEDICINE, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, DC

Dr. TRESTMAN. Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, on behalf of the American Psychiatric Association, I really want to thank you for conducting this hearing, and for all of the work you have been doing in this domain. We greatly appreciate your continuing bipartisan efforts to confront the mental health and substance use crises in our country, and we are grateful for the opportunity to give testimony today.

Ghost networks affect private-sector health plans purchased by individuals and employers and public plans like Medicaid and Medicare Advantage. My written testimony references data from several studies about the ubiquitous nature of directory inaccuracies. These include, as we have already heard, misrepresentations that clinicians are accepting new patients, wrong phone numbers, and even listings for clinicians who are no longer in the State. But I would like to speak to you about my personal experience with how phantom networks affect our patients, burden physicians and other providers, and increase costs.

My department at Carilion Clinic is in rural Virginia. We deliver over 90,000 care visits per year to individuals living with a broad range of complex mental illnesses and substance use disorders. Access to care in rural settings like mine is particularly challenging.

These areas are generally physician shortage areas to begin with, and patients can be required to travel for hours to find psychiatric care. Finding anyone who is accepting new patients can be nearly impossible. Carilion Clinic is the region's only tertiary center, and we function as the public health point of access for so many people.

My clinic is in almost all networks, and our waiting list for patients currently numbers over 800 people. For those who are healthy and well-educated, going through an inaccurate provider list and being told repeatedly that we are not taking new patients,

this provider is retired, we no longer accept your insurance, or leaving a message that no one returns, is frustrating.

But for people experiencing significant mental illness or substance use disorders, the process, at best, is demoralizing and, at worst, is a set-up for clinical deterioration and a preventable crisis. Many are already experiencing profound feelings of worthlessness, grief from loss and trauma, and/or the impact of substance use. Patients have shared with me that they felt themselves repeatedly rejected, and that somehow the fact that they could not find a provider was their fault.

Some give up looking for care. At Carilion, keeping our credentialing updated with insurance plans is time-consuming and expensive. We have multiple full-time employees doing nothing but maintaining our credentialing with insurance companies and public payers, including Medicaid and Medicare Advantage. This is a burden insurance companies, I believe, should bear, not those of us trying to provide desperately needed care.

The national administrative burden for physician practices to send directory updates to insurers through disparate technologies, schedules, and formats is $2.76 billion annually. Not all mental health clinicians practice in settings like mine that are willing and able to invest the resources needed to participate in the networks.

Private practitioners make up a significant portion of the psychiatric workforce, and many do not participate in the networks because of the administrative burden. Ghost networks are both a cause and a symptom of a system that has shortchanged mental health care for decades. We need the help of Congress to change that. My written testimony includes recommendations that we ask the committee to consider, many of which you are already pursuing.

It is time to hold plans accountable for maintaining accurate directories and making accurate representations to patients, to clinicians, and to employers. Our patients also need public and private-sector plans to be held accountable to the mental health parity law.

Further investment in expanding the mental health workforce, particularly in underserved areas, is vital. Our Congress might further incentivize the adoption of models of integrated care like the collaborative care model that improves outcomes and expands access, while furthering the support of our primary care physicians in their ability to deliver a lot of the care.

Thank you for the opportunity to testify. I look forward to your questions.

[The prepared statement of Dr. Trestman appears in the appendix.]

The CHAIRMAN. Great. Thank you, Doctor.

Ms. Giliberti?

STATEMENT OF MARY GILIBERTI, J.D., CHIEF PUBLIC POLICY OFFICER, MENTAL HEALTH AMERICA, ALEXANDRIA, VA

Ms. GILIBERTI. Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for the opportunity to testify today regarding provider directory inaccuracies and ghost networks—issues that my organization has been working on for over a decade—that cause great harm.

My name is Mary Giliberti, and I lead the public policy efforts for Mental Health America. My written testimony details my experiences helping friends, families, and community members access mental health providers. The very first question I ask them is, "Do you need these services covered by insurance?"

I ask that question because I know it is going to be quicker and less effort if they can pay out of pocket, but so much more expensive. For example, I was helping one young woman who, like many others, found that her mental health condition was deteriorating during COVID, and her therapist recommended that she seek medication.

Not surprisingly, she wanted to pay a minimal copay and not hundreds of dollars each visit. So I helped her make a list of recommended psychiatrists that were on her directory, and by now you have heard the story many times. She started making calls. Some did not call her back. Others told her they were not on her network, even though they were in her directory. Weeks went by, and her condition only worsened.

Fortunately, somebody at work knew of a telehealth option in her plan, and she was able to get in-network care, but only after a very painful delay. Some people, as was noted, give up entirely after making these unsuccessful calls. When you are experiencing symptoms like lack of motivation, anxiety, and psychosis and you are getting worse, you are least able to navigate these inaccurate directories.

And these are not just anecdotes. They are supported by many studies, and unfortunately, Chair Wyden, your State did not do very well either in this study of Medicare managed care programs. Using claims data, researchers found that two-thirds of the mental health prescribers listed in the plan directories were phantoms who were not billing the plan—two-thirds. Reviews of Medicare Advantage plans also show high levels of inaccuracies.

So what can be done? We know from studies of State statutes that it is not enough to just require accurate directories. That has been done, and over this past decade has not worked. We have three recommendations for policy change. First, the data must be verified by a reliable method, such as an independent audit and claims data. At nonprofit organizations like mine, we cannot just submit our financial data. We have to have it audited by somebody.

Last week, CMS issued a proposed Medicaid managed care access rule requiring States to use secret shopper surveys by an independent entity. The surveys would determine the accuracy of directories and wait times for mental health and substance use services, among others. This policy is an important step forward and should be finalized, but CMS also needs to require audits of Medicare Advantage plans through its own review and those of independent entities.

Plans also should be required to use their claims data to periodically reconcile these directories. With the workforce shortages we have, if they are not seeing somebody—you know, we know that if they are not filing claims, they are not seeing people; they are not in the directory.

Second, the information should be transparent. In other areas of health care, CMS requires transparency. This area needs more

sunlight. The proposed Medicaid rule requires secret shopper information to be posted on a State website. That should be very easily understood by consumers and regulators, and we should have that kind of transparency across all plans regulated by CMS, so we can see what is going on by plan. Not in the aggregate, but by plan.

Third and most importantly, plans have to be fiscally incentivized to provide accurate directories. This requires carrots and sticks. On the carrot side, we can incorporate accuracy rates into overall quality ratings that affect which plans consumers choose and bonus payments like the star rating system. It is important that the plans that are doing well are rewarded for doing well.

Then we should have penalties for those that are not doing so well, similar to HIPAA's enforcement provisions, with compliance reviews, clear benchmarks, and civil monetary penalties that are enough to change behavior. An individual should always have financial protection if they rely on an inaccurate directory.

In my written testimony, I reference related areas that would also affect directories, including reimbursement rates, integrated care, telehealth flexibilities, and expanding parity coverage to Medicare Advantage and Medicaid and Medicare fee-for-service.

In conclusion, there will always be some provider directory inaccuracies. But the high rates consistently revealed in recent studies are not minimal errors. They are consumer and government deception, misrepresenting the value of the plan, undermining consumer choice, and causing great suffering. With the right verification of data, transparency requirements, and fiscal incentives, we can do so much better.

Thank you, and I look forward to your questions.

[The prepared statement of Ms. Giliberti appears in the appendix.]

The CHAIRMAN. Thank you, Ms. Giliberti, and we will have questions, for sure.

Dr. Rideout?

STATEMENT OF JEFF RIDEOUT, M.D., MA, FACP, PRESIDENT AND CEO, INTEGRATED HEALTHCARE ASSOCIATION, OAKLAND, CA

Dr. RIDEOUT. Good morning, Chairman Wyden, Ranking Member Crapo, and members of the committee. Thank you for inviting me here today. I am Dr. Jeff Rideout, president and CEO of the Integrated Healthcare Association, a California leadership group whose members include physician groups, health plans, hospital systems, regulatory agencies, and other health-care stakeholders.

Among our many programs, IHA manages a California-wide provider data management program called Symphony, which is the focus of my remarks today. The issue of provider information accuracy is of great professional concern to me. Prior to joining IHA, I was the first senior medical advisor at Covered California, our State's insurance exchange, overseeing the launch and shortly following the wind-down of its first online provider directory.

So I am very familiar with the challenges in creating accurate provider information. The problem is real and pervasive. The key question is how to solve for it. The accuracy challenges that were exposed in that early Covered California effort led to new regu-

latory requirements in California through Senate Bill 137. It also led to a comprehensive industry effort to address the longstanding challenges in provider data accuracy, which became the Symphony program.

Symphony's goal is to simplify and unify how providers and health plans share, reconcile, and validate provider directory information. With our technology partner Availity, we are creating a single utility designed to be the primary source of information, which will replace existing and nonaligned processes between health plans and providers.

As an output of the process, Symphony creates a "golden record" by applying a strict set of agreed-upon rules that determine what the best information is when the information from multiple organizations is conflicting. It is a form of machine learning. The more organizations, the greater the likelihood of finding errors before this information goes back to the plans and providers for inclusion in their directories.

Symphony now has 17 contracted health plans, more than 100 contracted provider organizations, and is also engaged with Covered California. In fact, participation in Symphony is a Covered California contractual requirement for all participating plans. Symphony currently maintains over 170,000 unique provider records and supports more than 300 data elements, such as "license verification" and "accepting new patients." Ultimately, sustainable provider data improvement requires a collaborative solution.

The Centers for Medicare and Medicaid Services said it best in a 2018 report: "It has become that a centralized repository for provider data is a key component missing from the accurate provider directory equation." Symphony is exactly that type of centralized repository.

What have we learned so far? Provider data encompass literally hundreds of specific data elements, and most need to be verified on a very frequent basis. We need more. We need more data elements related to LGBT support. We need more data elements related to race and ethnicity. So this problem of the data elements will just grow, not shrink.

In addition to the data itself, providers need to attest to the accuracy of the information every 90 days or sooner. Under these conditions, providers are much more willing to do so if they can attest once for multiple plans. Understand it is the provider data that is ultimately populating a provider directory, and it is the ultimate source of accuracy.

Based on the number of different data elements, all Symphony stakeholders now have agreed to prioritize the data elements most important to consumers, such as "accepting new patients." Symphony is a dynamic process that continues to adapt. Before Symphony could even get started processing data, we had to first create standards that conform with regulatory requirements. These include standards for timeliness, data quality and completeness, and data accuracy. Critically these are the same across multiple plans and provider organizations. This allows Symphony to provide a mastering process to identify inconsistencies and resolve them.

Identifying inaccuracies and correcting them is necessary, and it is feasible. In the last 30-day period for Symphony, provider data

from 169,000 unique providers identified over 138,000 inconsistent data elements, which we call updates or corrections, that require health plan and provider changes.

Of these, 5,000 were errors in physical office address, which is an access issue, while nearly 2,200 were related to license issues. We do this every 90 days; improving provider data accuracy is a complex undertaking. For independent providers, which mental health providers are more likely to be, this can be cost-prohibitive.

Without a centralized data repository that supports a multiplan provider directory, health plans and providers will be unable to maintain accurate provider data and directories individually, even with the best of intentions. This is critical for mental and behavioral providers, who are increasingly less likely to be in health plan networks, making it even more critical for them to be able to update their data in a convenient, single, centralized repository.

Thank you for your attention.

[The prepared statement of Dr. Rideout appears in the appendix.]

The CHAIRMAN. Thank you very much.

Ms. Myrick, I was listening to your eloquent statement, and I was saying to myself, "What is it like in America when someone like you who was in the Obama administration, who specializes in health care, gets bounced around the mental health system the way you described?" I just kept thinking to myself, "What is it like for the typical person and the typical family if they go through what you describe?"

I think the question I have for you—because I think you are Exhibit A for why we so desperately need reform—is, what is going to be the consequence of doing nothing? What if the insurance companies just keep doing business as usual, what are going to be the consequences, because it seems to me the problem you describe—intersecting with the tremendous increase in demand—is a big problem for the country.

So just if you would, paint the picture of what happens if we do not do the kinds of reforms that you and your colleagues are talking about.

Ms. MYRICK. Thank you for the question. I do not know that I am a soothsayer, but I think—you know, if I think about the consequences, much of what I talked about in my testimony, that if you are going without health care and you are going without mental health care, the consequences are dire.

We see them in our statistics related to people with mental health conditions who become unhoused, who are criminalized, who end their own lives. And so really, I think the consequences, at the end of the day, are about the difference between life and death, and that is pretty dire.

The CHAIRMAN. We may have to put you in charge of the Federal Government. By the way——

Ms. MYRICK. No thank you.

The CHAIRMAN. That's right. You want to be in California.

When you were making those comments, your colleagues, particularly the physicians on the panel, everybody was nodding. So, thank you for that.

Let me go to you, Ms. Giliberti, with respect to the financial burden of these ghost networks. As I mentioned, you know, the Finance Committee made, it felt like a gazillion calls, but 120 looked for an appointment for a senior with depression. The vast majority of cases, the vast majority—it would be one thing if it was incidental—resulted in a dead-end phone call. We were able to make an appointment 18 percent of the time after hours and hours on the phone.

And the reason I wanted to talk to you is because it reminded me a little bit of my Gray Panthers experiences, what you were talking about, and kind of crunching some of the numbers. For some patients who were able to make an appointment, they found out that the provider they saw, who was listed in their plan's directory, was actually out of network.

So the patient gets stuck with the bill. Now why should the patient be on the hook here? The insurance company is not doing what they purported to do when they were taking the consumer's money. And yet the patient—and what you have been describing and others who are advocating for consumers, which seems to me actually backwards, is the insurance company has not done what they indicated that they would do, but it is the patient who is on the hook when they desperately need coverage and they have to go out of network. What should the committee do in a situation like this?

I want to—my friend Senator Crapo has always been so constructive on this. We work in a bipartisan way. So, when we see a problem, we say, "Hey, where is the common ground we can get Democrats and Republicans to be for? What is that kind of common ground here, so that we can actually help that patient, who in my view is just being fleeced?"

That is what we said back when I was codirector of the Gray Panthers. We did not talk health lingo. We said, "This person is just being fleeced." But now we have to figure out how to navigate reforms. What kind of reform should Senator Crapo and I pursue here with our colleagues?

Ms. GILIBERTI. Well, first of all, it should not be the responsibility of the individual, right? In my view, they should be compensated for the stress that comes when you get a bill like that. You open the paper, and it is like, you know, hundreds of dollars. You expect a $25 copay, and you are looking at hundreds of dollars. They should compensate you for that stress, and instead, you are expected to pay that.

So, if the directory is inaccurate, the consumers should pay in-network prices—so, their regular old copay—and the plan should have to cover the rest of that cost, because their directory was inaccurate. So it should not fall on the person who is least able to bear this cost, right?

I mean, if you think about these companies, who is in the best position to bear the cost, the individual or the company where the mistake was made, and they represent this network. That is part of what you are paying for when you choose that plan, when a consumer goes to the website to choose a Medicare Advantage plan.

And that is one of the advantages, right? They can pick one. But they pick based on what they see, and then if it is not accurate,

that should not be their problem. They should not have to pay for that.

The CHAIRMAN. I am over my time. Thank you all. The panel has been excellent.

Senator Crapo?

Senator CRAPO. Thank you, Senator Wyden.

And, Dr. Rideout, I would like to start with you. And I am going to ask a question similar to the one that Senator Wyden just asked Ms. Giliberti, and that is—well, first of all, thank you for the work that you have done on the ground in terms of helping to improve the accuracy of provider directories.

You talked about a lot of important things in your testimony. If you could just summarize for us, what are some of the key practices that we need to be focusing on here as the solution? Bring it down to some of the best.

Dr. RIDEOUT. Well, I think you highlighted several of them, transparency being one: better auditing being one; potentially, penalties being another. My concern would be, if this is done without sort of on-the-ground operational solutions, you would double down on bad practices.

We will get more intensity from health plans to avoid penalties. We will get more suppression of networks, potentially. We will get more urgency and challenges for the physicians and other providers who cannot afford it and are really being distracted from what they are doing.

So I think, ultimately, having a single source of truth, however that is organized—whether by State or nationally—gives everybody a fighting chance to say this problem is about intentions or it is about accuracy, or it is a combination of both. So I would say it is hard work, but you have to kind of get that part fixed as well, or else we will just double down on what is happening now.

Senator CRAPO. Well, thank you.

And, Dr. Resneck, again following up on the same thing. You mentioned in your testimony that the physicians are facing a crisis here themselves, trying to deal with the solution, and we are seeing a lot of unprecedented stress and burnout exacerbated by administrative burdens.

We do not want another government program or another government mandate that just puts burdens on everybody and does not get to the solution. If you could just concisely bring it down to what are some of the best things we should consider here to achieve this objective, without causing the damage that could be caused?

Dr. RESNECK. We appreciate your leadership on this, and the bipartisan engagement. There are some things we think you can do, and there are some excess regulations to reduce. We would love to talk about it at another hearing. This is one area where we actually need congressional help, and I think there are some straightforward things.

We hear from HHS that they do not think they have the tools to audit and enforce and impose monetary penalties on the MA plans and the exchange plans that they have oversight of. I know it may not be in this committee's jurisdiction, but the Department of Labor needs additional authority around ERISA plans. And then we at the American Medical Association are putting in a lot of

work with our colleagues in State medical associations and specialty societies, going to States to make sure that insurance commissioners also at the State level have increased authority.

If we do not have monetary penalties on these plans for continuing to put out these fake directories to make their networks look bigger than they are, we are not going to make progress.

Senator CRAPO. Well, thank you.

And, Dr. Trestman, according to the National Institutes of Health, Americans in rural communities, as you indicated in your testimony, experience a significant disparity in mental health outcomes, even though the rates of mental illness are consistent in rural and metropolitan areas.

Over the course of the past two Congresses, we have explored how different problems within our mental health-care system disproportionately impact rural communities. Could you just tell us, from your experience in practicing psychiatry in a rural community, how do inaccurate provider directories and other access issues impact these areas differently than metropolitan areas?

Dr. TRESTMAN. Thank you, Senator. I think many of the issues are identical. The challenge is that provider directories are even more sparse for us, and the geography is really challenging. The challenges that our patients have faced have driven us to many limited resolutions.

Oftentimes, their primary care physicians have been tasked to take care of the psychiatric issues because there is no one else available. Helping us to empower them is really critical as well.

I think that telehealth has been another extraordinary advantage—for people with broadband access and the ability to afford data plans. They have telehealth with video, which is wonderful. But in many rural areas, including mine, they do not. This last week, I did some of my visits by audio-only, because that is all that was available.

Senator CRAPO. All right; thank you. Thank you very much.

The CHAIRMAN. A very important point. Senator Crapo and I, during our telehealth discussion, we heard consistently from rural communities that they support broadband, but if they do not have it, they want audio-only.

Senator Cornyn is next.

Senator CORNYN. Thank you, Mr. Chairman, for this hearing today. Thanks to all the witnesses. This is a disturbing issue, the ghost networks.

I wanted to ask, though, there is a bill that Senator Cortez Masto and I have introduced—and, Dr. Trestman, you happened to mention this in your written testimony—the Complete Care Act.

I know the nature of practicing medicine has evolved a lot, probably during your professional career, both yours and Dr. Resneck's. But one of the things that seems to make a lot of sense to me—as we now are embracing the whole person and not just dealing with physical health but mental health too—is to find ways to integrate mental health into physician practices.

Could you share more about how you think the bill might be able to help, Dr. Trestman?

Dr. TRESTMAN. Absolutely, and thank you so much for your work on this. As I understand the bill, the opportunity is with the partnership between primary care and psychiatry.

We have seen some challenges over the years, and I worked closely with our colleagues who developed the collaborative care model at the University of Washington. I have worked with people around the country, and I have tried to implement the collaborative care model in my own health system.

It is challenging, and frankly, the challenge is not so much on the side of psychiatry. The challenge is on the side of primary care. It is hard to change work flows. It is hard to have an integration and support system. So I think that the complete proposal that you and Senator Cortez Masto have developed is critical, because it front-loads reimbursement and support for primary care, to make this real for the first few years. That is central and a wonderful opportunity.

Senator CORNYN. Well, we look forward to working with you and others on that. I know the chairman and ranking member have talked about things that Congress has done recently in the mental health area, and certainly I agree with them that the status quo is completely unacceptable. We have failed to provide that mental health safety net.

But one of the things that I would just draw your attention to or refresh your memory on is, we passed the Bipartisan Safer Communities Act last year. It was Senator Tillis and I who were involved in hot and heavy negotiations with Senator Sinema and Senator Murphy on this, after the terrible shooting in Uvalde.

But one of the most overlooked aspects of that, I think, happens to be one of the most important aspects of it, that is: expanding the Certified Community Behavioral Health Clinics and the funding for that. As you know, that had been a pilot program. Senator Stabenow and Senator Blunt had been taking the leadership on that for many years, and I congratulate them for that. They have really led the way.

But we made, I think, the single largest investment in mental health delivery in American history, which is incredible and great. But here is the challenge. Dr. Resneck, where are we going to find the workforce? Where are we going to find the trained physicians, psychologists, counselors, and the like?

Dr. RESNECK. It is a great question, and I am glad you brought it up, Senator. As you all probably know and we have talked with all of you about over the years—and many of you have led in this area—we have a graduate medical education crisis in the United States as well, and psychiatry is a part of it.

But it is really across all specialties where we are now seeing shortages. Patients are facing long wait times. I think about this in a few ways. So, there is the front end, as you mentioned: training more physicians and non-physician clinicians and nurses, et cetera. We need more GME dollars. We need support for that big bill that will help to accomplish that.

Training physicians does take a while. We need immigration reform and additional resources for the Conrad 30 program, to help to grow that as well. That provides critical physician access in cities around the country. I also think about workforce as sort of the

tail end of the pipeline. I am worried because, as I look at my colleagues around the country, I see soaring rates of burnout in the last few years.

We know all the things that contribute to that. But, if we continue to have health plans adding burdens to physicians, whether it is prior auth, whether it is inaccurate directories, we have one in five physicians telling us that they are likely to retire in the next 2 years.

So we could acutely lose a lot of that workforce too. So it is important that we think both about the training end, and about getting those obstacles and burdens out of the way, so we retain the workforce we have.

Senator CORNYN. Thank you. And of course, that applies, as you have indicated, not just to physicians, but to allied health-care professionals and even school counselors, where part of the problem is. We made an investment in safer schools too, because that is where most of the mental health problems, I believe, are likely to be identified and then referred for the kind of care that these kids need in order to get well and not get sicker and sicker and be a danger to themselves and perhaps others.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague. And my colleague, who spent a lot of time on these mental health issues and, with Senator Stabenow, has been doing some good work, is making a very important point. That is, we have a big challenge ahead of us, some serious lifting with respect to workforce.

That is why Senator Crapo and I so appreciated the chance to work with the two of you, Senator Stabenow and yourself, on those workforce issues. The fact is, in the gun safety bill, the reason we were able to get it in was we had taken the time to write black letter law and we were ready to go, and the two of you spearheaded the effort. We are going to build on it.

I do want to make sure that, apropos of my approach to this, I am going to be all in, all in on these workforce issues. But that is not the same thing as running a ghost network, which is misrepresentation. So we've got to deal with both of these issues, and I look forward to working with my colleagues in a bipartisan way on both of these questions.

Senator Grassley is next.

Senator GRASSLEY. Well, can you skip me?

The CHAIRMAN. Of course.

Senator GRASSLEY. There is nobody to skip to, right?

The CHAIRMAN. No, we have plenty of people. What we will do is, because Senator Grassley has strong views on these issues, we will have Senator Tillis now, and then Senator Stabenow, and if other colleagues are on the way, let us get Senator Tillis and Senator Stabenow and Senator Grassley in, and then I hope other colleagues will come.

Senator Tillis?

Senator TILLIS. Thank you, Mr. Chair. Thank you all for being here.

I am glad that Senator Cornyn brought up the Safer Communities Act. People call it a gun safety bill; I call it a mental health and safer communities bill, because it is an extraordinary invest-

ment. And I am proud that North Carolina is one of the first 10 States to receive the tranche of funding to expand behavioral health access, particularly in rural communities, but across the board.

Ms. Myrick, back in 2007 I was diagnosed with an illness that required me to take medications that caused me to have pharmacologically induced mania, followed by clinical depression, so I got a window into mental health that I consider to be a blessing.

Had I not had a wife—you know, when I was in mania, I felt like I could fix any problem anyway—I simply would not have sought a health-care or a behavioral health professional. When I was in depression, if I went to a website, went through what you did, I would have said, "What's the use?"

So we need to understand, this has real-life consequences, and you are in the worst possible state to have the complexity and maybe even have it in the middle of depression, finding out that you have to pay out-of-network costs. So now you have financial stressors, you have whatever the underlying condition is. The insurers, the providers, everybody needs to understand that.

I want to get to getting regulations right. I think if we are punitive, then the resources to the health care, to the insurers are going to come from somewhere, and most likely they are going to come from the pockets of patients at the end of the day or from providers by lower provider rates.

So we have to get this right, but we have to do something.

What would be wrong with HHS and CMS—I worked for Big Four audit firms in management consulting for most of my professional career, and for one thing, it is shocking to me that the insurers would not have it as a part of their annual audit regimen. All of them have internal audits, they have the skill. They have to have it, and compliance.

It is shocking to me that they do not have an audit program of record where they are going through their provider networks. So rather than mandating that, why could we not move towards mandating to CMS—and giving CMS the technology, the resources necessary to do it—that we are going to perform audits? We are going to determine—I think in one example of Medicare provider information, we found that they are about 50 percent accurate. What would be wrong with an audit or a review by CMS giving them an F, because they have a failing grade, and having that published on the website?

A part of the carrot—and I think a competitive advantage for the insurers—would be go to the CMS website, see our rating. We have an A, B, C grade, one star, two stars. But why not a kind of an incentive for them to just make this a part of standard operating procedure, auditing it and then getting the underlying information systems that they have in place to get a higher grade?

Because if we come down with a heavy hammer, they are going to comply, but that is also taking their attention away from finding additional providers, driving down the cost of insurance, and a number of other things. What would be wrong with a light regulatory regimen as a way to start that I think, generally, would get bipartisan support?

Ms. GILIBERTI. Well, I think that that is absolutely an important component, so it would be a great advance forward.

Senator TILLIS. Yes.

Ms. GILIBERTI. You know, obviously, we would like the whole piece, but I think that having that would be very, very helpful. CMS has done some auditing, but they did not identify the plans, which I think is what you are saying, Senator——

Senator TILLIS. Yes, but I think if you can do that, you are going to find the audit at a test ecosystem very quickly come up with advisory services that are going to go after these companies and figure out how they can accelerate it, get beta integrity right, get out of the over-promising and under-delivering that we have today.

And I also think you said something that is very important. If you have somebody select a plan—maybe because they looked and saw a very large provider network and that proves not to be the case—and they have to go out of network, I think that is a legitimate case where the person who sold you the expectation that you had these options, and when you came into crisis you have those, that should be the insurer's problem, not the insured—the insurer's problem.

But to me, those are relatively modest changes that, if they are implemented properly, I think could have a significant behavioral impact that benefits the insured.

I have no more time left, but on the workforce thing, if we want to get this right, it cannot be just about educating more doctors, because we simply will not get the pipeline.

I spent a lot of time—I have a couple of schools you may have heard of: Duke, Chapel Hill. They train a lot of doctors. They tell me that the outlook is bleak. So, if we knock the cover off the ball, we are still not going to have enough, and we are not going to knock the cover off the ball getting people into this profession if we do not deal with a number of other underlying reasons why people are leaving earlier and not getting into the profession.

The CHAIRMAN. Thank you, Senator Tillis.

Senator TILLIS. So those are the things we have to talk about if we are seriously going to get it done.

Thank you, Mr. Chairman.

The CHAIRMAN. We are going to work with you.

Senator Grassley?

Senator GRASSLEY. I am ready now.

I am a strong supporter of telehealth, and when I was Finance Committee chairman, I helped make it permanent in Medicare. Several States have followed suit in their Medicaid programs. I supported making telehealth permanent for all services. Mental telehealth is an important tool to improve access, especially in rural America.

So, I am going to give one question to Ms. Giliberti and then another question to Dr. Trestman. The questions—I am going to state both of these now. Ms. Giliberti, in your written testimony you said nearly half of the adults and youth with mental health needs do not receive treatment. Access to care can have many challenges. Have telehealth and the investments in broadband helped improve the access issue?

And for Mr. Trestman, in your written testimony you said access to care in rural settings is challenging. You specifically highlighted how telehealth improves access to more timely care. Given the recent expansion of telehealth, are patients getting the best mental health care, and if not, what can we do to improve the quality of care?

Ms. Giliberti?

Ms. GILIBERTI. Yes, Senator; absolutely telehealth has had a tremendous effect on access. In fact, the story that I told—the young woman actually finally got care using telehealth. So it has disproportionately affected the mental health community. You want to have access to in-person as well, but having telehealth, particularly in rural areas, has definitely been a game-changer.

We need to extend those flexibilities and make them permanent. We also need to worry about licensing between States, because that becomes a problem as the emergency ends.

Senator GRASSLEY. Now Dr. Trestman.

Dr. TRESTMAN. Senator, thank you, and thank you for your work on this issue. It is enormously challenging, and as Ms. Giliberti has said, the benefits of telehealth during the pandemic have been demonstrated. They are substantial. Many people in rural areas are simply unable to meaningfully come to us without telehealth, without taking off days of work. Many do not have paid medical leave. They lose a lot of money coming to see us. The opportunity with telehealth is really substantial in providing appropriate care.

The data is still evolving as to who is best served in person, who is adequately or appropriately served by video, and who is adequately served by audio-only, and in what conditions. But in my own experience—and I still see a lot of patients—I have had insights into people's lives by seeing them in their homes that I otherwise never would have gotten if they traveled to me.

So, I have had the opportunities that have benefited both me as the doctor as well as our patients, by having access to them in a timely way, and a way that does not put additional burdens of cost and time on them, and that allows me to see them in the environment in which they live.

Thank you.

Senator GRASSLEY. Yes. I have heard from Iowans about the challenges finding in-network providers, including mental health services. There are many reasons for the bad provider directories. Even the best information may not be user-friendly. Patients may have to navigate pages and pages of information.

For any of you witnesses who want to comment on this question, are government regulations or incentives preventing the private sector from solving this problem? I do not care which one of you or two of you comment on it. Okay.

Dr. RIDEOUT. I would say the lack of standardization is a problem, and several panel members discussed this. The fact is that a provider may have to—whether it is a physician provider, a mental health provider of any type—may have to deal with literally dozens of health plan requirements that come at them—different elements, different times, different submission standards, different expectations—and then have to repeat that over and over again every time something is potentially wrong.

It is just a burden that they cannot absorb, even the largest organizations, and that is what we see in our work. We have to fix the accuracy problem together.

The CHAIRMAN. Thank you, Senator Grassley.

We have to call a lot of audibles around here, and because of Senator Casey's graciousness, Senator Stabenow will go next.

Senator STABENOW. Well, thank you so much, and thank you to all of you. It is so important that we actually have accurate provider directories, and this is just part of the whole big picture. I remember back in this committee when we were writing the Affordable Care Act and I authored the provisions on mental health parity.

We are still finding this. I mean it is just—it is in every way that we are coming back all the time to health care above the neck not being treated as well as health care below the neck. And, Ms. Myrick, thank you for your testimony and sharing with us. I am sorry you had to go through all of this.

I do want to expand a couple of things, because I am all in, Mr. Chairman, on what you want to do—absolutely all in. I do want to stress, as Senator Cornyn was talking about, that we have made progress. Frankly, one of the alternatives—I would love, Ms. Myrick, for you to be able to contact your local Certified Community Behavioral Health Clinic. They are in areas now where we have them fully funded.

They are funded like health care. You can walk in the door a third of the time—in Michigan, one of the 10 States where we are fully funding it, a third of the time people are seen immediately, and people are seen within 10 days as required. I mean, there are a whole bunch of things there.

But we have 10 more States coming on in the beginning of the year. We are moving to get all the States engaged—largest investment in permanent mental health funding ever for the country that is coming. So, step by step by step, this is part of the answer. It is not the whole answer but, if they want to put up ghost registries, go to your CCBHC and we will get you some care as a start.

But I want to talk—and certainly we can come back to that. But I wanted to follow up also on the issue of providers, because we have the provider networks. We have these ghost lists, and then we just do not have enough providers, right? We know this. And one of the things I so appreciated that we worked on last year, Senator Daines and I as co-chairs of a workforce working group that Senator Wyden and Senator Crapo set up, a really important part of our mental health work—we actually did a few things, but there are some more things to do. We were able to get a small number of graduate medical education slots, 200 slots, and half of those were psychiatrists—small, but it was the first time we designated psychiatric slots. So that was something. We were able to get Medicare coverage for licensed professional counselors and marriage and family therapists.

But I wanted to ask, Ms. Giliberti, one of the things that Senator Barrasso and I have introduced—and it has been around for a long time—relates to social workers. We have the Improving Access to Mental Health Act as it relates to Medicare beneficiaries being able

to access social workers and the complete set of services they provide, as well as appropriately compensating social workers.

And so, I wonder if you might speak to that, because it seems to me that is a big hole we have here when we are talking about providers in mental health as well, and how could this help meet the demand on behavioral health?

Ms. GILIBERTI. Oh, absolutely; social workers are critical. You know, as I talked about how hard it is to find providers, they are particularly helpful if you have a chronic health condition or you have a disability and you have to find multiple providers.

Social workers can help you with that coordination. They provide treatment, as you mentioned, and we do not have enough people doing that. So they provide an important role there. They are very important with the social determinants of health, right? We know that housing, food insecurity, transportation, all those things affect people.

Social workers can help people get connected and really serve underserved communities that disproportionately are not able to access those kinds of things, and it affects health and mental health. And integrated care, which we have talked about today, they provide some of those services. They coordinate care.

So social workers have an important role to play, and we definitely need them in that continuum of care.

Senator STABENOW. Okay; thank you so much. I have limited time.

Dr. Trestman, just a couple of things. One, in our discussion draft on workforce, Senator Daines and I proposed raising physician bonus payments in shortage areas, and allowing non-physician providers to receive bonus payments, really focused on rural and underserved areas.

Any thoughts on that, and also CCBHCs? Any comments you would have on that as part of what we need to be doing?

Dr. TRESTMAN. Senator Stabenow, yes and yes, the short answer clearly. Having additional compensation and encouragement for people to join us in rural areas is phenomenally valuable. Helping them pay down their sometimes profound student loans, hundreds of thousands of dollars, is an enormous incentive to allow them to do what they want to do in the first place, but frequently cannot do because of their financial status.

And with regard to the new access issues and opportunities, these are phenomenal programs. Our challenge will be, where do you go for an FQHC, where do you go to these, when do you go in-network, when do you go for Medicaid—helping us understand what is what.

Senator STABENOW. Right. Well, the great thing is FQHCs—and our mouthful, CCBHCs—are now funded structurally the same. It is the same. High quality standards, full Medicaid reimbursement, and so on. And what we are seeing is, they are oftentimes together at the same site, which is really the long-term goal.

Thank you, Mr. Chairman.

The CHAIRMAN. I thank my colleague.

Senator Casey is going to be next, and just so we are clear, after Senator Casey the next would be Senator Brown and Senator Bennet in order of appearance.

Senator Casey?

Senator CASEY. Mr. Chairman, thanks very much, and happy birthday.

The CHAIRMAN. Thank you.

Senator CASEY. I know that might have been indicated earlier.

The CHAIRMAN. Thank you.

Senator CASEY. I will not sing. Do not worry about it.

I want to thank the panel for being here, and I will direct my—I think I have two questions for Ms. Giliberti, and I just wanted to thank you and the whole panel for the work you are doing.

As many of you know, so many of our colleagues in both parties support making investments that shore up the number—the number—of mental health providers in integrated physical and mental health. Last year for example—last Congress, I should say—Senator Cassidy and I introduced a bill called the Health Care Capacity for Pediatric Mental Health Act. It was a bipartisan bill to increase investment in children's behavioral health integration, also workforce development, and health system infrastructure.

As your testimony indicated, so many people do not have access to that integrated care, yet the process of finding a mental health provider can be overwhelming for people suffering from mental health challenges. Someone who needs help has to sort through provider lists and make lots of phone calls to find a provider with affordable pricing and availability. I know you have covered this.

It is especially hard when these lists have countless errors in them. One constituent who reached out to my office was already very well-acquainted with a top health system, but it still took her months to find a mental health provider for her daughter. As you indicated, you get calls from family and friends for that kind of help.

So, I guess my first question is, how can we work together to help people find the provider who has both availability, as well as one who accepts insurance? I know this is by way of reiteration, but I think it bears emphasis.

Ms. GILIBERTI. Yes, I think that—well, just to talk about integrated care for a moment, if you go to primary care, most of that is in-network, right? So that is a way that, if you could expand that, we would have more providers—it would be easy for a family with a child. They would already be there to be able to get that care in network. So that would be one way.

But then of course, we need these directories to be accurate. So we need audits, we need them to be using their claims data. If there are no claims, they are not seeing people, right? With the shortages that we have, and the mental health crisis for children in particular, if they are not seeing patients, we know that they are not in-network.

So they need to clean up those provider directories, make them very clear, and that will help people find care. And then we need to expand integrated care, because I think most families would just love to be able to go their pediatrician and get the care.

Senator CASEY. Yes. The other question I have is, how can we help people find primary care practices that offer this integrated mental health care, such as practices that have telehealth partnerships with mental health providers?

Ms. GILIBERTI. I think that would be very helpful to have on the directories—when a primary care practice has integrated care capacity—and I think that the barriers that we see often are just the rates at this point, and we just need to put more financing into integrated care as well if we really want to see it happen.

Senator CASEY. Great.

Mr. Chairman, thanks. I will yield back my time.

The CHAIRMAN. I thank my colleague.

The next three in order of appearance would be Cardin, Brown, and Bennet, and those three are not here.

Let's see. That would then mean Senator Cassidy is next.

Senator CASSIDY. Hey, all. Thank you for being here.

I actually have two issues here. One is the ghost networking, which could be false advertising, and, Ms. Myrick, your experience is so typical. Thank you for sharing it. It takes courage to do so, but just thank you for doing so.

Second is access itself, because Ms. Myrick speaks of both: the false advertising and the lack of access. I think you set the tone for the questions, if you will.

Now, one thing that I am struck by, Dr. Trestman, is when I would speak to—I am a physician, so I would speak to my colleagues back home who are in psychiatry, and they would say that Medicaid and Medicare rates were so poor, and they have to pay the bills, et cetera, so they typically went to either private insurance or to cash pay.

Then I have heard the reimbursement has been mentioned. But one thing that has not been mentioned in this is that in traditional Medicare—which actually does not have a provider panel per se—the access is equally poor for the traditional Medicare if you are speaking about something such as mental health providers. Is that a fair statement?

Dr. TRESTMAN. Yes, sir, it is.

Senator CASSIDY. I asked my staff, because we did a literature review beforehand, but they were not quite sure if there had been kind of a cross-tab, if you will, of access for Medicare patients, MA versus traditional Medicare. And I would not be surprised if they are kind of roughly the same. Your thoughts on that?

Dr. TRESTMAN. I expect that they are, sir. The challenge in so many situations really is the administrative burden, it is the access, the management. So I think that the MA versus Medicare traditional plans have some of the same challenges.

Senator CASSIDY. Now theoretically, an MA plan, if they are challenged to increase their provider panel, they could actually pay better than Medicare rates in order to achieve that. If you will, the Medicare MA model, if done right, actually addresses the market issue; correct?

Dr. TRESTMAN. Absolutely true, and supply and demand is what this country was built on. But I do not think that has applied appropriately to insurance plans. You know, I think that part of the challenge for us is to come up with an appropriate strategy where people—I mean, psychiatrists have told me repeatedly "You know, I wish I could afford to be in the insurance plans, in Medicare, in MA. But it costs me more to deliver the care."

Senator CASSIDY. Oh, I get that, believe me. I hear that too, so I am not disputing that.

Dr. Resneck, as you are kind of representing the entirety of health care, at least physicians, you can speak to this. There is also a little bit of a quandary that a doctor will see a Medicaid patient because her friend asked her if she will see the Medicaid patient.

She does not really see Medicaid, but she is going to see this particular Medicaid patient because her friend asked her to, and so she remains on the Medicaid provider panel, but she does not really see it. I think Ms. Giliberti said something along the lines of they are not seeing patients, so therefore they are not in-network.

Technically that is not necessarily true. If I will see three patients a month on Medicaid because my friend whom I have known since we were both in kindergarten together calls me and says, "Please see this patient for me," would you accept that as a valid kind of "occasionally occurs" at least?

Dr. RESNECK. Yes. I think—thank you, Senator Cassidy. You know, I have such pride in my colleagues on the front line around the country who are doing their best every day to take care of their communities and the patients who present, and the primary care colleagues who call to refer those patients.

But as you have identified, payment rates are an issue, and we have, as we have talked about, 3 decades of stagnant rates in traditional Medicare. We have Medicare Advantage plans. In some markets they are so consolidated that they are paying less than Medicare rates.

Senator CASSIDY. So, let me ask you this. My wife—a retired general surgeon, once said, "If they pay you below your cost, you cannot make it up on volume."

Dr. RESNECK. That is true.

Senator CASSIDY. And so, to that point, and knowing that there are people who—yes, I am on the provider panel because I still have some patients whom I see, and I will occasionally see a new patient under certain circumstances. It almost seems, though, that we have to have some sort of threshold to analyze this. Yes, they are open for new patients, but how many new patients will they receive a year from this particular payment plan?

Because I think we have to bring sophistication to this analysis, as opposed to "insurance claims are all bad," for example. Your thoughts on that?

Dr. RESNECK. Well, there are physicians on panels who have not seen any patients for years——

Senator CASSIDY. I get that.

Dr. RESNECK [continuing]. And so that is fixable by the health plan. If it is a small number, then I think we need to turn to the physician. And there is a difference between being contracted—and we see this also with physicians at multiple locations, right, where they are contracted at 30 spots in case they go there, but they would not want to be listed on the directory because they literally go cover for a colleague every couple of years.

So I think this is where we need a low-burden way for physicians to have input and actually be able to tell the plans when and if they want to appear on those directories based on whether they are accepting new patients in that plan.

Senator CASSIDY. Well, so with my last—I am over time—but 5 more seconds, send me that low-burden way. If AMA has a way that we could somehow add sophistication to this analysis, we would like to hear from the front-line providers.

Dr. RESNECK. We will be convening stakeholders to help you to that point.

Senator CASSIDY. I appreciate that, and I yield.

The CHAIRMAN. Thank you, Dr. Cassidy.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you, Mr. Chairman, and thank you to the panel. It is a great discussion. I had the opportunity to listen in my office to a lot of the discussion this morning, particularly the integrated model concept that we are talking about today, and I am so appreciative of my colleague Senator Cornyn asking Dr. Trestman a question about why it is important, and that is where we need to start, obviously.

But let me ask you this, Dr. Trestman. How would this integrated model help us alleviate the existing workforce shortage? Would it?

Dr. TRESTMAN. I think it would go a long way to helping, Senator, and thank you for all of your work in this domain. The opportunity is this: if we partner psychiatrists with appropriate support staff, embedding them into primary care, we can keep people in primary care without them having to physically be seen by psychiatry. One psychiatrist for 2 or 3 hours a week can review a panel of between 40 and 60 patients to provide adequate support to the primary care team so that we can give guidance and support them.

Additionally, something that was already addressed is workforce burnout, keeping people in play, keeping them satisfied with their work. It is morally frustrating not to be able to refer someone to care if you are the primary care doc. You see someone who needs care, it is beyond your scope, and you cannot do it.

The collaborative care model and other potential models allow primary care docs to do what they want to do.

Senator CORTEZ MASTO. Thank you.

And, Dr. Resneck, I appreciate your comments regarding the burnout issue and the preauthorization. I just had some doctors in my office talking about the concerns about this prior authorization requirement and how frustrating it can be. So, thank you.

But can I jump to—I only have about 5 minutes—I want to jump to rural Nevada, which is similar to northern California. And so, Dr. Rideout, let me ask you this, because, as with the integrated primary care, telehealth has proven to be a valuable tool for rural Nevada in my State, and essentially to also extend our mental health workforce.

And, while we are making steps in the right direction, I am concerned that the telehealth and expanded primary care alone will not meet our workforce needs, particularly in our rural communities, when it comes to behavioral health professionals, in the long term.

So, in your view, how are contracting issues driving the supply problem in rural areas? How do we address that?

Dr. RIDEOUT. Well, I would agree with you that, despite the huge uptick in telehealth visits, it is not going to be enough to solve the

supply problem. And, as I think a number of panelists have mentioned, primary care physicians—and I am one of them—do provide a certain level of mental health care. But they too are burning out; they too are aging out.

So you have essentially stopgap measures, and I think in terms of contracting, my experience across plans, purchasers, and providers is that the conditions of participation, including rates but not limited to rates, really drive whether people want to participate or not.

We have heard for psychiatrists, which are actually a relatively small percentage of the total mental health providers, it just costs too much to do it. I would bring back a thought of integrated care. We have talked a lot about integrated care in terms of medical and behavioral integration. There is also an integrated care model where physicians of multiple specialties practice under one organizational structure, in an organization that is large enough to provide telehealth, large enough to provide data analytics, and large enough to essentially cover some of the shortages through better contracting or better load management within the group.

So I think that is hard in a rural area, because people do not concentrate that way in terms of practice very well.

Senator CORTEZ MASTO. Thank you.

Dr. Resneck, did you have a comment?

Dr. RESNECK. Well, Senator, I am really glad you brought up contracting, because when we look at the data—and the AMA produces these data every year—most areas around this country have highly concentrated insurance markets, where one or two plans cover the vast majority of patients in that area.

So in rural Nevada or in big urban centers, there is not meaningful contracting. We have physicians who have a big panel of patients, and the insurer just sends them a letter at the end of the year that says, "Thanks very much, we are done with you." Or it is really take-it-or-leave-it contracts that they present, that increasingly are lower and lower percents of Medicare.

So it is not a level playing field between the physicians who actually want to be contracted to be able to take care of their patients and the health plans.

Senator CORTEZ MASTO. Well, it sounds like we need another panel of health-plan providers to be able to talk to, and I look forward to that opportunity.

Thank you, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Senator Brown will be next, and I understand one of our colleagues on the Republican side is coming back as well. But with that, unless there are people we do not know about, we will wrap up, and there is a vote on.

Senator Brown?

Senator BROWN. Thank you, Mr. Chairman, and I am glad I got here in time. Welcome, all of you. Thanks for joining us and for the service you provide to so many people. And it is more important than ever. I mean we all—living through the pandemic, we all saw different parts of the health-care system perhaps, and it is more important than ever that people in my State, in Nevada, in Oregon, and Idaho get the mental health care when they need it.

We know that we did not pay enough attention to mental health during the pandemic, and mental health is fundamental basic health care. It works; it saves lives. Too many families though, as you know, cannot get this lifesaving care. Finding someone to help is hard enough—trying to call for an appointment with a doctor who does not exist or does not exist at this number and is a so-called ghost.

We agree, we spend too much time trying to schedule doctor's visits. For most people, it is far too troubling and difficult and Rube Goldberg-like to get through. The problem worsens when we cannot be sure that the doctor listed in the insurance directory is actually practicing medicine in the place that we think that person is.

Doctors listed are not taking patients sometimes. In other cases, the doctors have retired or are practicing at altogether different locations, sometimes in a different State. I mean, it is infuriating. It is also preventable.

So, Dr. Trestman, what should Congress do to make it easier for you to work with plans to make sure they have the right information? How would you feel if you tried to call a doctor, only to realize the number—I mean, you know where I am going on this. So talk to me.

Dr. TRESTMAN. Thank you, Senator. You know this—to be very trite, this is complicated. There are many, many opportunities. But I do think some of the things we have heard today are really critical. The first is, if Congress could pass a standard that everyone shares to reduce the inconsistencies in format and reporting time and sequence.

The more we can have consistency and essentially interoperability, making it electronic, making it as close to real time as possible, that would be of enormous benefit to everyone. So I think it is some of the things that Dr. Rideout mentioned, in one form or fashion, that could be transformative for our Nation, if we have a standard. That would really reduce some of the challenges.

Sharing the burden between the physicians and the insurance plans so that we own responsibility for how many patients can we see? How much can we afford to see of which plans? I think that a standard that would be federally structured and guided would help all of us. Thank you.

Senator BROWN. Thank you, Dr. Trestman.

Ms. Myrick, kind of along those lines, let us continue down that path. First, thank you for sharing your story to this committee. It always takes guts to talk about personal stories in public and in Congress. No one should have to fly—of course, no one should have to fly across the country at her own expense because she cannot find a psychiatrist to treat her.

Ohioans just want to get the treatment they need using the benefits that they actually paid for. Several years ago, we passed a law making sure all of the patients are held harmless when they relied upon an incorrect insurance directory. Sadly, patients must file an appeal with their insurer, the same insurer that made the error.

So, Ms. Giliberti, isn't this approach, isn't this appeals process just one more annoying, time-consuming—I hate to use the words Rube Goldberg again—but kind of a hurdle that Ohioans and oth-

ers should not have to face when they want to get mental health treatment?

Ms. GILIBERTI. These kinds of processes can also be very difficult for people. So we talk a lot about making sure people know their rights. It is clear. You know, we have been talking about financial protection. If you use somebody in a directory, that should be really clear to you that you have a right to get that reimbursed.

So we need to make things clear to people, and I agree that a lot of these procedures wind up making it rather difficult for the person, and the insurance companies really need to bear the burden here.

Senator BROWN. Thank you for that.

Mr. Chairman, thank you.

The CHAIRMAN. I thank my colleague.

Senator Lankford is next. Oh, excuse me, Senator Warner is next, and we are going to go in order of appearance. Senator Warner is next.

Senator WARNER. Well, thank you, Mr. Chairman, and I am sure others have already mentioned this, but happy birthday. And you know, I really do appreciate the fact that you and Senator Crapo are holding these hearings. I mean, this issue is around mental health. I think we always knew it was a huge issue, but in a post-COVID world, I do not know any family, including mine, that does not have some challenges around mental health.

I want to also acknowledge Ms. Giliberti and Dr. Trestman, who are both in service in Virginia. You have a lot of great talent there. I wanted to raise quickly—I am going to go to Dr. Rideout on a question, but I want to brag for a moment about something we started in Virginia.

Way back in the 1990s, I had started something called the Virginia Health Care Foundation. And then subsequent to that, seeing how my dad was trying to take care of my mom and access services, we started something called Senior Navigator, you know, providing the kind of directory issues we are talking about on a real time basis, linking up services.

That Virginia Senior Navigator program grew into something called Virginia Navigator, and it is now up to 9,000 service providers who provide 26,000 programs. We have kind of taken this high-tech, high-touch approach. And you know, it is one of the things that kind of makes me crazy, that these insurance companies and providers do not update.

I know everybody—this has been the focus of the whole hearing: how you update these directories, how we make sure there is that navigator role, rather than simply putting out a tech site.

Dr. Rideout, I know you have had some experience in this, and how do you—how do we—do a better job on these high-tech, high-touch approaches, so we can get the incentives right so that people can access these services out of these directories in a user-friendly way?

Dr. RIDEOUT. I would answer that, Senator Warner, by saying I do not think it is the tech or the touch that matters. It is the quality of the information and the willingness of the participants to share that information before it gets published. I know there are many ways to do that, but in our experience with Symphony, you

have to get it right before you start pushing it back to the plans or the providers as right.

And then, if the patient is experiencing a disconnect, they are not taking a new patient when they said they were, then you can resolve those, I think, on more of a one-on-one basis. But I think if the core problem is 80 percent of the information is wrong to begin with, I do not know that technology is going to solve that.

I think navigators are great. We have used those in many settings in health care and housing and other things. But then what you have is, is the energy of the individual, of the navigator to kind of hang in there, better than the patient's? The answer may be "yes," but they may not have any more success.

Senator WARNER. But don't you think even if you get the information right, the amount of time that that information stays right is going to be a short term? So one of the things that I think that is important is—you know, I agree with you: you have to get the information right.

But, boy oh boy, you also have to make sure that there is an update process. Have you found in your experience with Symphony how you make sure that data is constantly updated?

Dr. RIDEOUT. We update pretty much weekly, and then physicians attest at least every 3 months, because they only have to attest once. Imagine if you were having every health plan and every large provider organization ask the same physicians for the same information over and over and over again. A lot of times they will just stop providing it.

So I think you have to do it very frequently—not quite real time, but pretty much closer to that, to get it right.

Senator WARNER. And, Ms. Giliberti, I was interested in your testimony when you said that there was a California consumer protection law that basically said that if a plan does not provide these mental health services, there is almost a consumer protection law that says the plan has an obligation to define that service.

Has that been a good way to keep the plans a bit honest or——

Ms. GILIBERTI. I think it is a relatively new requirement, Senator, but the idea is that they have to arrange for it, and then if they cannot find it in network, they have to pay the out-of-network charge for the person that they found, the provider that they found. So, like you are saying, it takes the burden, again, off the person.

Senator WARNER. Yes, it shifts the burden to the——

Ms. GILIBERTI. It shifts the burden to the plan to help you find it. Again though, it has to be really clear on your directory that they can provide this help to you, right, because otherwise people will not know about it. So I think it is really important that people know about it and that they are actually going to be able to get that kind of help.

Senator WARNER. I do think, and again we are—I may take a little issue with Dr. Rideout's position, because I do think you have to get the information right. But Lord knows, there are plenty of user-friendly sites that invite a user in and do not make it this technology opaqueness, and I think again there are examples across the spectrum that we can look at for best practices.

But I do appreciate the chair and vice-chair holding this hearing.

The CHAIRMAN. Thank you, Senator Warner. And you are being logical, and heaven forbid that logic should break out over this, because I too believe in these navigator approaches. The reason that it has been an important issue is there has been a misrepresentation, not something that spells out what you are talking about. So we are going to look at it.

Senator Lankford?

Senator LANKFORD. Thank you, Mr. Chairman. Happy birthday as well, and thanks for holding the hearing. Thank you all for the testimony today.

Exceptionally important to be able to get out there—all of us deal with this. We all have casework staff to try to help chase through things, so we hear it as well. This is really important that this gets out, and we find ways that are practical, realistic ways to be able to actually process this.

Dr. Resneck, I want to try to drill down a little bit from the physician side of this. So, an insurance plan reaches out, let us say early summer, and says, "We are looking to be able to put all our networks together for next year. Do you want to be in-network or out-of-network," and they negotiate with you.

They tell you this is what we are going to pay you flat out, and no, we will not negotiate. Then you go through all that back and forth on it, finally resolve it. By the end of the summer they put out their open season plan with their list of all their providers on it for the next year. People select their plan based on who their providers are, if they are near them, or if their own physician is there. And then they pick up the phone and start calling people.

Is there a requirement for physicians, if they say, "I am going to be in a plan," to actually be in that plan for the next year, or can a physician say, "Yes, I will be in the plan," and then let us say January, February, March decide no, I really do not feel like being in this plan?

Are they locked in typically—again, company to company it may be different. But is there a commitment on the physician's side, if I said I am going to be in this plan for a year, I am actually going to be in the——

Dr. RESNECK. In general, physicians contract on an annual basis, but I think this probably varies by State and by type of plan. And we see plans terminate plans midyear for no reason, which is the other piece of that as well. But we will get back to you with more information.

Senator LANKFORD. That is right. That is helpful, because that is one of the areas where we have to be able to resolve this. Is there a commitment from the physician to also be in the plan? We have heard several times from different plans, or from individuals who will say by the time that they actually pursued the plan and got into the plan and starting in January–February started calling people, they said, "Oh no, I actually dropped out last year," but they are still listed. Or, "I just changed and shifted over," and we are trying to figure out the mechanics of where all the players are.

Dr. RESNECK. And if you talk to that physician, they probably called the plan—just like your office staff helping people in your district and the State have—and probably sat on hold for 3 hours

and then got disconnected, trying to update the directory themselves. So the plans have made it really difficult for the docs.

Senator LANKFORD. Yes, really difficult for the patient and for the docs, and that is what has been the challenge on this. So the next layer in this, and, Dr. Rideout, let me ask you about this as well.

From the industry side—and you are dealing with this—there is a lot of insurance companies right now that are not following the current CMS regulations even. So the issue always comes back to us. They are not following it currently; let us add one more and see if they will follow that one as well.

What do you see as the solution here in this process, because I do not want a single constituent to call and hear, "I do not know who that is." Ms. Myrick's testimony was powerful, to be able to say, "I do not know who that is. That person died. Sorry, we do not take people anymore. We have not been on that for years."

That is plans just not updating and doing their work, but they are already violating CMS rules. So, from the industry perspective, what is the answer on this?

Dr. RIDEOUT. Standardization across the board, and that is a challenge because most plans are regulated on a State basis, and States have their own variations on what they do or do not want.

Senator LANKFORD. Right.

Dr. RIDEOUT. But I think it starts with very, very detailed, aligned standards. And the old adage is, "standards are great because there are so many of them," and that is the problem. We are now dealing with Medicaid standards, CMS standards, Medicare Advantage standards, State standards. So, it is——

Senator LANKFORD. Yes. There are State regulations, but this is Medicare Advantage. This is unique—this falls right into this committee, what is happening in Medicare, Medicare Advantage, and creating a centralized standard for that.

Dr. Resneck, do you want to say something?

Dr. RESNECK. Well, your colleague earlier mentioned carrots and sticks, and liking carrots, I completely agree. Transparency would be great. Carrots are very helpful. My fear is I am going to be walking around with a backpack of carrots for another 10 years, and they are going to rot in my backpack because I will not have any to give out.

The plans are so consolidated and have such an incentive to look like they have a full network when they do not, that I think—in the Medicare Advantage space that you have jurisdiction over, and the exchange space that you have jurisdiction over—we do need some sticks. We do need monetary fines.

These are big plans with big resources that have the capability and responsibility to put out accurate records.

Senator LANKFORD. So the sense would be, like the chairman was saying before, if we end up calling with secret shopper-type calls—or whatever process that we do from a third party or whether it be a Federal agency—and find out these folks do not actually exist, then they get a fine to be able to come in, so it is a requirement on them to be able to fulfill that.

Dr. RESNECK. Right, right. There is always going to be a little background noise and a few inaccuracies, but when 80 percent of

the directory is inaccurate, I think you can say that is a plan failure.

Senator LANKFORD. That is a massive issue, and it is a big issue for us in rural Oklahoma that there will be companies that will put out a plan, and then everyone looks at it and selects a plan. Then they get into that plan in January and find out it is not real, and they cannot go anywhere. Or if they are going to go anywhere, they are going to have to drive 150 miles to be able to get to someone. They assumed the people who were listed locally actually existed, and they accepted the process.

So, I appreciate your testimony today.

The CHAIRMAN. And, Senator Lankford, you have just given a snapshot of why this issue is so important in rural America, and I appreciate it.

Senator Whitehouse is next.

Senator WHITEHOUSE. Thanks. I will be very brief, because I know Senator Menendez has a lot to do, but I wanted to flag, not exactly the topic of this hearing, but it has been extremely important in Rhode Island to have had mental health access through COVID through telehealth.

It has been extremely important for people who are in recovery to be able to talk to their peer recovery coaches and to the people who are providing them treatment. I just wanted to take a moment—I am seeing a lot of heads nodding, that this is a good thing, that we need to extend those telehealth protections and waivers. Because the information I have is not only did compliance, "attendance," improve compared to having to come into the office but—and I know this is anecdotal and there is no way to put a scientific proof behind it—over and over again I have heard from the professionals in the community that the quality of the engagement increased with telehealth.

I suspect that is just the human aspect of not having to drive someplace, not having to wait in the waiting room, not having to fill out a clipboard, not having to be in unfamiliar territory. Instead, you just go to your quiet place in your own residence, you click on, and there you are. So I wanted to make that pitch.

I also wanted to try to make the point that this problem of required networks and fake networks, in essence, is part of a suite of payment and cost-saving strategies that have developed in our current health-care system. They include just plain payment denial and delay.

We have an enormous armada of insurance efforts to slow or deny payment to providers, obliging providers to then stand up a whole countermeasure apparatus. I remember years ago going to the Cranston Community Health Center and finding out that they actually had more personnel on staff who are devoted to trying to get paid than they had devoted to providing the health care that the Cranston Community Health Center provided.

So there is an enormous, enormous burden of unnecessary administrative cost from that. There is an enormous burden of administrative cost and pain from these fake networks. And I think that prior authorizations are another vehicle frequently used by the insurance industry to evade and avoid payment for services that are pretty clearly required.

What I would really like to have anyone who is interested do—and you can do this as a response in writing, consider this a question for the record—I think the way out of most of those problems is comprehensive payment reform.

The more we get away from fee-for-service, the less ability there is to deny and delay the payments for those services, to shrink networks, and to impose prior authorization restrictions that foul up treatment. So, we are continuing to work to get that done here.

I think the ACOs, the Accountable Care Organizations, provided a good lead, have provided, particularly in Rhode Island through Coastal Medical and Integra, some really good results showing what is possible.

But I would love to have your careful thoughts on that, and is this area of reducing the deadweight cost burden of the administrative warfare between insurers and providers likely to be alleviated by payment reform, and if so, what payment reforms are likely to alleviate it most?

With that, I will yield back to Senator Menendez, I guess. I am not sure who is next.

Senator CARDIN. Senator Cardin. We are going way up the line here.

So first, I want to thank you all for your testimony. I just really want to add one other dimension to these ghost networks. My colleagues have heard me talk frequently about the tragedy in dental care with Deamonte Driver losing his life in 2007, a 12 year-old, because he could not get access to dental care.

I know that our focus here is on a broad range of services, particularly mental health services. But Deamonte Driver's death had many contributing factors. One was that his mom really could not find a dentist who would treat him. There was not an accurate directory available that could provide guidance, and she could not find a dentist who would be willing to provide services.

I guess what I just want to underscore is that this topic is critically important for health care throughout our country, but particularly in underserved communities. They need help, and if we do not have accurate directories, if they have a list that does not have accurate telephone numbers, or the provider is not taking any new patients, and it may be somewhat redlined, it makes it even more challenging.

So I just really wanted to add that into the record, and I thank you all for your participation. But as we look at ways to solve the issues, let us not lose sight of the fact that it is not equal throughout this country. Underserved communities are suffering the most.

So with that, I will yield back.

Senator MENENDEZ. Thank you very much.

The problem of ghost networks is particularly harmful in mental health care, and one arguably made worse in recent years. Amid the Nation's ongoing mental health crisis, though the pandemic and beyond, those desperate for health care continue to get ghosted.

The reality is that there are just not enough providers. I was proud to secure—with my colleagues on the committee—100 new graduate medical education slots reserved for psychiatry in last year's Consolidated Appropriations Act. Last week, I reintroduced

my Resident Physician Shortage Reduction Act alongside Senators Boozman, Schumer, and Collins. It is a bipartisan bill that would raise the number of GME positions by an additional 14,000 over 7 years.

So, Dr. Resneck, would you agree that increasing graduate medical education positions would complement efforts to improve provider directories and mental health access overall?

Dr. RESNECK. Senator, I cannot thank you enough and agree enough, and the 100 additional slots for psychiatry—every little bit helps. But the larger act is absolutely necessary as we face an aging population. We need more physicians for this country, so thank you.

Senator MENENDEZ. Thank you.

Dr. Trestman, for children in need of care, the problem is even worse. According to the data by the American Psychological Association, only 4,000 out of more than 100,000 U.S. clinical psychologists are child and adolescent clinicians.

What can Congress do to specifically address the workforce shortage of child and adolescent mental health clinicians?

Dr. TRESTMAN. Senator, I think that the trajectory that you and your colleagues have started has been wonderful. We need to think broadly about the needs of health care in this society—so training at the community college level, the college level, getting people in, the people for allied health professions, whether it is nursing, social work, community health workers, as well as psychologists and physicians.

We need to think broadly so that we can provide adequate care. And many professions other than physicians can be trained in a timelier way, and any of the ability that they have to provide care, whether through social work or others, can make a profound difference and really expand and leverage the care that only physicians can provide.

Thank you.

Senator MENENDEZ. Yes, yes. Well, imagine for a moment that you or someone you love is in the midst of a mental health crisis. You call 70-plus doctors listed in your insurance plan's network. Not one is available for an appointment within 2 months. Most never call you back. Some are retired. Others are deceased. Some phone lines are disconnected.

This is a reality for far too many people seeking mental healthcare services in New Jersey and across the country. It is critical that people seeking mental health services have access to accurate, up-to-date provider directories. This outdated information hurts people who are desperate to get help for themselves or a loved one.

Ms. Giliberti, what mechanisms can Federal regulators use to hold those responsible for provider lists accountable? How can we highlight how CMS can better enforce regulation and oversight of provider directories?

Ms. GILIBERTI. Well, I think they could do several things. One, we could have audits of these plans for their behavioral health networks, and those audits could be done either by CMS itself or by a third party—and transparency, right, the results of that.

We have also talked about making sure it is included in the star rating system, so that they get incentivized to make those changes.

And we have talked about civil monetary penalties, which currently do not exist, right? So that is another way, and it would have to be sufficient to affect behavior.

So those are an array of choices that could make a difference if they were combined together.

Senator MENENDEZ. And finally, we have to address the challenges of ghost networks, but we must also prioritize policy to support low-income and marginalized populations.

Last week, HHS released proposed access and quality standards for Medicaid and CHIP. Among other things, these proposals would require States to conduct "secret shopper surveys of Medicaid and CHIP managed care plans, to verify compliance with appointment wait time standards, and to identify where provider directories are inaccurate."

How would these requirements mitigate impacts of ghost networks for low-income communities, Ms. Myrick?

Ms. MYRICK. Thank you very much for asking that question. And I think anything that can help, especially folks of color, people in low-income communities, to be able to get the accurate information that they need in order to get the care when and where and how they need it, is going to be critical. And I also add to that being able to empower the consumer. The word consumer, I actually like it. I know in our community sometimes it is a little—people do not like it. But the reason I like it is, I think of John F. Kennedy's consumer rights bill and what he talked about in 1962, about the consumers' rights to be heard, the consumers' rights to have information to make a choice, and then lastly the U.N.-added, to redress.

I think the things that you are talking about give us those rights, especially if we have something like a 1–800 number or an online portal to report when we are not able to get our needs met because of the ghost network. Because we want to inform too. We want to be empowered to inform, so that either the carrots or the sticks can happen.

So, thank you.

Senator MENENDEZ. Thank you very much for your insights.

Senator WARREN. On behalf of the chairman, I call on Senator Blackburn.

Senator BLACKBURN. And thank you so much, and thank you to each of you for being here. Ms. Myrick, thank you for sharing your story. I appreciate hearing that.

I know we are talking about Medicare, Medicare Advantage. But Senator Blumenthal and I have been busy today introducing the Kids Online Safety Act.

And, Ms. Myrick, as I was listening to your testimony, I thought how closely it mirrors what I hear, not only from moms and parents, but the teens themselves. I hear it from the psychiatrist and psychologist, from principals, that there is not enough access, and that there seems to be complete confusion when you call the insurance company and say, "We are desperate for help. I have my child, we are here at the emergency room. We are not getting any answers," and it is just so imperative that we look holistically at this system. And I appreciate it, hearing from you on this issue.

Dr. Resneck, let me come to you, because telehealth is something—even when I was in the House and we were working on 21st

Century Cures, then I did not get my telehealth bill in there, but we got it across the line during COVID. During COVID, people really began to use telehealth. What I hear from providers, especially down in Shelby County, Memphis, that area, where you are dealing with Mississippi, Arkansas—and, of course the MED is there in Memphis.

And they talk a lot about interstate licensure requirements. So just very briefly, if you would talk to me a minute about what you are hearing from providers when it comes to that licensure issue, and also what you are hearing about the digital therapeutics and their utilization in these instances.

Dr. RESNECK. Thank you, Senator. My dad grew up in Clarksdale, MS, so I know the Memphis area well, even though I am now a Californian. And I am always reluctant to use the term "bright spot" about anything in the pandemic, but telehealth clearly opening up coverage, whether it was Medicare or commercial insurers, was a huge bright spot. Thank you for your leadership in that area.

We have seen not only patients learn how to use it well and discover when it is convenient, but we have seen physicians in every specialty, psychiatry included, learn how to integrate it seamlessly into a care plan, because sometimes patients need to be seen in person, and now we know more about what those instances are and what they are not.

You mentioned licensure. We still believe in maintaining State licensure, and that it exists in the place where the patient is. The reason we believe in that is, if I am taking care of a patient in Florida, I believe I have a responsibility to follow Florida's rules and that that patient needs to be able to go to their State insurance commissioner if I provide lousy care, to seek redress.

But we have some really cool stuff going on to aid in people being able to do telehealth in multiple States. We have the interstate medical licensure compact, where it makes it much easier for many physicians to just click off several States that they want to be licensed in and agree to follow those rules. We also—lastly, I will just quickly say——

Senator BLACKBURN. Is that the reciprocity model?

Dr. RESNECK. It is not pure reciprocity. It is not like the nursing reciprocity model because individual States do still maintain the ability to police what happens in their States and take your license away. But it makes it much easier to get multiple licenses.

The other thing is, we have seen the medical boards, the Federation of State Medical Boards, agree unanimously nationally, and now it has to be implemented in the States, on reasonable exceptions. If I am taking care of a patient and they go off to college and they happen to be out of State, or they are vacationing or spend 3 months a year in Arizona, that is not really practicing across State lines. I have an established relationship.

If a patient needs to go to a center of excellence and wants to do one pre-visit via telehealth across State lines, that should be okay. But we do want to protect patients and make sure they have local care.

Senator BLACKBURN. All right.

Do you want to weigh in on this, either of you? Go ahead.

Dr. TRESTMAN. Telehealth has been transformative.

Senator BLACKBURN. Okay. You were nodding your head, and I thought you might have a little something to say.

Dr. TRESTMAN. Yes. Thank you, yes. And the continuing availability, particularly in rural areas, is extraordinarily valuable, but also, even in urban areas, where it may take people 2 hours to take three buses to get to us.

Senator BLACKBURN. Okay.

Dr. TRESTMAN. And by the way, I trained at the Elvis Presley Memorial Trauma Center in Memphis, so——

Senator BLACKBURN. God bless you.

Ms. Giliberti, did you want—I saw you nodding your head.

Ms. GILIBERTI. I was just going to say that I am very glad to hear about the college students, because we hear that all the time about college students who have a provider, and then they lose access to them. I think that this idea really needs to be thought through, particularly for mental health—you know, the issues in a State.

I really do not understand why we cannot get more reciprocity and more ability to go across State lines with mental health care, because it is very problematic.

Senator BLACKBURN. Increasing access is what we ought to do.

Thank you, Madam Chair.

Senator WARREN. Thank you.

So, America is facing a mental health crisis. One in five Americans live with a mental illness, and for Medicare beneficiaries, it is one in four. Federal law requires Medicare to cover mental health services in both traditional Medicare and Medicare Advantage, or MA, the program that allows private insurance companies to offer Medicare coverage.

Now, unlike traditional Medicare, the private insurance companies in Medicare Advantage can establish networks to restrict the doctors and facilities that beneficiaries can use. So, if your doctor is in-network, the plan will cover those services for a small copay, but an out-of-network doctor can leave patients with skyrocketing costs.

This can be especially devastating for seniors or for people with disabilities who are more likely to be living on fixed incomes. To help beneficiaries avoid these surprise costs, MA plans are required to publish directories which enrollees can use to find new doctors, to make sure their existing doctors are covered.

So let us start with what we know about the accuracy of these directories. There have been some references to them, but, Ms. Giliberti, what do we know about the accuracy of the provider directories in Medicare Advantage?

Ms. GILIBERTI. So CMS has done some audits, Senator, and what they found was, on average, the accuracy rate was about 45 percent.

Senator WARREN. What does that mean, that the accuracy rate was 45 percent?

Ms. GILIBERTI. You know, they found, in 2018 I think it was, almost 50 percent had at least one inaccuracy. So we are seeing a good deal of inaccuracies. That is with physical health care. Let's just say there is a gap in data, because they have not done this for behavioral health.

Senator WARREN. And might we surmise that behavioral health accuracy——

Ms. GILIBERTI. It is always worse.

Senator WARREN. It is always worse; it is always worse. Okay. So, you think you have a list of people you can go to, and the odds are actually in favor of the list being wrong, and probably even worse on behavioral health. All right.

So here we have a patient who does everything right. They still may be hit with a huge bill, because a directory has outdated or inaccurate information. Or they might call up every doctor, only to find out what we have heard about some of this: phone numbers do not work; they are not accepting new patients. I think we have heard the story about this, and I appreciate your being here to talk about your story, Ms. Myrick.

We know that MA plans use all kinds of tricks and traps to squeeze more money out of Medicare. They have a lot of different ways that they do this to boost their numbers. But here is the one I want to focus on. Do these MA plans stand to gain anything from having inaccurate information? In other words, is it inaccurate because they just have not spent enough money to make it accurate, or is it inaccurate by design?

Ms. GILIBERTI. Well, I think there are advantages that they have when their directories, unfortunately, are inaccurate. If they use those directories for network adequacy standards, for example, they might meet the standards, but they are not accurate. People make choices based on what they see as their network, so if it looks like a bigger network but it is not real, people are choosing a plan——

Senator WARREN. Okay, so it is a way to defraud consumers, to say you have this really big list of people you could go to if you had a problem. And it turns out that really big list, if it were accurate, is actually this little tiny list, right?

Ms. GILIBERTI. Right, right.

Senator WARREN. Okay. So that is one way it is to the advantage of the Medicare Advantage plan, in order to be inaccurate. They get paid, in effect, or they make more money by being inaccurate. Did you have another one?

Ms. GILIBERTI. Well, just that—oh, I think it is about 60 percent of the plans do not have out-of-network coverage. So, if you get really frustrated and you pay on your own, then they are not paying anything.

Senator WARREN. So, the more I can frustrate you, the more that I—meaning the Medicare Advantage plan—the more the Medicare Advantage plan can frustrate you, the more you will just go somewhere else, and that means it is not money out of their pockets.

Did we get the two main ones? You wanted to add——

Dr. RESNECK. Well, I just was going to add, Senator, this is—yes, we see this all the time. This is health plans delaying and denying care.

That same patient—once they finally find the needle in the haystack and even get to a physician who is in network and sit down and get a diagnosis and a treatment plan—then goes to the pharmacy and discovers the health plan requires prior auth for the treatment for that condition, which then takes weeks to get approved.

Sometimes they never go back to the pharmacy. They give up. Their mental health or other chronic condition gets worse.

Senator WARREN. Right. So conditions get worse, and they do not have to pay for the treatment, the Medicare Advantage plan. So look, what we are really saying here is that it is in the financial interest of these Medicare Advantage plans to discourage beneficiaries from accessing care.

We also know that the Medicare Advantage plans are paid a set amount per beneficiary, which can be dialed up if the beneficiary is sicker. So the more diagnosis codes that a beneficiary has, the higher the payment. The insurance companies have built entire businesses around making these beneficiaries look as sick as possible, and they are overcharging taxpayers by hundreds of billions of dollars, because here is the key that underlines this.

Whatever insurers do not spend on care as a result of tactics like outdated provider directories or overly restricted networks or inaccurate information, whatever they do not spend on care they get to keep. So let me ask you one last question on this. What penalties, Ms. Giliberti, do MA plans face for being out of compliance with regulations and provider directories and network adequacy?

So we have a bunch of rules. When they are in violation of the rules, what is the consequence?

Ms. GILIBERTI. I am not aware of any penalties, Senator. The audit that I mentioned earlier talks about notices of noncompliance and warning letters, but they do not mention anything about penalties. So I know there have been some legislative proposals to that effect, but I am just not aware of any penalties that are being assessed.

Senator WARREN. I tell you, nobody is jumping in with any other answer. You know, this is the part that just drives me crazy. People look at the regulation, they think, "Oh, well we are going to be okay, because this is regulated." But we are not okay if there is no enforcement.

Now, to the extent they have enforcement tools, CMS really needs to step up the enforcement here. At a minimum, beneficiaries should not be on the hook for out-of-network costs that were incurred because of the inaccurate directories. That would be a nice starting place on this.

CMS should also penalize Medicare Advantage plans that are out of compliance, just put penalties on these guys, and it is Congress's job to put tougher regulations in place. I also want to say this.

If these Medicare Advantage plans continue to mislead beneficiaries about covered providers, at the same time that they are overcharging taxpayers for this crumby coverage, then we should be taking another look at whether or not MA plans should continue to enjoy the privilege of restricting provider networks at all.

Now there is a serious question that should be on the table. If they cannot do better in managing these restricted networks, then maybe they ought to have to cover anyone who is a licensed practitioner that you go to see.

So, with that, I will now say I am finished, and I will put on the hat of the chair and say, without objection, I would like to submit the majority staff report into the record.

[The report appears in the appendix beginning on p. 88.]

Senator WARREN. Anybody object? No.

Senators have 1 week from today to submit questions for the record. Those will be due at 5 p.m., and this hearing stands adjourned.

Thank you all.

[Whereupon, at 12:13 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Last Congress, this committee came together to enact dozens of bipartisan policies to expand access to mental health-care services. These reforms will increase the number of providers participating in Medicare and allow patients to receive care in more convenient locations, including through telehealth. However, in order for these improvements to achieve their potential, patients need accurate and up-to-date information on their health-care options.

I have long championed Medicare Advantage for its ability to offer patients choice and control over their health care. Through robust competition and innovative benefit offerings, Medicare Advantage provides consumer-focused health coverage to millions of Americans. As enrollment continues to grow, improving the accuracy of provider directories could further strengthen Medicare Advantage.

The patient-provider relationship is the foundation of the health-care system. Whether a patient is suffering a mental health crisis or just received a troubling diagnosis, directories should serve as crucial tools to help seniors across the country. While we work to better align incentives to improve provider directory accuracy, however, we must do so without increasing burdensome requirements that will only weaken our mental health workforce.

Regulatory red tape and reimbursement strain, among other factors, can also decrease patient access, exacerbating physician shortages, compounding burnout, and eroding health-care access and quality. Congress should build on the targeted relief measures we advanced last year, including temporary physician fee schedule support and Medicare telehealth expansion, to address these issues on a bipartisan and sustainable basis.

Physician payment stabilization and telehealth coverage for seniors have received strong support from members of both parties and in both chambers. As we look to enhance Medicare, we should prioritize these and other bipartisan goals, and we must do so in a fiscally responsible manner.

I look forward to hearing from our witnesses today about opportunities to streamline provider reporting requirements, empower patients with accurate information, and advance a more transparent health-care system.

PREPARED STATEMENT OF MARY GILIBERTI, J.D., CHIEF PUBLIC POLICY OFFICER, MENTAL HEALTH AMERICA

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 100 years later, MHA continues to address issues that harm people

with mental health conditions and limit access to mental health care, 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 one in four adults aged 18 and older and one in three adults aged 18 to 25 had a mental health condition in the previous year.[1] The pandemic has exacerbated mental health conditions in youth, with 2021 CDC data showing 40 percent of high school youth feeling persistently sad and 22 percent seriously considering attempting suicide.[2]

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 percent for the past 6 years, indicating that over half of youth with mental health needs are also not getting the help that they need.[3]

Ghost networks also have a financial cost on individuals and distort the market for health insurance. Studies by Milliman,[4] researchers from the Congressional Budget Office,[5] and NAMI[6] indicate that people with mental health conditions are

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[1] Substance Abuse and Mental Health Services Administration (SAMHSA). "SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021." *HHS.gov.* January 4, 2023. Retrieved from: *https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html#:~:text=Nearly%201%20in%204%20adults, those%20with%20any%20mental%20illness.*

[2] Centers for Diseases Control (CDC). Youth Risk Behavior Survey: Data Summary and Trends Report 2011–2021. February 13, 2023. Retrieved from: *https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf.*

[3] Substance Abuse and Mental Health Services Administration (SAMHSA). Highlights for the 2021 National Survey on Drug Use and Health. N.d. Retrieved from: *https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlights092722.pdf.*

[4] Melek, S., Davenport, S. and Gray, T.J. (2019). "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement." Retrieved from: *https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.*

[5] Pelech, D., and Hayford, T. (2019). "Medicare Advantage and Commercial Prices for Mental Health Services." *Health Affairs,* 38(2), 262–267. Retrieved from: *https://doi.org/10.1377/hlthaff.2018.05226.*

[6] National Alliance on Mental Illness. "Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity." November 2016. Retrieved from: *https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf.*

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.[7] 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.[8] 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.[9] 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.[10] They found that 67.4 percent—more than two-thirds—of mental health prescribers and 59 percent 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 1-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 percent.[11] 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 percent and two MA plans with deficiency rates above 90 percent. 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

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[7] Burman, A. (2021). "Laying Ghost Networks to Rest: Combating Deceptive Health Plan Provider Directories." *Social Science Research Network.* Retrieved from: *https://doi.org/10.2139/ssrn.3869806.*

[8] *Id.,* citing Sharma, N., Chakrabar, S., Grover, S., Sharma, N., Chakrabar, S., Grover S. "Gender differences in caregiving among family-caregivers of people with mental illnesses." *World Journal of Psychiatry*. March 22, 2016 [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." Center for the Study of Social Organization, Working Paper No. 9. 2014 [finding that women are twice as likely as men to act as caregivers for their parents.]

[9] *Id.* at 82–83.

[10] Zhu, J.M., et al. (2022). "Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid." *Health Affairs,* 41(7), 1013–1022. Retrieved from: *https://doi.org/10.1377/hlthaff.2022.00052.*

[11] Centers for Medicare and Medicaid Services. Online Provider Directory Review Report. 2018. Retrieved from: *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.*

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.[12]

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 percent of listed psychiatrists were reachable, with many out-of-date phone numbers or addresses.[13] More than 10 percent 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.[14] 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.[15] 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 health care, 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

[12] Burman, A. (2021). "Laying Ghost Networks to Rest: Combating Deceptive Health Plan Provider Directories." *Social Science Research Network.* Retrieved from: *https://doi.org/10.2139/ssrn.3869806.*

[13] Mental Health Association of Maryland. "Access to Psychiatrists in 2014 Qualified Health Plans." The Maryland Parity Project. January 26, 2015. Retrieved from: *https://www.mhamd.org/what-we-do/services-oversight/maryland-parity-project/.*

[14] Mental Health Association in New Jersey. Managed Care Network Adequacy Report. 2013. Retrieved from: *https://www.mhanj.org/content/uploads/2022/07/MHANJ-Managed-Care-Network-Adequacy-Report-7-13.pdf.*

[15] Medicaid and Children's Health Insurance Program (CHIP). "Managed Care Access, Finance and Quality." Centers for Medicare and Medicaid Services. Retrieved from: *https://public-inspection.federalregister.gov/2023-08961.pdf.*

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."[16]

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.[17]

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 health care: 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.[18] A study by the Kaiser Family Foundation found that only 1 percent of physicians have opted out of the Medicare program, but psychiatrists were disproportionately represented, making up 42 percent of those opting out, followed by physicians in family medicine (19 percent), internal medicine (12 percent), and obstetrics/gynecology (7 percent).[19] Medicare's

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[16] Kaiser Family Foundation. "Mental Health and Substance Use Disorder Coverage in Medicare Advantage Plans." 2023. Retrieved from: *https://www.kff.org/medicare/issue-brief/mental-health-and-substance-use-disorder-coverage-in-medicare-advantage-plans/*.

[17] SB 855, Sec. 4, adding section 1372(d). Retrieved from: *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855.*

[18] U.S. GAO. "Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts." March 30, 2022. Retrieved from: *https://www.gao.gov/products/gao-22-104597.*

[19] Ochieng, N., Schwartz, K., and Neuman, T. (2020). "How Many Physicians Have Opted Out of the Medicare Program." Kaiser Family Foundation. Retrieved from: *https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/*.

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 percent less than fee-for-service reimbursement rates for in-network mental health services while paying up to 12 percent more when care was provided by physicians in other areas of health care.[20]

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.[21] 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 health care.[22] 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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[20] Pelech, D., and Hayford, T. (2019). "Medicare Advantage and Commercial Prices for Mental Health Services." *Health Affairs,* 38 (2), 262–267. Retrieved from: *https://doi.org/10.1377/hlthaff.2018.05226.*

[21] Kaiser Family Foundation. "Medicaid to Medicare Fee Index." 2019. Retrieved from: *https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Loca.on%22,%22sort%22:%22asc%22%7D.*

[22] Melek, S., Davenport, S. and Gray, T.J. (2019). "Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement." Retrieved from: *https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf* [finding that in-network behavioral health reimbursement rates are lower than medical/surgical rates (as a percentage of Medicare-allowed amounts) and the disparity has been increasing.]

QUESTIONS SUBMITTED FOR THE RECORD TO MARY GILIBERTI, J.D.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

MENTAL AND BEHAVIORAL HEALTH PARITY

Question. The Mental Health Parity and Addiction Equity Act of 2008 requires insurers to cover mental and behavioral health conditions equal to coverage of any other medical conditions. However, these protections only apply to private and employer-provided plans. Medicare beneficiaries need these protections as well. An estimated one in four Medicare beneficiaries live with mental illness, and almost half of beneficiaries don't receive treatment for their mental health conditions.[1] I introduced the Better Mental Health Care for Americans Act with Chair Wyden this year to address this issue. One of the provisions of the legislation would extend parity requirements to Medicare Advantage.

Is there any reason why Medicare Advantage should treat mental and behavioral health services differently than physical health services?

Answer. There is absolutely no reason why Medicare Advantage plans should treat mental and behavioral health services differently than physical health services. Currently, the parity requirements apply to Medicaid managed care plans and to Affordable Care Act plans offered in the marketplace. There is no reason that Medicaid managed care and marketplace plans are required to treat mental health the same as physical health, but Medicare Advantage plans are allowed to discriminate and are not subject to the same requirements of fairness between mental and physical health care.

MEDICARE ADVANTAGE PROVIDER DIRECTORY REQUIREMENTS

Question. Senate Finance Committee staff recently conducted a secret shopper survey of Medicare Advantage (MA) plans to understand responsiveness and appointment availability.[2] Their results were similar to other studies conducted over the last decade.[3] The staff selected the two largest non-employer MA plans in Denver and called a total of 20 providers posing as the adult child of a parent with the given MA plan, seeking treatment for the parent's depression. Of the 20 calls, 5 went unanswered. Of the calls that were answered, 50 percent of them were not successful either because the provider was out-of-network (despite being listed in the plan's directory), the provider was not accepting new patients, or the provider required a referral to set an appointment. The results of this study are troubling for Coloradans. One of the provisions in my mental and behavioral health bill would address the issue of provider directory inaccuracy by strengthening requirements for MA plans.

What more can Congress do to ensure patients have access to accurate directories?

Answer. The struggles of families across the Nation must be addressed so it is easier to access mental health services. I recommend three categories of solutions. First, it is important to hold plans accountable for accurate information. This can be accomplished through secret shopper surveys and audits by third parties or CMS. Another solution in this category is requiring plans to use their claims data and adjust their provider directories and network adequacy submissions accordingly.

Second, this is an area that needs more sunlight. Any audit results around inaccuracies in the provider directory and long wait times for services should be publicly available by plan.

Finally, to ensure that transparency does not lead to adverse selection and reward plans that make it difficult to get care, financial incentives must be aligned. This can be accomplished in several ways. Penalties can be assessed against plans that exceed benchmarks for accuracy and wait times. Another solution is adjusting the Star rating system, which gives plans a 1–5 star rating. No plan should get a high rating if it has inaccurate provider directories and long wait times for care. Factoring these into the Star ratings at a meaningful level of input (making accuracy and wait times count for a lot in the Star system) would help consumers make better decisions.

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[1] *https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2771518.*

[2] *https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.*

[3] *https://pubmed.ncbi.nlm.nih.gov/25354035/.*

MENTAL AND BEHAVIORAL HEALTH INTEGRATION

Question. In order to access care, a patient first needs to be able to find a provider. In 2020, a third of adults aged 18 or older reported having a mental illness but not receiving care because they did not know where to go for services.[4] Primary care providers are often more accessible for patients, and studies have shown that patients with mental health illnesses are more likely to discuss them with a primary care doctor than with psychiatrists or other health professionals.[5] But our current system is not designed for collaboration to coordinate a patient's care. Mental health illnesses are often diagnosed and treated separately from physical health services.

Given how frequently individuals bring up mental health concerns in primary care settings, could a behavioral health integration model work to increase services in rural areas?

Answer. Yes, a primary care integration model is particularly well-suited for rural areas. People much prefer going to their primary care practice, rather than specialty mental health providers and, given workforce shortages, mental health providers are often unavailable. The problem, however, is that primary care practices operate on very low margins and the rates for compensating integrated care have not been sufficient to incentivize these services. As a result, I strongly recommend the committee increase payment for integrated care services and for practices that have integrated behavioral health care.

Question. Are there other models that could increase access to mental and behavioral health services?

Answer. In addition to primary care, young people are in school settings. Accordingly, models that integrate behavioral health care into school settings have been effective. This includes school-linked services where a community mental health provider has an agreement with the school to operate in the school, either in person or virtually. Parents and students prefer to receive services in school because it reduces transportation time and is convenient. In addition, studies have shown school-based services reduce disparities and increase access for children from underserved communities.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What is the impact of prior authorization requirements on access to mental health care?

Answer. Prior authorization policies have severely restricted access to mental health care in several ways. First, onerous prior authorization requirements disincentivize providers to take insurance. Many behavioral health providers cite the time and effort required by burdensome prior authorization processes as critical factors in their decision not to participate in Medicaid, Medicare, and private insurance. These prior authorization delays affect access to services and medication and behavioral health providers are very frustrated by the amount of time they must divert from patient care to arguing with insurance reviewers, who often do not have the appropriate background to make these decisions.

Second, insurers use medical necessity standards in their prior authorization processes that are designed to deny services. A district court in *Wit v. United Healthcare,* found that United Healthcare had ignored medical association guidelines and instead, specifically designed its criteria for financial gain by denying care. CMS has recently proposed requiring Medicare Advantage plans to use clinical guidelines in making medical necessity determinations.

Question. What are the largest sources of administrative and payment-recovery costs for mental health providers, and how do these affect their ability to serve patients and communities?

Answer. Burdensome prior authorization processes lead to high costs for mental health providers and make it difficult for them to serve patients and communities by taking needed time away from patient care and disincentivizing taking insurance.

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[4] *https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care.*

[5] *https://www.aamc.org/media/62886/download.*

A recent article[6] by Kaiser Health News noted that health insurance denials are increasing and cost millions for doctors and patients to address. They note that some insurers use automated reviews to deny services at high rates and with little review of the person's individual circumstances.

Providers also find step therapy and fail first policies for medication particularly problematic from administrative and human cost perspectives. If the provider has clinical reason to recommend a particular treatment, it is not cost effective or humane to require the individual to decline in mental health before they can access the medication that their provider recommends. Providers are often forced to prescribe medications according to insurance coverage that have not previously worked for people or that are contra-indicated due to adverse interactions with medications the person is taking for other conditions, allergies, or if the person is pregnant. These policies are often shortsighted because medical costs increase and unnecessary time and suffering results from increased emergency service use and hospital costs.

Question. What payment reforms have reduced these administrative costs, and which models hold the greatest promise to reduce the administrative burden on mental health providers?

Answer. Policies have required that insurers make decisions based on clinical guidelines of medical associations, rather than making up the medical necessity criteria. Requiring the appropriate educational background and a review of the individual's record is also helpful.

The Kaiser Health News article noted that information on denials is required to be public and reported by plan, but HHS has not implemented and enforced these policies. The author writes:

> The Affordable Care Act clearly stated that HHS "shall" collect the data on denials from private health insurers and group health plans and is supposed to make that information publicly available. (Who would choose a plan that denied half of patients' claims?) The data is also supposed to be available to state insurance commissioners, who share with HHS the duties of oversight and trying to curb abuse.
>
> To date, such information-gathering has been haphazard and limited to a small subset of plans, and the data isn't audited to ensure it is complete, according to Karen Pollitz, a senior fellow at KFF and one of the authors of the KFF study. Federal oversight and enforcement based on the data are, therefore, more or less nonexistent.

States have taken a number of legislative approaches to lessen the administrative burden, and the burden of denial and delay for medication access for individuals experiencing serious mental illness. Examples include:

- No step therapy or prior authorization for medications for serious mental illness in private insurance (ME).
- No step therapy or prior authorization for medications for serious mental illness in Medicaid (TX).
- Disallowing therapeutic substitution for medications for serious mental illness for people who are stabilized on a medication (WA).
- Partial remedies, such as mandating that no more that one step before access to clinically indicated and prescribed medication for serious mental illness (CO—awaiting the Governor's signature).

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. Are government regulations or policies preventing the private sector from solving the problem of inaccurate provider directories?

Answer. I am not aware of any government regulation or policy that prevents the private sector from solving the problem of inaccurate provider directories, but there are policies that incentivize them not to solve the problem. If a plan has an inaccurate directory, it is likely that the person will not be able to find in-network help. Given that 60 percent of Medicare Advantage plans do not offer out-of-network coverage, the plan pays nothing if the individual either goes out of network or does

[6] *https://kffhealthnews.org/news/article/denials-of-health-insurance-claims-are-rising-and-getting-weirder/*.

not receive care. So current policy gives plans fiscal incentive to have inaccurate directories and no fiscal incentive to correct the problem.

If a plan with inaccurate directories was no longer able to get a high Star rating and the corresponding bonus payments, then there would be a financial incentive to fix the problem. Similarly, a significant penalty payment would also be a financial incentive to fix the problem.

PREPARED STATEMENT OF KERIS JÄN MYRICK, M.S., M.B.A.,
VICE PRESIDENT OF PARTNERSHIPS, INSEPARABLE

Chair Wyden, Ranking Member Crapo, and members of the Senate Finance Committee, thank you for conducting this hearing today and providing me the honor of testifying regarding ghost networks and provider directories.

My name is Keris Myrick, and I am the vice president of partnerships for Inseparable, a nonprofit organization working to advance policy that reflects the belief that the health of our minds and our bodies is inseparable. We are focused on closing the treatment gap for the many people who need mental health services and aren't getting them, improving crisis response, and promoting prevention and early intervention. I am also a mental health advocate and survivor with lived experience of ghost networks in health plans. I am here today to share my story and bring attention to this critical issue that affects so many people living with mental health conditions.

Ghost networks and inaccurate provider directories erect invisible, unexpected barriers within our health system, preventing people from accessing the care and support they need. They are particularly damaging for those of us living with serious mental health conditions, like me, as they can result in delayed or inadequate treatment or even going without treatment, any of which can have devastating consequences.

My first experience with ghost networks occurred when I had to change my health insurance due to a move and a new job in 2014. Leaving California to work for the Federal Government was both exciting and daunting. It was imperative that I find the health-care professionals that I needed, especially a psychiatrist who could provide the continuity of care that was essential to my ongoing mental health recovery.

My California-based psychiatrist provided me with a few DC-based recommendations. However, those providers were not accepting new patients. I was left to navigate the Blue Cross Blue Shield for Federal Employees provider directory to find a psychiatrist. Calling psychiatrists within DC and Maryland, selected out of what was like a digital white-pages phone book, turned into one rejection after another. Call after call resulted in the following types of responses:

> "Who? Hmm, s/he doesn't work here. No, I don't know where s/he works now."
>
> "Who? I don't know who that is, not sure they ever worked here. Hold please . . ." [dial tone].
>
> Recorded message: "Dr _____ is no longer accepting new patients. If this is an emergency, hang up and call 911."

I spent countless days and hours scouring the network, despite working long hours in a high-level management position. When was there time to find a psychiatrist? I had to make the time, though, as my job, and more importantly my life, depended on it. Continued attempts finally lead me to a psychiatrist who was taking new patients. Success, though, was short-lived. In our phone conversation to set up an initial in-person appointment, I was asked about my diagnosis. I had no worry or fear; this doctor, this psychiatrist, was taking new patients. I respond without hesitation—schizophrenia. A pause, a long silence . . . and then the response: "Oh. . . . I do not take patients with a schizophrenia diagnosis."

I ask if they have any suggestions or referrals to help me find a doctor who does. The answer is: "Check the provider directory."

I am back at the beginning now with a heightened fear of rejection. Going back to the directory was like looking for a needle in a haystack. Lots of hay, very few needles, and none that can stitch together the needs of my schizophrenia garment.

Finally, I contacted my psychiatrist in California and asked if and how he could remain my doctor. While in the DC area, I had regular appointments with this psy-

chiatrist and flew at my own expense to Los Angeles over a 4-year period to ensure that I could be and stay well. I also paid high copays for my out-of-network provider, but I HAD a provider.

On the same plan, when I needed a doctor for what turned out to be thyroid cancer, I was able to find an endocrinologist the very same day. There was no guessing in the directory how to find that type of specialist or to find one that was taking new patients. But for mental health, it was a very different story—a story that continued throughout my career.

In 2018, I left the Federal Government to work for Los Angeles County Department of Mental Health, leaving me with new insurance and a new provider directory to navigate. My L.A.-based psychiatrist was now a colleague, so I had to find a new psychiatrist. I searched the directory with trepidation and the response to my calls led to all-too-familiar dead ends. In 2020, I accepted a position with the Mental Health Strategic Initiative, and, in 2022, began my current role with Inseparable. Again, new insurance plans and new provider directories. Each time, it felt like the movie, "Groundhog Day," with the same responses—there is no provider here by that name, they are retired, and/or they aren't taking new patients, especially not one with a diagnosis of schizophrenia.

Unfortunately, my story is not unique. Many of my peers with mental health diagnoses face similar challenges when seeking care, regardless of whether they are covered by Medicaid, Medicare, or private insurance. I know I have been extremely fortunate that I could bear the expense of out-of-network care and that I have not had a psychiatric emergency. Many are not so lucky and the outcomes can be terrible, even tragic. As you know, people with serious mental health conditions have disproportionately high rates of being unhoused, unemployed, incarcerated, hospitalized, disabled, or dying early of treatable medical conditions or by suicide. And the difference between maintaining a life of our dreams and unimaginable outcomes can come down to whether a person is able to get the care they need.

Health plans, you are not doing the job you are paid to do. My health plans were supposed to cover mental health care, yet I was left without reasonable access to providers. I'm also covered for my thyroid condition, but have always had ready access to a specialist, an endocrinologist. But for mental health, it's been a different story.

Even today, despite having health insurance that is otherwise considered "excellent," I have no regular psychiatrist. This leaves me with ongoing anxiety about what will happen if I should need more intensive and ongoing care. I have experienced being unhoused, unemployed, having interactions with the criminal justice system and involuntary hospitalizations. I don't ever want to go through those traumatizing experiences again because I wasn't able to find a provider through my health plan's directory and get the help I need to stay well.

I do not have this worry about my thyroid condition; I have had a specialist, an endocrinologist, readily available under every insurance plan. Why, then, do I not have the same for my mental health? Senator Wyden, you stated: "Too often, Americans who need affordable mental health care hit a dead end when they try to find a provider that's covered by their insurance. Ghost networks mean that the lists of mental health providers in insurance company directories are almost useless." *Never a truer word.*

It is time to require health plans and insurance companies to take responsibility and be accountable for providing accurate and timely information to their members and for maintaining adequate networks of providers. We are no longer patient—we demand to see improvements. As a survivor with lived experience of ghost networks in health plans, I urge you to take action on this critical issue. The Senate Finance Committee can play a vital role in promoting access to mental health care, especially for someone, like me, living with a diagnosis of schizophrenia, through policies that:

1. Provide the oversight, enforcement, and incentives and/or penalties necessary to result in highly accurate provider directories;
2. Require the inclusion of psychiatric subspecialties in provider directories; and
3. Implement a federally operated mechanism (online reporting system or dedicated 1–800 number) for consumers/plan members to report their experiences of ghost networks and use this data to inform policy and enforcement actions.

I encourage you to consider the impact of ghost networks on individuals with mental illness and their families and adopt solutions that ensure that everyone has access to the care and support they need to thrive.

QUESTIONS SUBMITTED FOR THE RECORD TO KERIS JÄN MYRICK, M.S., M.B.A.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What is the impact of prior authorization requirements on access to mental health care?

Answer. Prior authorization requirements, a process that requires patients and health-care providers to obtain approval from insurance companies before certain treatments or services can be covered, can have a significant impact on access to mental health care. While prior authorization is intended to manage costs and ensure appropriate care, it can create barriers and delays in accessing mental health services. Here are some specific impacts:

1. Delays in treatment: The prior authorization process often involves paperwork, documentation, and review by insurance companies. This can lead to delays in receiving mental health care, which is especially problematic for individuals who need timely intervention or are in crisis situations.
2. Administrative burden: Mental health providers may spend a significant amount of time and resources dealing with prior authorization requests. This can divert them away from providing direct care to patients, leading to decreased capacity to serve patients, as well as increased administrative burden and potential burnout.
3. Limited provider options: Insurance companies typically have a list of preferred providers or a network of contracted mental health professionals. If a patient's preferred provider is not in-network, they may have to switch to a different provider or face higher out-of-pocket costs. This can limit patients' choices and disrupt established therapeutic relationships.
4. Discontinuity of care: Prior authorization requirements can disrupt the continuity of mental health treatment. If a patient needs to change providers or if there are delays in obtaining authorization for ongoing treatment, it can result in interruptions in care, which can be detrimental to the patient's progress—or even result in crises and other harmful outcomes.
5. Stigma and privacy concerns: The prior authorization process may require patients, when contesting a denial of prior authorization, to disclose personal and sensitive information about their mental health conditions to their insurance plan. This can create privacy concerns and potential stigma, discouraging individuals from seeking the care they need.
6. Inconsistent criteria and denials: Prior authorization requirements can vary across insurance plans, leading to inconsistencies in approval criteria. Denials for coverage may occur even when treatment is deemed necessary by mental health professionals, leading to additional challenges in accessing appropriate care.

These factors collectively contribute to decreased access to mental health care and may negatively impact individuals seeking help for mental health conditions.

Question. What are the largest sources of administrative and payment-recovery costs for mental health providers, and how do these affect their ability to serve patients and communities?

Answer. The largest sources of administrative and payment-recovery costs for mental health providers can vary, but some common factors include:

1. Prior authorization requirements: As mentioned earlier, prior authorization requirements imposed by insurance companies can create significant administrative burdens for mental health providers. The process involves paperwork, documentation, and communication with insurance companies to obtain approval for specific treatments or services. This administrative workload can divert resources and time away from patient care.
2. Insurance claim processing: Mental health providers often need to submit claims to insurance companies for reimbursement of services provided. The administrative tasks involved in claim submission, coding, and documentation can be time-consuming and costly. Providers may need to hire additional staff or invest in electronic health record systems to manage these processes efficiently.

3. Billing and collections: Mental health providers must handle billing and collections processes to receive payment for their services. This includes verifying insurance coverage, processing claims, following up on denied or unpaid claims, and managing patient payments. These tasks require dedicated administrative staff and can be complex and time-consuming.
4. Compliance and regulatory requirements: Mental health providers are subject to various compliance and regulatory requirements, such as those related to privacy (HIPAA), billing practices, and documentation standards. Ensuring compliance with these regulations often involves additional administrative efforts and costs, including staff training, audits, and maintaining adequate documentation.

These administrative and payment-recovery costs can have several effects on mental health providers' ability to serve patients and communities:

1. Financial strain: The costs associated with administrative tasks and payment recovery can strain the financial resources of mental health providers, particularly smaller practices or those serving underserved communities. Providers may have limited resources available for hiring qualified staff, investing in technology, or expanding their services.
2. Reduced capacity and access: The administrative burden placed on mental health providers can limit their capacity to see and serve patients. Providers may have to spend more time on administrative tasks, leading to fewer available appointment slots and longer wait times for patients. This can impede timely access to mental health services, particularly in areas already facing shortages of mental health providers.
3. Increased operational costs: Administrative tasks and payment recovery processes require additional staff, software, and infrastructure, all of which contribute to increased operational costs for mental health providers. These costs may need to be passed on to patients through higher fees or copayments, making mental health care less affordable.
4. Burnout and job dissatisfaction: The heavy administrative burden placed on mental health providers can lead to burnout and job dissatisfaction. Providers may feel overwhelmed by the administrative tasks, spending less time on direct patient care and the therapeutic aspects of their work. This can negatively impact their overall well-being and ability to provide quality care.
5. Disparities in care: The administrative and payment challenges faced by mental health providers can disproportionately affect underserved populations and communities with limited access to mental health services. Providers in these areas may struggle to sustain their practices or may be unable to accept certain insurance plans, exacerbating existing disparities in access to care.

Efforts to streamline administrative processes, simplify billing and reimbursement, and reduce regulatory burdens can help alleviate some of these challenges and enable mental health providers to focus more on delivering quality care to their patients and communities.

Question. What payment reforms have reduced these administrative costs, and which models hold the greatest promise to reduce the administrative burden on mental health providers?

Answer. Several payment reforms have been implemented to reduce administrative costs and streamline billing processes in health care, including mental health. Here are some payment models that have shown promise in reducing the administrative burden on mental health providers:

1. Value-based care and alternative payment models: Value-based care models, such as accountable care organizations (ACOs) and bundled payments, aim to shift the focus from fee-for-service reimbursement to paying providers based on quality and outcomes. These models incentivize coordination of care, reducing the need for excessive administrative tasks associated with billing and claims processing. By aligning payment incentives with patient outcomes, value-based care models can promote efficiency and reduce administrative burdens.
2. Integrated care and collaborative models: Integration of mental health services within primary care settings or through collaborative care models can streamline administrative processes. In these models, mental health providers work closely with primary care providers, sharing information and coordinating care. This integrated approach can reduce administrative tasks

related to referral processes, claim submissions, and coordination of benefits across different providers.
3. Telehealth and digital health solutions: The increased utilization of telehealth and digital health technologies has the potential to streamline administrative processes. Telehealth allows providers to deliver mental health services remotely, reducing the need for in-person administrative tasks. Digital health solutions, such as electronic health records (EHRs) and online billing systems, can automate administrative processes, improve billing accuracy, and simplify claims submissions.
4. Simplified billing and coding practices: Simplifying billing and coding practices can significantly reduce administrative burdens. Standardizing billing codes, implementing electronic claims submission, and adopting clear and uniform reimbursement guidelines can streamline the payment process and reduce administrative complexities for mental health providers.
5. Reduced prior authorization requirements: Revising and reducing prior authorization requirements can alleviate the administrative burden on mental health providers. Simplifying the criteria, implementing evidence-based guidelines, and adopting streamlined processes can expedite access to mental health services, reducing the administrative workload for providers.

Administrative simplification initiatives: Various administrative simplification initiatives, such as the adoption of standard transaction formats (*e.g.,* HIPAA EDI) and electronic funds transfer (EFT) for reimbursement, aim to streamline administrative processes and reduce paperwork. These initiatives focus on standardizing communication and transactional processes between providers and insurance companies, which can improve efficiency and reduce administrative costs. It's important to note that the effectiveness of these payment models in reducing administrative burdens may vary based on the specific health-care system, insurance practices, and regulatory environment in different regions. Continued collaboration among policymakers, payers, and providers is crucial to identify and implement payment reforms that effectively reduce administrative costs and improve the overall delivery of mental health care.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Are government regulations or policies preventing the private sector from solving the problem of inaccurate provider directories?

Answer. Inaccurate provider directories have been a longstanding issue in the health-care industry. While government regulations and policies can play a role in shaping the health-care landscape, this is a complex issue that involves various factors. Government regulations and policies can play a role in helping the private sector address the problem of inaccurate provider directories. Inaccurate provider directories can cause significant challenges for patients seeking health-care services, leading to frustration, delays in care, and potential health risks. Here are a few ways in which government regulations and policies can assist in resolving this issue:

1. Data Accuracy Standards: Governments can establish standards and regulations requiring insurers, and health plans to maintain accurate and up-to-date provider directories and for health-care providers to assist by providing timely and accurate information to insurers and health plans. This can include guidelines on data quality, regular verification processes, and penalties for noncompliance.
2. Transparency Requirements: Governments can mandate transparency in provider directory information, ensuring that accurate and relevant details are accessible to the public. This can include requirements for providers and insurers to disclose information such as location, contact details, specialties, and accepted insurance plans.
3. Reporting and Auditing: Governments can implement mechanisms for reporting and auditing provider directories to identify inaccuracies and monitor compliance. Regular audits and assessments can help identify areas for improvement, hold accountable entities responsible for maintaining accurate directories, and ensure that corrective measures are taken.
4. Collaboration and Information Sharing: Governments can facilitate collaboration between private health-care organizations, insurers, and other stakeholders to share accurate provider data. This can involve the development of standardized data formats and interoperability standards to enable seamless exchange of provider information.

5. Consumer Protection Measures: Governments can introduce consumer protection measures to address the consequences of inaccurate provider directories. This may include provisions for patients to report inaccuracies, seek remedies, or file complaints against providers or insurers that consistently provide incorrect or misleading information.
6. Incentives and Rewards: Governments can offer incentives or rewards to private entities that maintain accurate and up-to-date provider directories. This can encourage compliance with regulations, spur competition among providers and insurers to improve data quality, and ultimately benefit patients. For example, in the United States, the Centers for Medicare and Medicaid Services (CMS) has established guidelines for Medicare Advantage plans to maintain accurate directories. These regulations can incentivize private insurers and providers to improve the quality of their directories.

Government regulations and policies can have both positive and negative impacts on the private sector's ability to address inaccurate provider directories. On one hand, regulations can introduce standards and requirements for provider directories, aiming to ensure accuracy and transparency. On the other hand, compliance with regulations can sometimes be burdensome and costly for private entities. Strict regulations may impose administrative requirements and reporting obligations that could divert resources away from addressing specific problems like inaccurate provider directories. Additionally, regulatory frameworks can vary across different jurisdictions, making it challenging for the private sector to develop standardized solutions.

It's important to note that inaccurate provider directories can result from a range of factors, including the dynamic nature of health-care networks, changes in provider information, outdated technology, and data management challenges. Addressing these issues requires collaboration between government entities, private insurers, health-care providers, and technology companies.

Government regulations and policies can influence the public and private sector's ability to address inaccurate provider directories. A comprehensive and balanced approach involving government regulations and oversite, collaboration between public and private entities, along with advancements in technology, is necessary to tackle this complex problem.

Question. In your written testimony, you offered ideas to improve provider directories. How do your solutions account for rural patients' needs?

Answer. When considering the solutions I provided to improve provider directories, it is important to account for the specific needs of rural patients. Rural areas often face unique challenges in accessing health-care services, including a shortage of providers and limited network options. Here's how each solution could address rural patient needs:

1. Provide oversight, enforcement, incentives, and penalties: This solution aims to ensure highly accurate provider directories across the board. In rural areas, where provider shortages are more pronounced, it becomes even more critical to maintain accurate and up-to-date directories. By enforcing regulations and incentivizing accurate reporting, rural patients can have better access to reliable information about available providers and services. Examples include:
   a. Incentives for Data Reporting: Create incentives for health-care plans and providers, especially those in rural areas, to regularly update and maintain accurate information in the directories. Incentives could include reduced administrative burden, financial incentives, or improved visibility for plans and providers who actively participate in maintaining directory accuracy.
   b. Data Verification and Validation: Implement robust mechanisms to verify and validate provider information regularly. This can involve cross-referencing information from multiple sources, leveraging data analytics to identify discrepancies, and employing automated processes to flag potential inaccuracies for manual review.
2. Require inclusion of psychiatric subspecialties: Mental health services are crucial in rural areas, where access to specialized psychiatric care can be limited. By mandating the inclusion of psychiatric subspecialties in provider directories, rural patients can have clearer visibility into the availability and specialty of mental health professionals especially providers that specialize in schizophrenia disorders which are woefully underrepresented in all areas

of the country. Further, by promoting and integrating telehealth services into provider directories inclusive of subspecialties should be part of this solution for rural communities. Telehealth can play a crucial role in delivering health-care services to rural areas where access to specialists and subspecialties may be limited. Including telehealth providers and their subspecialties in directories can provide rural patients with more options for receiving care remotely. Supporting the development of user-friendly mobile applications and online platforms that are easily accessible to rural patients can also facilitate access to psychiatric subspecialties. These platforms can provide real-time information about available providers, their specialties, appointment availability, and other relevant details such as search functionalities, location mapping, and filtering options to help patients find nearby providers and understand the services they offer. Designing these tools to be compatible with low-bandwidth Internet connections or offline access can be beneficial for rural areas with limited connectivity. It's crucial to ensure that these platforms are designed with simplicity and accessibility in mind, considering potential limitations in Internet connectivity and technology usage in rural areas. Requiring psychiatric subspecialties and tools to access them can help people in rural communities to make informed decisions and identify providers who can address their specific needs.

3. Implement a federally operated reporting mechanism: Establishing a dedicated reporting system for consumers to share their experiences, such as encountering ghost networks (insufficient provider networks), can be beneficial for rural patients. It allows them to voice their concerns and provide valuable feedback about their access to care.

   Conducting community outreach programs with Peer Supporters and Community Health Workers (CHWs) can raise awareness among rural populations about the importance of accurate provider directories and can educate patients about how to navigate the directories, understand provider information and report inaccuracies easily through the federally operated reporting mechanism. Empowering rural patients with the knowledge to utilize and contribute to improving provider directories is invaluable. By incorporating rural patient experiences into the reporting system, policymakers can gain insights into the unique challenges faced by rural communities and take targeted actions to address them. This data can inform policy decisions, enforcement actions, and potentially lead to interventions that improve network adequacy in rural areas.

It's crucial to recognize that rural health-care challenges are multifaceted. Addressing the needs of rural patients requires a comprehensive approach that encompasses factors like provider recruitment, telehealth solutions, transportation infrastructure, and financial incentives. The solutions provided for improving provider directories can serve as a part of a broader strategy to enhance rural health-care access. Continuous collaboration between government, health-care stakeholders inclusive of peers and people living with mental health conditions and rural communities is essential to tailor and implement effective solutions that meet the unique needs of rural patients.

PREPARED STATEMENT OF JACK RESNECK, JR., M.D.,
PRESIDENT, AMERICAN MEDICAL ASSOCIATION

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 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 and Medicaid Services (CMS), in a review of 52 MA organizations (MAOs) (approximately one-third of MAOs at the time), found that nearly

[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).

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 committee[5] 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 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 paper[8] with the hopes of identifying how insurers and physicians can work together to improve the data collection and directory updating processes.

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[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," Power Point 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.*

[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).

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. 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 pro-

viders 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 2 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's 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 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 3 percent reported that they had filed a complaint with a government agency and only 9 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-

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

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 7 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.

QUESTIONS SUBMITTED FOR THE RECORD TO JACK RESNECK, JR., M.D.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

WORKFORCE

Question. Our country is currently facing a shortage of health-care workers, especially as we work to recover from the COVID–19 pandemic. A 2021 Washington Post-Kaiser Family Foundation survey found that about 30 percent of health-care workers are considering leaving the profession and about 60 percent reported that the pandemic impacted their mental health. The American Hospital Association estimates that the U.S. will face a shortage of 124,000 physicians by 2033.

The health workforce shortage is especially problematic for mental and behavioral health. 158 million people currently live in a mental health workforce shortage area, and the U.S. is expected to be short about 31,000 full-time mental health practitioners by 2025.

In my State of Washington, there is just one mental health provider for every 360 people. In rural or underserved areas, like the eastern counties of Washington State, access barriers are even higher. Nearly half of all counties in Washington do not have a single working psychiatrist.

When Americans are already struggling to find adequate health care because of workforce shortages, it is unacceptable that ghost networks add yet another barrier to care. Someone who is in the midst of a mental health crisis, or already overburdened with caregiving responsibilities, or exhausted from working multiple jobs, should not have to waste hours calling providers only to find that no one takes their insurance or accepts new patients.

We know there's a shortage of providers in certain specialties such as psychiatry. To what degree are challenges in accessing behavioral health care an outcome of health-care workforce shortages versus inaccurate provider directory information?

Answer. It is impossible to compare these two issues. Inaccurate provider directories challenge patients' ability to access timely, in-network care by failing to provide patients with the information they need to pursue care. Inaccuracies can also create the impression that a network can meet the needs of enrollees, when, in fact, the network is insufficient. When provider directories are *inaccurate,* they may be masking *inadequate* networks of providers. Accuracy of directories and adequacy of network is ultimately the responsibility of the health plan offering the network product.

Physician workforce shortages is a different issue that will also result in decreased patient access to care because, unless action is taken, there will simply not be enough practicing physicians to meet patient demand. 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 7 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.

Question. To expand the mental health-care workforce, Congress created 100 new Graduate Medical Education slots specially reserved for psychiatry and psychiatry subspecialties as part of the FY 2023 appropriations legislation.

Do policies like additional GME slots help make provider directories more adequate and accurate?

Answer. No, policies like additional GME slots do not help make provider directories more accurate but will ultimately increase/sustain access to care.

Question. Is the current availability of GME slots sufficient in addressing the growing mental health provider shortage?

Answer. No, additional GME slots are needed to sufficiently address the growing mental health provider shortage.

Though I appreciated and welcomed the additional 200 new Medicare-supported residency positions in psychiatry and psychiatry subspecialties that were provided

in the Consolidated Appropriations Act, 2023, that is just the beginning of what is needed. Given the severity of the current and projected workforce shortage, a greater investment in this space is necessary to increase the supply of physicians with expertise in mental health. The United States is facing a shortage of between 37,800 and 124,000 physicians by 2034—a dearth that is almost certain to be exacerbated by rising rates of physician burnout and early retirement due to the COVID–19 pandemic. On top of this, there is a current shortage of mental health providers that has resulted in 163 million individuals living in mental health HPSAs requiring an additional 8,200 mental health professionals to eliminate the current shortage areas according to the Health Resources and Services Administration (HRSA). Therefore, it is crucial that we invest in our country's health-care infrastructure to help provide patients with the physicians they need and improved access to care. As such, I urge you to take this opportunity to further invest in the physician workforce by again increasing the number of Medicare-supported GME positions. The Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389) is bipartisan legislation that would take steps to better alleviate the physician shortage by gradually providing 14,000 new Medicare-supported GME positions over 7 years. Additionally, Congress could provide more funding for mental health providers through the National Health Service Corps, provide more scholarships or loan forgiveness programs for physicians providing mental health care especially for those who agree to serve in underserved communities, and increase the cap building window so that new programs have a longer period of time to establish their cap (*e.g.,* H.R. 4014/S. 2094, the Physician Shortage GME Cap Flex Act). Additional legislation that should be supported to help mitigate GME shortages in this space include:

- Medical Student Education Authorization Act of 2023 (House and Senate).
- Resident Education Deferred Interest (REDI) Act (H.R. 1202).
- Restoring America's Health Care Workforce and Readiness Act.
- Strengthening America's Health Care Readiness Act (S. 862).
- Specialty Physicians Advancing Rural Care Act, or the "SPARC Act" (H.R. 2761 and S. 705).
- Taskforce Recommending Improvements for Unaddressed Mental Perinatal and Postpartum Health for New Moms Act of 2021 or the "TRIUMPH for New Moms Act of 2021" (H.R. 4217 and S. 2779).

Question. Our mental health workforce is already overworked and understaffed, especially coming out of the pandemic. Do you believe it is the provider's job to ensure that provider directories are up-to-date, or is this the responsibility of insurance companies?

Answer. The provider directory is a critical component of the product that a health insurer sells. As such, the accuracy of a directory is ultimately the responsibility of the health plan.

Question. Is there a middle ground where the two sides can meet to coordinate on this issue?

Answer. While the responsibility of accurate provider directories lies with the insurer, there is of course a role for physician practices to play in improving accuracy, and efforts should be made to assist practices in doing so. Recently, the AMA published a paper with CAQH, an alliance of health plans, providers and other healthcare stakeholders, to analyze the current state of the provider directory problem, identify best practices and recommend practical approaches that both health plans and physician practices can take to solve the problem. Among the solutions considered, the paper recognizes that health plans have a responsibility to streamline data update channels and providing practices with a way to differentiate between locations where a clinician is seeing patients versus one where he or she is contracted but not regularly seeing patients. Meanwhile, efforts should be made by practices to provide timely and accurate updates when key directory data, such as office address and phone number, change and associating clinicians to practice locations where they regularly see patients as opposed to registering every clinician at all possible practice locations in the event they are covering for colleagues.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

MEDICARE ADVANTAGE PROVIDER DIRECTORY REQUIREMENTS

Question. Senate Finance Committee staff recently conducted a secret shopper survey of Medicare Advantage (MA) plans to understand responsiveness and ap-

pointment availability.[1] Their results were similar to other studies conducted over the last decade.[2] The staff selected the two largest non-employer MA plans in Denver and called a total of 20 providers posing as the adult child of a parent with the given MA plan, seeking treatment for the parent's depression. Of the 20 calls, five went unanswered. The calls that were answered, 50 percent of them were not successful either because the provider was out-of-network (despite being listed in the plan's directory), the provider was not accepting new patients, or the provider required a referral to set an appointment. The results of this study are troubling for Coloradans.

While the Senate Finance Committee's secret shopper study targeted major cities, the results are also concerning for access to mental and behavioral health services in rural areas. In my State, 22 of the 64 counties do not even have a psychologist or psychiatrist.[3]

Could you describe how ghost networks affect rural America?

Answer. Inaccurate provider directories leave patients scrambling to find a physician and oftentimes with expensive out-of-network care. This phenomenon is demoralizing to patients and can lead to serious adverse health outcomes for vulnerable patients in need of mental health-care services, patients with serious health conditions, and patients living in rural and underserved areas. Patients who live in rural areas might be left traveling hundreds of miles to find a physician who accepts their insurance and is taking new patients, leading to unreasonable delays in care, despite the directory showing more accessible options. Patients who do not have the means to travel will often forgo needed care leading to much more dire and in some cases deadly health-care consequences.

MENTAL AND BEHAVIORAL HEALTH INTEGRATION

Question. In order to access care, a patient first needs to be able to find a provider. In 2020, a third of adults aged 18 or older reported having a mental illness but not receiving care because they did not know where to go for services.[4] Primary care providers are often more accessible for patients, and studies have shown that patients with mental health illnesses are more likely to discuss them with a primary care doctor than with psychiatrists or other health professionals.[5] But our current system is not designed for collaboration to coordinate a patient's care. Mental health illnesses are often diagnosed and treated separately from physical health services.

Given how frequently individuals bring up mental health concerns in primary care settings, could a behavioral health integration model work to increase services in rural areas?

Answer. Yes, the AMA is a strong supporter of the Collaborative Care Model where a primary care physician serves at the head of the care team, coordinating with mental health professionals to treat both mental and behavioral health-care problems in the same setting. This is a model that has been proven to work and is one effective approach to treating access issues in rural and underserved areas.

The AMA and seven leading medical associations have established the Behavioral Health Integration (BHI) Collaborative, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices. As part of this initiative, the BHI Collaborative has created a Compendium that serves as a tool for clinicians to learn about integrating behavioral health care, which includes mental health and substance use disorders, and how to make it effective for the practice and patients.[6] The AMA offers additional resources to support practices in integrating behavioral health services.[7]

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[1] *https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.*

[2] *https://pubmed.ncbi.nlm.nih.gov/25354035/.*

[3] *https://coruralhealth.org/wp-content/uploads/2013/10/2022-Snapshot-of-Rural-Health-February-final-release.pdf.*

[4] *https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care.*

[5] *https://www.aamc.org/media/62886/download.*

[6] *https://www.ama-assn.org/delivering-care/public-health/compendium-behavioral-health-integration-resources-physician.*

[7] *https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices.*

Question. Are there other models that could increase access to mental and behavioral health services?

Answer. Yes, the COVID–19 Public Health Emergency saw the emergence of many new hybrid models of care combining telehealth, in-person, and remote monitoring services that have been extremely helpful in improving access to mental and behavioral health services. Even before COVID, Project Echo was a successful telehealth model, started in New Mexico, that utilizes telehealth to connect specialists in cities to primary care physicians in rural and underserved areas. Specialists collaborate and train primary care physicians to treat patients with conditions traditionally treated by the specialist. This model was initially founded to help treat hepatitis C, a treatable condition with high survival rate when caught early. A patient in New Mexico who was unable to access the specialized treatment in their rural town eventually saw a specialist when it was too late. The patient ended up needlessly dying from hepatitis C. This and other models that combine virtual and in-person services based on the patient's needs could be applied to help address the mental health professional shortage in rural and other underserved areas.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What is the impact of prior authorization requirements on access to mental health care?

Answer. Prior authorization (PA) has been used by insurers as another tool to delay provision of and payment for necessary health care to patients. The 2022 AMA Prior Authorization Physician Survey quantifies the patient harms associated with PA.[8] An overwhelming majority (94 percent) of surveyed physicians reported that PA delays access to necessary medical care, and 80 percent of physicians indicated that PA can lead to treatment abandonment. The downstream consequences can be devastating: 89 percent of physicians reported that PA has a negative impact on clinical outcomes, and 33 percent said that PA has led to a serious adverse event (hospitalization, life-threatening event, or even death) for a patient in their care.

The impact of PA on access to mental health care aligns with the AMA's physician survey data. There is a finite number of medications that are proven to treat opioid addiction and other substance use disorders, yet insurers continue to apply PA to these treatments. When it comes to behavioral health care, delaying care for a person in a mental health crisis can have deadly consequences. That is why the VA in response to their suicide epidemic is allowing veterans to receive mental health care at any facility where they seek care. The VA is taking access to mental health care seriously, the private sector needs to follow suit.

Several recent Federal studies have also identified a lack of parity between health plans' PA programs for behavioral health services and traditional medical care. For example, a March 2022 Government Accountability Office study found that private health plans and Medicaid were less likely to grant PA for mental health hospital stays compared with medical and surgical hospital stays, with this delaying access to initial mental health treatments.[9] Concerningly, the 2022 Mental Health Parity and Addiction Equity Act Report to Congress found that many health plans were unprepared to respond to requests for comparative analyses of non-quantitative treatment limitations for behavior health services vs. medical/surgical care (as legislatively required), and none of the analyses initially reviewed contained sufficient information.[10] These data indicate that PA-related barriers to care may be particularly significant for patients seeking mental health care.

Question. What are the largest sources administrative and payment-recovery costs for mental health providers, and how do these affect their ability to serve patients and communities?

Answer. My colleague from the American Psychiatric Association will be able to provide information more specific to the impact and costs of administrative burdens such as PA on mental health-care professionals. Speaking broadly across medical specialties, I can confidently say that PA is the most significant and costly administrative requirement facing physicians today. That's why fixing PA is one of the pil-

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[8] *https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.*
[9] *https://www.gao.gov/assets/gao-22-104597.pdf.*
[10] *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.*

lars of the AMA Recovery Plan for America's Physicians.[11] The AMA's 2022 physician survey found that practices complete an average of 45 PAs per physician, per week, and that this PA workload for a *single physician* consumes nearly 2 business days of physician and staff time.[12] Over one-third (35 percent) of physicians report having staff who work exclusively on PA. This represents an enormous amount of administrative waste in our health-care system—resources and time that could be much better spent on taking care of patients and improving health outcomes.

Administrative tasks such as PA can be particularly burdensome for physicians in smaller practices. Data from the AMA's 2022 Physician Practice Benchmark Survey show that many more psychiatrists work in smaller practices compared with other medical specialties: 45 percent of psychiatrists work in practices that include between one and four physicians, compared with 33 percent for all specialties combined.[13]

Question. What payment reforms have reduced these administrative costs, and which models hold the greatest promise to reduce the administrative burden on mental health providers?

Answer. Any meaningful PA reform must involve a reduction in the overall volume of requirements. Physicians consistently report that the number of both medical services and prescription drugs that require PA has increased in recent years,[14] despite the fact that health plans agreed to reduce PA volume over 5 years ago in the Consensus Statement on Improving the Prior Authorization Process.[15] The AMA urges health plans to eliminate requirements on treatments that are routinely approved, as these low-value requirements merely add cost to the health-care system and delay patient care. In addition, our Prior Authorization and Utilization Management Reform Principles—which are supported by over 100 organizations representing health-care professionals and patients—state that health plans should offer at least one physician-driven, clinically based alternative to PA, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems, or clinical pathways.[16]

One of the great promises of alternative payment modes (APMs) that accept two-sided financial risk is the ability to be subjected to fewer, if any, utilization management policies, such as PA. Indeed, our PA Principles state that a physician who contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from PA and step-therapy requirements for services covered under the plan's benefits.[17] With most two-sided risk models, physicians are permitted to receive a portion of associated savings when the cost of the care delivered does not exceed certain spending benchmarks and quality assurance standards are met. The quality assurance standards are crucial to ensuring that value-based care does not inadvertently lead to rationing of care. Conversely, physicians are responsible for the cost of care when the services delivered within a model eclipse spending benchmarks or quality assurance standards are not met. Not only can two-sided APMs incentivize better care by linking payments to quality, care coordination, and more health-care outcomes, but the models can also help alleviate administrative burdens on physicians, including those treating mental health conditions. By incentivizing physicians to have a greater financial stake in the ultimate patient outcomes, PA requirements, which are a huge source of administrative burden, can be lessened or even completely eliminated within an APM. However, I must stress that APMs alone will not solve the PA problem, as fee-for-service (FFS) remains the most prevalent payment method. In 2020, 88.1 percent of physicians reported at least some payment from FFS; moreover, an average of 70 percent of practice revenue came from FFS and 30 percent from APMs.[18] In addition, CMS has not designed APMs in ways that alleviate the burdens physicians face from PA. Common-sense PA reforms must be enacted in regular FFS payment systems as well as in APMs to prevent delays in patient care, alleviate the crushing administrative burdens, and reduce costs to the system.

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[11] *https://www.ama-assn.org/amaone/ama-recovery-plan-america-s-physicians.*
[12] *https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.*
[13] *https://www.ama-assn.org/about/research/physician-practice-benchmark-survey.*
[14] *https://www.ama-assn.org/system/files/prior-authorization-reform-progress-update.pdf.*
[15] *https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.*
[16] *https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.*
[17] *https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf.*
[18] *https://www.ama-assn.org/system/files/2020-prp-payment-and-delivery.pdf.*

To help physicians accelerate the implementation of coordinated care within the mental health arena, in 2021 the AMA released the Behavioral Health Integration Compendium. Created by several of the Nation's leading physician organizations, the Compendium is a tool for physicians and their practices to learn about and implement behavioral health integration (BHI) in order to achieve the goal of optimal, whole-person care. There are many ways to approach BHI and practices have a number of models to choose from. Yet, the integrated care spectrum typically covers six defined levels: minimal collaboration; basic collaboration at a distance; basic collaboration on-site; close collaboration on-site; close collaboration; and full collaboration. Minimal collaboration, which features care delivered in separate facilities with separate systems and infrequent communication typically initiated under compelling circumstances and driven by the physician, marks the least integrated level of the overarching spectrum. Full collaboration, or physicians and other clinicians being in the same facility, sharing all practice space, and functioning as one team, marks the most integrated option. The Primary Care Behavioral Health (PCBH) and Collaborative Care Model (CoCM) are two examples of these innovative care structures that fall within the larger integrated care spectrum.

Despite their strong potential, APMs are still not widely available for all physicians, especially specialists. In addition, payment reforms need to support redesigning care delivery to improve access to mental and behavioral health services and collaboration and teamwork between primary care physicians, psychiatrists, and other mental and behavioral health professionals. As outlined in my written testimony and responses to other questions for the record, the CoCM is an evidence-based approach to improving patient care for mental health conditions but payment reforms, especially ones geared towards primary care physicians, are needed to support it. This reality is one reason behind AMA's longstanding concern about multiple Centers for Medicare and Medicaid Innovation (CMMI) primary care medical home models being terminated. Unfortunately, Medicare still lacks a nationwide, voluntary primary care medical home model more than a decade after the creation of CMMI. This is also one reason why AMA supports strengthening the ability of Accountable Care Organizations (ACOs) and other APMs to engage specialists through approaches such as the Payments for Accountable Specialty Care framework, which would significantly improve collaboration between primary care physicians participating in ACOs and specialists to whom they refer patients with certain conditions who require enhanced specialty care. The AMA also recently provided information to the PTAC on this topic.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Are government regulations or policies preventing the private sector from solving the problem of inaccurate provider directories?

Answer. I would not go so far as to say government policies are preventing resolution of this issue, but some policies may cause health plans to focus on the completion of regulatory/statutory requirements rather than the goal of directory accuracy. For example, regulation may require twice yearly outreach to practices. Completing such outreach could be accomplished without any improvements in the accuracy of directory information. There are also policy gaps. For example, when outreach does occur, each health plans' directory requires that physicians provide different types of data in different formats. Our experience also shows that this lack of uniformity is a major driver in physician burden.

Additionally, CMS is currently considering the development of a National Directory of Healthcare Providers and Services (NDH). While we support the goals of advancing public health, improving data exchange, streamlining administrative processes, and promoting interoperability, CMS's authority only extends to its regulated programs, and not to other payers and providers. As such, it could be difficult for an NDH to have meaningful impact. In comments on the recent RFI exploring such an initiative, the AMA stated that CMS should avoid creating another place for physicians and practices to submit and update data by working with physicians, and those experienced in managing physician data, to identify and solve for directory inaccuracy root causes, starting with standardization.

Question. In your written testimony, you mentioned how separate systems of credentialing and contracting can result in siloed information. What responsibility do providers have in communicating their in-network status to patients? What role do providers have in communicating their appointment availability information in real-time?

Answer. To address unexpected out-of-pocket expenses for patients, health plans must provide more usable plan and product information to practices and ensure it is correct in directories. While practices and health plans agree that their contract is the "source of truth" on whether a clinician is participating, the question of whether a clinician is accepting insurance for a particular patient or accepting new patients is more dynamic. These agreements can contain many nuances: providers participating in multiple plan-products, contracts including a subset of locations and specialties and "accepting new patients" being a function of both the contract and whether the clinician's panel is full. Practices and health plans should agree, based on how a contract is structured and the practice's current situation, how information about whether a clinician is accepting insurance and is accepting new patients should be presented.

Links:

https://www.aamc.org/news/press-releases/aamc-report-reinforces-mounting-physician-shortage

https://data.hrsa.gov/topics/health-workforce/shortage-areas

https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmps.zip%2F2023-5-9-Letter-to-Menendez-Boozman-Schumer-and-Collins-re-S-1302-Resident-Physician-Shortage-Reduction-Act-v2.pdf

https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Flfcmps.zip%2F2023-5-9-Letter-to-Sewell-and-Fitzpatrick-re-HR-2389-Resident-Physician-Shortage-Reduction-Act.pdf

https://nhsc.hrsa.gov/about-us

https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-23-Letter-to-Barrasso-and-Cortez-Masto-re-Physician-Shortage-GME-Cap-Flex-Act-Senate-v3.pdf

https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-6-23-Letter-to-Ruiz-et-al-re-Physician-Shortage-GME-Cap-Flex-Act-House-v3.pdf

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https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fmlfd.zip%2F2023-5-5-Letter-to-Joyce-and-Ross-re-HR-2761-SPARC-Act-Support-v2.pdf

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https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-10-15-Letter-to-House-re-TRIUMPH-Act-v2.pdf

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https://www.ama-assn.org/system/files/improving-health-plan-provider-directories.pdf

https://www.ama-assn.org/system/files/bhi-compendium.pdf

https://www.ama-assn.org/system/files/apm-payments-accountable-specialty-care-pasc.pdf

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https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services

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PREPARED STATEMENT OF JEFF RIDEOUT, M.D., MA, FACP,
PRESIDENT AND CEO, INTEGRATED HEALTHCARE ASSOCIATION

EXECUTIVE SUMMARY

The Integrated Healthcare Association (IHA) is a California leadership group whose members include physician groups, health plans, hospital systems, regulatory agencies, and other health-care stakeholders. One of IHA's key programs is a California-wide Provider Data Management program called Symphony, with a goal to simplify and unify how providers and health plans share, reconcile, and validate provider data. With our technology partner Availity,[1] we are creating a single utility to increase accuracy and reduce administrative burden, designed to be the primary source of data and to replace non-aligned existing processes between health plans and providers.

As an output of the process, Symphony creates a "golden record" by applying a strict set of agreed upon rules that determine what the best information is when information from multiple organizations is conflicting. The more organizations, the greater likelihood to finding and correcting errors before this information goes back to plans and providers for inclusion in their directories. Ultimately, sustainable provider data improvement requires an industry solution. As the Centers for Medicare and Medicaid Services noted in a 2018 report,[2] "it has become clear that a centralized repository for provider data is a key component missing from the accurate provider directory equation." Symphony is exactly that type of centralized repository.

Some key findings from our work:

- Provider data encompasses literally hundreds of specific data elements. Some are critical for consumers, such as license verification or accepting new patients. Others may be less critical, but all need to be verified on a very frequent basis, some as frequently as weekly. In addition, providers need to attest to the accuracy of the information on a very frequent basis and are much more willing to do so if they can attest once for multiple plans.
- In order to function, Symphony has created data quality standards centered around: (1) timeliness; (2) data quality and completeness; and (3) data accuracy that conform with regulatory requirements and are standardized across multiple plans and provider organizations. Symphony also has created a standardized data validation and mastering processes to identify inconsistencies or errors and resolve them. This is what creates a "golden record" that uses the most accurate information available from all participant organizations—both plans and providers.
- Identifying inaccuracies and correcting them is necessary and feasible. In the last 30 days, review of provider data from three plans representing 169,731 unique providers, with up to 300 data attributes each (which translates to over 50 million data elements), Symphony's data mastering identified 138,124 inconsistent data elements ("updates" or "corrections") that required health plan and provider changes based on validation and survivorship rules adopted

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[1] As one of the Nation's largest health information networks, Availity facilitates billions of clinical, administrative, and financial transactions annually. Our suite of dynamic products, built on a powerful, intelligent platform, enables real-time collaboration for success in a competitive, value-based care environment. For more information visit *www.availity.com.*

[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.*

by all parties. Of these, over 5,000 were errors in the physical office address, while nearly 2,127 were related to license issues.

Of the 300 data elements that IHA tracks, all stakeholders have agreed to a standard tiering process for data elements most important to consumers—such as accepting new patients.

- Provider data accuracy should be measured with robust and agreed-upon metrics including (but not limited to) timeliness, completeness, and benchmarks against peers. Currently accuracy is measured through phone surveys of provider's offices, which have been shown to be an inaccurate and inconsistent way to measure. Audits of individual plans may actually increase the burden on providers unless the audits are coordinated across multiple plans.

  A Council for Affordable Quality Healthcare (CAQH) survey of 1,240 physician practices, conducted in September 2019, determined that updating directory information costs each practice $998.84 on average every month, the equivalent of one staff day per week.[3] For independent providers—of which mental health providers are more likely to be—this can be cost prohibitive to network participation.

- Symphony market research and customer feedback suggests that without a centralized data repository that supports a multi-plan provider directory, health plans and providers will be unable to maintain accurate provider data and directories individually, even with the best of intentions. This is particularly true in states with delegated entities such as Independent Physician Associations (IPAs) and Provider Organizations that are also responsible for provider data accuracy creating additional contractual and relationship complexities. It is even more important for mental and behavioral health providers who are increasingly less likely to be in health plan networks,[4] making it even more critical for them to be able to update their data in a convenient, single, centralized repository.

I. Background

Provider directory inaccuracy has been a challenge for decades. These challenges were magnified with the implementation of the Affordable Care Act (ACA). There was an influx of consumers entering the marketplace looking to confirm that their provider of choice was part of their new health plan. This coupled with a rise in "narrow network" plans and consumers moving between health plans more frequently made provider directory accuracy critically important for consumers.

Many of the plan provider directories they were searching had inaccurate data, causing confusion and frustration for patients, providers, and plans. Health plans expressed frustration that they were unable to keep their directories up to date without providers updating their information. Providers were frustrated that they had to update their information with each health plan and for each contract they participate under. It was difficult for everyone, and made it more urgent for plans, providers, and regulators to come up with a solution.

In November 2015, California's Department of Managed Health Care fined its two largest network plans, Anthem Blue Cross and Blue Shield of California, for their inaccurate directories.[5] Additionally, Blue Shield of California committed $50 million to addressing provider data inaccuracy as part of its acquisition of Care1st.[6]

II. The Need for a Multi-Plan Directory

In early 2016, the industry began to coalesce around the same basic idea—the need to create one location for plans and providers to go and update information.[7]

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[3] CAQH Survey: Maintaining Provider Directories Costs U.S. Physician Practices $2.76 Billion Annually, November 13, 2019, *https://www.caqh.org/about/press-release/caqh-survey-maintaining-provider-directories-costs-us-physician-practices-276.*

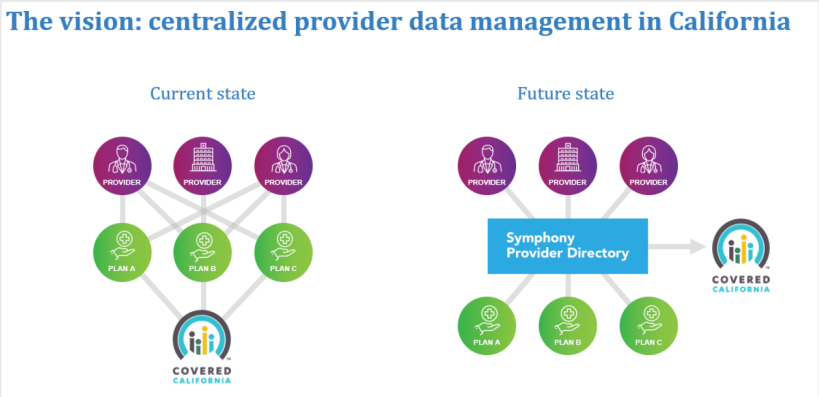
[4] Susan Busch and Kelly Kyanko, "Incorrect Provider Directories Associated with Out-Of-Network Mental Health Care and Outpatient Surprise Bills," *Health Affairs,* June 2020 *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.*

[5] Joanne Finnegan, Blue Shield of California, "Anthem Blue Cross Fined for Inaccurate Provider Directories," November 4, 2015, *https://www.fiercehealthcare.com/payer/blue-shield-california-anthem-blue-cross-fined-for-inaccurate-provider-directories.*

[6] DMHC Approves Blue Shield's Acquisition of Care1st Health Plan, *https://californiahealthline.org/morning-breakout/dmhc-approves-blue-shields-acquisition-of-care1st-health-plan/.*

[7] CAQH Survey: Maintaining Provider Directories Costs U.S. Physician Practices $2.76 Billion Annually, November 13, 2019, *https://www.caqh.org/about/press-release/caqh-survey-main-*

The problem was providers, plans and even Covered California were all working with different vendors to pilot different solutions.



Around this time, California legislators passed Senate Bill 137. This bill was instrumental in bringing the industry together. It stipulated a shared responsibility between providers and plans to make sure directories were accurate.

In August 2016, California held the California Provider Directory Summit to inform and align key stakeholders. The result was the formation of three working groups made up of representatives from plans, hospitals, provider groups, health information exchanges, consumer groups and regulators to drive towards creating a single, statewide provider directory utility/repository:

- Data definitions and standards group—this group defined each data element, who was responsible for submitting it and what, if any, the authoritative data source would be. What we learned was that even something as straightforward as "name" could vary based on who was asking and when, which demonstrated the need for standardized and agreed upon definitions.
- Business and technical requirements group—this group defined what functions the provider directory utility/repository had to do based on the use cases developed during the summit.
- Governance group—this group decided who would own the database and created criteria that any governance body would have to meet—a nonprofit with a history of successfully working with diverse stakeholders that was financially sound and agile enough to act quickly.

There was some urgency to find a solution because of SB 137 requirements, but also, the more time people spent on the pilots already in flight, the less likely they would be to pivot to this new solution.

The Governance group chose Integrated Healthcare Association as the governance body for the statewide provider directory in September 2017. The statewide directory was piloted in January 2018 and the utility was fully launched in January 2019 with the name Symphony Provider Directory.

III. IHA's Market Research

As part of its planning, IHA did market research and targeted interviews with 27 plans, providers, and purchasers to assess current directory management processes and desired features for a statewide utility. IHA confirmed the current challenges:

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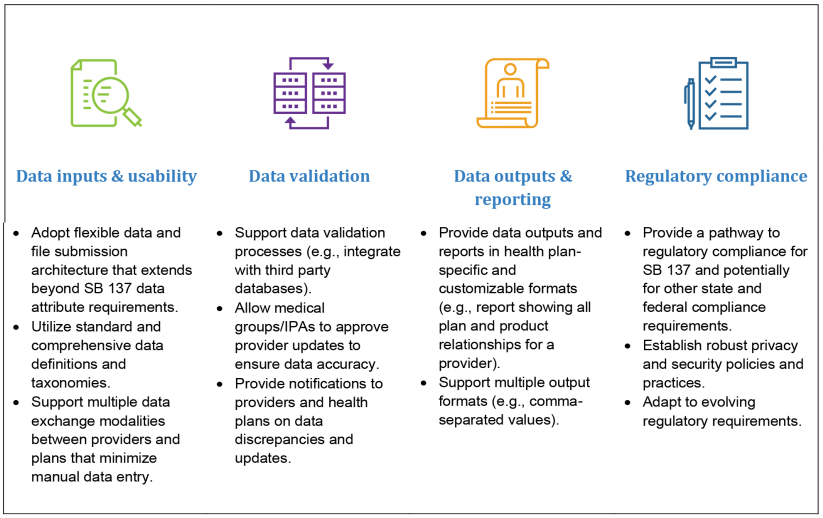
taining-provider-directories-costs-us-physician-practices-276. (Practices that use one channel for all plans spend 39.6 percent less per month than those who use multiple approaches. Assuming similar efficiencies, using a single channel to update directory information could save the average physician practice $4,746 annually. Nationwide, streamlining directory maintenance through a single platform could save physician practices at least $1.1 billion annually.

- **Directory update processes are manual and labor-intensive,** with reporting requirements, data definitions and templates varying across health plans.
- **Data quality is inconsistent,** specifically regarding data accuracy, completeness, and timeliness.
- **Data validation requires significant time and resources,** and often must be done manually across each individual health plan's network.
- Most plans are unable to accurately estimate resources devoted to directory management activities, as many of the resources support other plan activities (*e.g.,* labor, IT infrastructure).
- **Providers vary in the level of resources dedicated to directory management activities,** ranging from 0.5 to 7 full-time equivalents (FTEs) to support directory updates, manual data validation and IT infrastructure. In fact, a CAQH survey of 1,240 physician practices, conducted in September 2019, determined that directory maintenance costs practices nationwide $2.76 billion annually. Updating directory information costs each practice $998.84 on average every month, the equivalent of one staff day per week.[8]

IHA's market research also showed what features and functionality the provider utility had to have to meet its customer's needs.

It called for the industry to come together and collaborate to ensure a fully functioning utility that provides value and drives the outcomes needed.

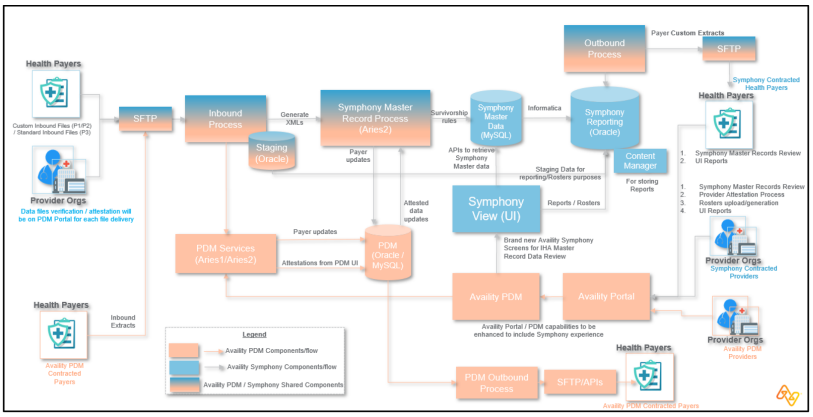


IV. Symphony's Progress To Date

The Symphony Provider Directory, enabled by IHA's technology partner Availity, is an advanced cloud-based platform, uniting California health plans and providers around a centralized solution to improve the efficiency, quality, and ease of provider directory data.

The Symphony solution is complex and outlines the various inputs, processes, validations, and outputs needed to facilitate an end-to-end solution.

[8] CAQH Survey: Maintaining Provider Directories Costs U.S. Physician Practices $2.76 Billion Annually, November 13, 2019, *https://www.caqh.org/about/press-release/caqh-survey-maintaining-provider-directories-costs-us-physician-practices-276.*



Symphony commitments:

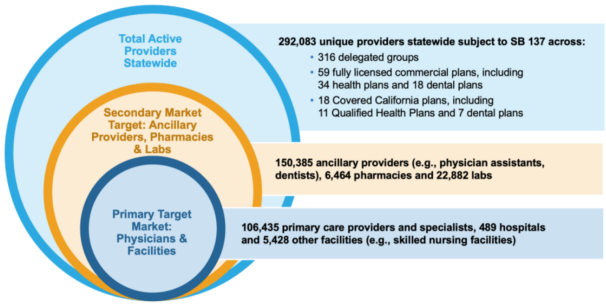
- Support **compliance** by ensuring highest-level data accuracy for complex regulatory mandates, while streamlining cumbersome data exchange between providers and health plans. It ensures frequent, routine updates and automated attestation outreach on behalf of contracted health plans.
- Ensure provider **data is high-quality** by validating data from numerous primary and secondary resources, while simplifying provider data updates via routine, automated outreach. This enables health plans to quickly act on provider data inaccuracies.
- Leverage **industry experts,** including California's Department of Managed Healthcare, to maximize industry alignment. The Symphony Data Governance Committee is broadly represented across client organizations who advise on provider directory data standards, develop recommendations, and consult on interpretation and application of compliance requirements.

To date Symphony includes:

- 17 contracted health plans.
- 100+ contracted provider organizations.
- 550,000+ total provider records in production.
- 300+ supported data elements.

California Provider Landscape

IHA conducted an analysis of active providers and health plan provider networks to determine the total number of potential provider Utility users.*



*Data sources include state medical boards, state agencies, Cattaneo & Stroud, Centers for Medicare & Medicaid Services, Kaiser Family Foundation and the Bureau of Labor Statistics.

V. Symphony's Approach to Accuracy

Symphony supports complex contractual relationships in California, it does so at the granularity needed to comply with regulatory requirements. Each data attribute in Symphony has a specific data policy that helps determine how data is validated and which value survives as the recommended "golden master record." In addition to primary reference sources, Symphony leverages provider attestation, as well as the democratic opinion of other participants, offering a more complete view of data quality.

Symphony's data accuracy is structured around three pillars: (1) timeliness; (2) validity and completeness; and (3) accuracy. A recent review of provider data from the three largest network plans in California surfaced over 138,124 data events requiring data validation, mastering and corrections. Participants show confidence that Symphony reduces suppressed providers by nearly 25 percentage points.

QUESTIONS SUBMITTED FOR THE RECORD TO JEFF RIDEOUT, M.D., MA, FACP

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

TECHNOLOGICAL SOLUTIONS

Question. There is currently no national database of health-care providers, resulting in an unreliable patchwork system. Instead of being able to go to a one-stop-shop website and find a health-care provider, patients have to waste hours and hours calling around. The directories that insurers provide are often out-of-date, inaccurate, or list providers who are not taking new patients.

A centralized directory of providers could reduce inconvenience for patients, but we lack the nationwide technology and funding to establish one. In addition, provider data contains multitudes of specific data points, and each insurance company may have different requirements on data collection, data format, or other specifications. This complexity calls for creative solutions and cooperation between the government and the private sector.

Your organization created a centralized platform at the request of the California Government called the Symphony Provider Directory to help consumers in California find providers. The platform houses provider directory data for 18 health plans and purchasers and over 100 provider organizations. It's a public-private partnership, which has streamlined the complex collection of information and successfully reduced barriers to care for patients.

What metrics are you using to evaluate the effectiveness of the program you created? How does that differ from the traditional way that provider networks evaluate adequacy and accuracy?

Answer. IHA has followed a traditional "structure, process, outcomes" model in assessing effectiveness. Given our program is in its early stages and is just now becoming operational, our focus to date has been on:

- *Structural effectiveness*—Do we have a significant majority of health plans, providers and health systems under contract so that a consumer is looking at accurate information for the full range of licensed providers? Here we have all the major health plans and over 100 provider groups, which constitute nearly 1 million unique providers under contract. However, we have focused initially on physician, NP, PA and facility providers; our next wave will be ancillary, including dental, and behavioral health providers.
- *Process effectiveness*—Beyond measuring the basic "live on the system" effectiveness, we have focused on the core data elements being tracked and have prioritized those most meaningful to consumers, including license in good standing, correct address and phone number, and accepting new patients, as I outline in the testimony.
- *Outcome effectiveness*—This is down the road for Symphony, but ideally, we would test the accuracy of the data against the consumer's actual experience through surveys or other consumer direct information. Ultimately even if we correct thousands of errors, it only matters if that has a positive impact on consumers.

Question. Could the Symphony Provider Directory be scaled nationwide? What type of resources and coordination would be needed to effectively create a nationwide database?

Answer. Either the Symphony directory or a similar platform could be scaled nationwide. The major challenge is regional market and regulatory considerations that impact the data collected and the frequency of updating required. As California is probably the largest and most complex provider market given the degree of capitation and the presence of large provider organizations, Symphony has likely considered most of the issues a nationwide utility would encounter, especially as California State regulations in this area are sophisticated and well established. However, there would ultimately be important new issues to consider that are specific to individual regions. Probably an undesirable outcome would be for a nationwide provider directory to not consider the more complex needs of larger markets or to focus only on third-party information verification (such as licensing).

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What is the impact of prior authorization requirements on access to mental health care?

Answer. Symphony only addresses provider accuracy using a utility model that "masters" data from multiple sources, so my current experience does not extend to prior authorization requirements. However, in my past experience, I can offer that prior authorization is not generally effective as a care coordination/navigation process unless the intake is done by a clinical professional that is familiar with the consumer's condition and the plan's network.

Question. What are the largest sources administrative and payment-recovery costs for mental health providers, and how do these affect their ability to serve patients and communities?

Answer. My experience does not include any knowledge of this topic.

Question. What payment reforms have reduced these administrative costs, and which models hold the greatest promise to reduce the administrative burden on mental health providers?

Answer. Specific to a provider directory utility, mental health providers would theoretically reduce their own administrative burden significantly by only needing to complete a single, uniform process. According to a Council for Affordable Quality Healthcare (CAQH) survey of 1,240 physician practices, conducted in September 2019, updating directory information costs each practice $998.84 on average every month, the equivalent of one staff day per week.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Are government regulations or policies preventing the private sector from solving the problem of inaccurate provider directories?

Answer. It may be the lack of regulations and the lack of specificity in what is expected from providers that prevent the private sector from solving the problem. A huge first step in any standardization process is for the multiple organizations to choose to get together voluntarily and agreeing on a single standard approach (data, format, submission timing, process, mastering), when there is no requirement to do so. In a market-oriented health-care environment, this may feel unnatural or a "nice to do." Doing some will invariably require individual organizations to migrate to processes they do not fully own, additional costs, IT and operational changes, etc.

Question. In your written testimony, you shared how California has worked to address the problem of inaccurate provider directories. How has California worked to ensure provider directories are user-friendly? Does California's efforts account for rural patient needs?

Answer. The Symphony Provider Directory created was a direct response by plans, providers and purchasers in California to new State requirements for provider data accuracy under SB 137. These requirements were actually more stringent than both Medicare and Medicaid expectations and Symphony was designed to cover all programs regulated by the State of California or CMS. For better or worse, SB

137 specified that provider directory production would be the purvey of plans, so Symphony is precluded from producing an independent, consumer facing directory. Fortunately, the State insurance exchange, Covered California, has created a cross plan provider directory that will be supported by Symphony information. Currently any consumer can use the website provider look up function, but the plan networks are limited to those plans offered through the exchange.

PREPARED STATEMENT OF ROBERT L. TRESTMAN, PH.D., M.D., CHAIR AND PROFESSOR, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL MEDICINE, CARILION CLINIC, VIRGINIA TECH CARILION SCHOOL OF MEDICINE, ON BEHALF OF THE AMERICAN PSYCHIATRIC ASSOCIATION

Chairman Wyden and Ranking Member Crapo, on behalf of the American Psychiatric Association (APA), the national medical specialty association representing more than 38,000 psychiatric physicians, I want to thank you for conducting the hearing today entitled "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks." The APA appreciates your bipartisan efforts to examine and address the mental health crisis in our country.

My name is Robert Trestman, Ph.D., M.D., and I am professor and chair of psychiatry and behavioral medicine at the Carilion Clinic and the Virginia Tech Carilion School of Medicine. I also chair the APA Council on Healthcare Systems and Financing, serve as the liaison between the American Hospital Association and the APA, and am chair of the American Association of Chairs of Departments of Psychiatry's Clinical Enterprise Committee. In addition, I personally provide clinical care for general psychiatry patients and those living with Huntington's Disease at Carilion Clinic in Roanoke, VA. My department has 35 psychiatrists, 36 resident and fellow-level psychiatrist trainees, a dozen nurse practitioners, and a range of psychologists, therapists, and nursing staff. We are located in rural Virginia. We deliver more than 90,000 care visits per year for individuals living with a broad range of complex mental health and substance use disorder (MH/SUD) challenges. Our system provides care across all ages and delivers ambulatory, emergency, and acute inpatient treatment.

Ghost networks are false promises by insurers to provide access to care that shift the expense to the patient. They affect private sector health plans purchased by individuals and employers and public sector plans like Medicaid and Medicare Advantage. More than that, they can have negative health consequences for patients who forego or delay treatment because they cannot find a clinician able to provide the mental health care they need.

DATA ON GHOST NETWORKS

Psychiatric Services will soon publish a study where investigators called 322 psychiatrists listed in a major insurer's database in three cities to seek an appointment for a child using three payer types. Those calling psychiatrist offices as part of the study were able to schedule 34 appointments—10.6 percent of calls made—and it was significantly more difficult to obtain an appointment when utilizing Medicaid. In addition, 18.6 percent of the phone numbers were wrong and 25.5 percent of psychiatrists were not accepting new patients. These results are particularly concerning given the current mental health crisis among youth.

A 2017–18 CMS review of Medicare Advantage provider directories found that 48.7 percent of the provider directory locations listed had at least one inaccuracy, such as the provider not being at the listed location, at an incorrect phone number, or no longer accepting new patients.[1] A January 2023 study of directory information for more than 40 percent of U.S. physicians found inconsistencies in 81 percent of entries when comparing the listed networks of five large national health insurers.[2]

In a 2020 study, 53 percent of participants who had used a mental health directory reported encountering at least one inaccuracy, the most common being that the provider was incorrectly listed as taking new patients (36 percent).[3] Twenty-six per-

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[1] *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.*

[2] Butala N.M., BTech K.J., Bucholz E.M. "Consistency of Physician Data Across Health Insurer Directories." *Journal of the American Medical Association.* 2023. 329 (10): 841–41.

[3] Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills, *https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2019.01501.*

cent of participants found that a provider listed in the directory did not accept their insurance. Twenty-four percent encountered incorrect contact information, and 20 percent reported being told that a provider listed as taking new patients was not taking patients with their problem or condition.

A 2022 study of phantom networks among mental health services using claims data from Medicaid, the largest payer serving marginalized populations with serious mental illness, found 51.8 percent of providers listed in Medicaid directories had no evidence in claims data of having seen patients over the study period.[4] Phantom providers represented up to 90.3 percent of some provider lists, constituted 67.4 percent of the mental health prescribers, 59 percent of the non-prescribing mental health clinicians, and 54 percent of the primary care providers listed in the provider directories.

These findings are consistent with data APA gathered in our own "secret shopper" surveys of many States' insurance markets back in 2016. Our study of the DC market found that almost 25 percent of the phone numbers for the listed psychiatrists were nonresponsive or were nonworking numbers. Only 15 percent of psychiatrists listed in the directory were able to schedule an appointment for callers; under one plan, only four percent were able to schedule an outpatient appointment. Unfortunately, not much seems to have changed since 2016.

PATIENT AND CLINICIAN IMPACT

What these studies do not show is the impact of ghost networks on patients and clinicians. For those who are healthy and well educated, going through an inaccurate provider list and being told repeatedly that "we are not taking new patients," "this provider has retired," "we no longer accept your insurance," or leaving a message with no one returning the call is at best frustrating. For people who are experiencing significant mental illness or substance use disorders, the process of going through an inaccurate provider directory to find an appointment with someone who can help them is at best demoralizing and at worst set up to precipitate clinical deterioration and a preventable crisis. Many are already experiencing profound feelings of worthlessness, fear, grief from loss and trauma, and/or the impact of substance use; some are in crisis and suicidal. Patients have told me that they felt rejected repeatedly or that somehow they themselves were at fault. Even when they make the effort to reach out to find help, something that can be very difficult anyway, their efforts to cull through an inaccurate provider list results in more rejection and failure, exacerbating these feelings. Some give up looking for care. Others delay care.

I was a ghost physician in Connecticut after I moved to Virginia Tech 6 years ago. My former colleagues at the University of Connecticut Health Center told me that patients were calling for 2 years after my departure to request appointments with me because I was still listed in multiple commercial insurance plans. More recently, many patients, especially those with commercial insurance, have told me about their frustration that they could not find anyone who would answer the phone, call them back, or offer available appointment times. If the office had openings, the waiting time was 8 to 10 months, as opposed to days or weeks.

These patients typically run through the entire provider list and find nobody to care for them. Others give up and go to the emergency room (ER) for crisis stabilization. However, few psychiatric beds are available because insurance payment for those beds is below the cost of care, so patients are boarded in the hallways of the ER. Upon release, they are told to work with their insurance company to find outpatient care, which is inaccessible, and the cycle continuously repeats itself. This cycle is devastating for a person with a mental illness. Many plans do not cover ER visits for mental health as a substitute for outpatient care and the patients are left to pay the bill themselves, or complete payment of their annual deductible before their insurance applies. Even when the visit is covered, insurance copayments are higher for the ER than for an office visit.

Access to care in rural settings, like mine, is particularly challenging. These areas are generally physician shortage areas to begin with, and patients can be required to drive 2 hours or more to find psychiatric care, whether from a psychiatrist, nurse practitioner, or commonly from a primary care physician. Prior to March 2020, my team was delivering about 5 percent of our ambulatory psychiatric care via video

[4] Zhu J., Charlesworth C.J., Polsky D., McConnell K.J. "Phantom networks: Discrepancies between reported and realized mental health access in Medicaid." *Health Aff* (Millwood). 2022;41(7):1013–22, *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052.*

telehealth. By the end of March 2020, we were delivering 95 percent of our ambulatory care by telehealth: video and audio-only. Even after resolving the technical issues of video connectivity with our patients, many lived in areas without broadband access. Many others could not afford the data plans to allow for video interviews. We therefore delivered about 50 percent of our care by audio-only. Was it perfect, no. Was it better than not providing the care, absolutely. But it takes just as much provider time to deliver care, whether in person, by video, or by audio-only. And for the many people who do not have paid sick days, having access to telehealth visits, video or audio-only, means they don't have to lose a day of pay for a 30-minute visit to us. For those who rely on public transportation in rural areas, that means they don't have to take multiple buses over several hours to get to us—assuming they have the capability to do so without assistance.

Finding anyone accepting new patients can be nearly impossible. Carilion is the only tertiary referral center for 150 miles, and we function as the public health point of access for many people. My clinic is in almost all networks and our adult waiting list has more than 800 people in line.

Challenges are especially acute for children. School teachers tell us kids are in significant need due to the pandemic and overall current trends. Most are on Medicaid and teachers just refer them to the ER. The ER is typically the first point of contact when referred by teachers because kids cannot get help any other way.

FINANCIAL AND ADMINISTRATIVE BURDEN

Insurers intentionally make it difficult for psychiatrists and other mental health professionals to participate in their networks, which frequently enables them to avoid paying for mental health care. For example, at Carilion, keeping our credentialing updated with insurance plans is time-consuming and expensive. We have three full-time employees (FTE) doing nothing but maintaining our credentialing with insurance companies and public payers, including Medicaid and Medicare Advantage. My team of 35 psychiatrists and a dozen psychologists and nurse practitioners requires close to one-half FTE just to work with payers to be sure someone is in-network. The administrative burden of sending directory updates to insurers via disparate technologies, schedules, and formats costs physician practices a collective $2.76 billion annually.[5]

Not all mental health clinicians practice in settings like mine that are willing and able to invest the resources needed to participate in the networks. Private practitioners make up a significant portion of the psychiatric workforce and many do not participate in the networks because of the burdensome requirements imposed by the plans. The burden should be on the plans, whose profits appear sufficiently healthy, to maintain accurate directories, not on the clinicians who are in short supply and should be spending their time treating patients.

BURDEN ON EMPLOYERS

When employers purchase health coverage for their employees, they rely on representations about the breadth and depth of the mental health panel reflected in the network directory. Employers have a significant interest in ensuring that their mental health network is robust and available because connecting employees to treatment increases productivity, lowers absenteeism and presenteeism, and decreases overall health-care costs—boosting employer bottom lines and improving quality of life for all employees.

Despite their care in selecting insurers who purport to have robust psychiatric networks, employers generally see that more mental health care is provided on an out-of-network basis than on an in-network basis: demonstrating that employees cannot find mental health care in their plan. One study by Milliman found that 17.2 percent of behavioral health visits in 2017 were to an out-of-network provider compared with 3.2 percent for primary care providers and 4.3 percent for medical/surgical providers. The out-of-network rate for behavioral health residential facilities was more than 50 percent in 2017.[6] Forcing employees to seek out-of-network care shifts the expense from the insurer to the patient. Mental health care then be-

[5] Council for Affordable Quality Healthcare. *The Hidden Causes of Inaccurate Provider Directories.* Published 2019, *https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf.*

[6] Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement, *https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p.*

comes available only to those who can most afford it; many others go without treatment. Employers pay insurers to have mental health care available to their staff, and by not delivering the promised network, insurers often avoid the cost of mental health care altogether.

SOLUTIONS

Ghost networks are both a cause and a symptom of a system that has inadequately addressed mental health care for decades. Consequently, APA recommends that the committee confront the root causes of ghost networks in addition to holding insurance plans accountable to their network representations:

- **Hold plans accountable for the accuracy of their directories.** Plans should be required to maintain and regularly update their directories. They should have to demonstrate that the clinicians listed in their directories are actually seeing patients covered by the plan and are accepting new patients; there should be real enforcement for misrepresentations. To date, enforcement has largely fallen on States, efforts that have been weak at best.[7] The Behavioral Health Network and Directory Improvement Act (S. 5093), introduced last Congress by Senator Smith and Chairman Wyden, would require audits of plans' provider directories to determine if they are accurate and if the listed providers are serving patients in-network. Importantly, it allows the Department of Labor to levy civil monetary penalties on plans and third-party administrators whose directories are inaccurate or are filled with providers not seeing in-network patients.
- **Require Medicare Advantage plans to maintain accurate directories.** The Better Mental Health Care for Americans Act (S. 923), introduced this Congress by Senator Bennet and Chairman Wyden, would require Medicare Advantage plans to maintain accurate provider directories. Additionally, it would require Medicare Advantage plans and Medicaid managed care organizations to provide information on the performance of their behavioral health networks, including average wait times to see providers and the percentage of behavioral health providers accepting new patients.
- **Remove disincentives to clinicians joining networks.** In a survey of psychiatry fellows and early career psychiatrists APA conducted last summer, the majority reported they wanted to join a network but were concerned about the high level of administrative tasks and low reimbursement rates. APA members recognize their administrative responsibilities in participating in plan networks, however, the requirements have grown exponentially This results in psychiatrists, particularly those in solo or small practices, spending an inordinate amount of time on non-clinical work, often to an extent that far exceeds what their medical/surgical counterparts encounter—a practice that violates the Mental Health Parity and Addiction Equity Act (MHPAEA). APA members also indicate that the credentialing process to join a network panel takes many months, often a lengthier delay than what other physicians experience, which again violates MHPAEA. These practices, seemingly by design, discourage physicians from providing necessary treatments, reduce the time psychiatrists are available to treat patients, and violate a landmark anti-discrimination law.
- **Improve access by providing reasonable reimbursement rates.** Plans' reimbursement rates for psychiatric care have not been raised in decades. Meanwhile, unreimbursed time spent on administrative tasks has risen dramatically. When psychiatrists attempt to negotiate contract provisions, including their rates, plans respond "take it or leave it" even when there is a known and obvious shortage of mental health providers in the network. This is not how insurers behave when they face shortages of other physicians. They raise rates and loosen credentialing standards to ensure that they don't have a dire shortage of important specialists. This too is a violation of MHPAEA. Insurers must design and maintain their MH/SUD networks in a manner that is comparable to their medical/surgical network. This includes how they set reimbursement rates and how they adjust rates in response to market forces. Demand for care is skyrocketing. In-network provider availability is scarce, yet public and private plans do not provide adequate reim-

[7] "Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories," *Yale Law & Policy Review, https://ylpr.yale.edu/sites/default/files/YLPR/2_burman_pe.12.2_78-148.pdf.*

bursement rates for psychiatrists or other mental health clinicians. The basic economics of supply and demand suggest the predictable result that is desired by the plans—lack of access to care and violation of the law.

- **Extend MHPAEA to Medicare.** While regulators already can enforce the MHPAEA violations described above for private insurance plans and Medicaid managed care, they have no recourse when it comes to Medicare because the law does not apply. The Better Mental Health Care for Americans Act (S. 923), introduced by Senator Bennet and Chairman Wyden, takes an important step by applying MHPAEA to Medicare Parts C and D. Extending MHPAEA to Medicare Advantage would help to ensure that those plans respond to shortages and deficiencies in their MH/SUD treatment networks in a way that is comparable to how they respond to shortages and deficiencies in their medical/surgical provider networks.
- **Invest in the Physician Workforce.** With more than half of U.S. counties lacking a single psychiatrist, underlying workforce shortages will continue to impede patient access to behavioral health care even if ghost networks are adequately addressed. Last year, Senators Stabenow and Daines introduced legislation to increase Medicare funded graduate medical education (GME) slots specifically for psychiatry. The Fiscal Year 2023 Consolidated Appropriations Act (FY23 Omnibus) made a downpayment on this effort by adding 200 new GME residency slots with 100 going directly to psychiatry or psychiatric subspecialties beginning in 2026. With projections showing that the country will still be short between 14,280 and 31,109 psychiatrists by 2025,[8] it is imperative that we invest in additional GME slots for psychiatry and psychiatric subspecialties with residencies spread geographically in rural and urban areas alike. Such an investment would supplement efforts to address network adequacy and better position us to address the growing crisis of access to MH/SUD care and treatment. Additional incentives tied to practicing in shortage areas, like loan deferment or forgiveness, can also help to better distribute physicians and other practitioners where they are needed most.
- **Support Evidence-Based Integrated Care Models.** Despite ongoing network adequacy challenges, the integration of primary care and behavioral health has proven effective in expanding the footprint of our existing behavioral health workforce and is essential to improving patient access. The Collaborative Care Model (CoCM) is a behavioral health integration model that enhances primary care by including behavioral care management support, regular psychiatric inter-specialty consultation, and the use of a team that includes the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner. The evidence- and population-based CoCM can help improve outcomes and alleviate existing workforce shortages by enabling a primary care provider (PCP) to leverage the expertise of a psychiatric consultant to provide treatment recommendations for a panel of 50–60 patients in as little as 1–2 hours per week. By treating more people and getting them better faster, the CoCM is a proven strategy that enhances the efficient use of existing clinicians and in turn helps address the behavioral health workforce crisis in real time. The Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act (S. 1378), recently introduced by Senators Cortez Masto and Cornyn, would expand access to the CoCM and other evidence-based models by helping providers with the cost of implementing integrated care models. One advantage of the CoCM is the psychiatric consultant need not be in-network since reimbursement goes directly to the PCP.
- **Expand Access to Tele-Behavioral Health Services.** For individuals residing in rural areas, even when they can find an in-network physician, the reality of potentially having to travel long distances for behavioral health services is often a deterrent to receiving care. Telehealth access has helped alleviate the gaps exposed by workforce maldistribution, including in urban underserved areas, by providing a linkage between clients in their home communities and behavioral health providers in other locations. The FY23 Omnibus temporarily extended multiple telehealth flexibilities implemented in response to the public health emergency (PHE) and critically delayed implementation of the 6-month in-person requirement for mental telehealth services until December 31, 2024. At a time of unprecedented demand, it is imperative

[8] Projected Workforce of Psychiatrists in the United States: A Population Analysis—PubMed, *https://pubmed.ncbi.nlm.nih.gov/29540118/*.

that we continue work to remove unnecessary barriers and ensure the continuity of care for those seeking MH/SUD services by permanently removing this arbitrary in-person requirement.

In closing, thank you for your attention to the mental health needs of our patients across the country and for extending me the opportunity to testify on behalf of the American Psychiatric Association. I look forward to answering any questions you may have.

QUESTIONS SUBMITTED FOR THE RECORD TO ROBERT L. TRESTMAN, PH.D., M.D.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

SUBSTANCE USE DISORDER

Question. Mental health and substance use disorders are closely linked. According to the Substance Abuse and Mental Health Services Administration, over one in four adults with serious mental health problems also has a substance use problem. In addition, American Medical Association research shows that 37 percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness.

My home State of Washington reported a shocking 1,623 opioid overdose deaths during the second year of the COVID–19 pandemic, which to no surprise coincided with higher-than-normal rates of anxiety and depression in all population groups. That is why an adequate and accurate provider directory is so critical.

Oftentimes, people who are seeking mental and behavioral health care are already emotionally distressed, and may not have the capacity to call multiple providers only to find that no one is available, or their insurance is not actually accepted. One single call could be all they have before they resort to self-medicating or other means.

Ghost networks create an enormous barrier to care, but more importantly, they take away the opportunity for someone to help the patient in need. As a result, the patient sinks deeper into their mental health issues and could end up in tragic situations such as overdose or death.

If a patient is already suffering from mental health issues, are they more likely to spend hours looking through an inaccurate provider directory to look for help or resort to other means such as self-medicating?

Answer. Patients already suffering from behavioral health issues are not likely to continue to search through provider directories that are inaccurate to seek treatment. For those who are healthy and well educated, going through an inaccurate provider list can be frustrating at best. However, for people who are experiencing significant mental illness or substance use disorders, the process is at best demoralizing and at worst a set up for clinical deterioration and a preventable crisis. Many are already experiencing profound feelings of worthlessness, grief from loss and trauma, and/or the impact of substance use. Patients have shared with me that they felt repeatedly rejected and that somehow, it was their fault. Many patients will simply give up looking for care and may resort to self-medicating as their illness deteriorates.

Question. In your testimony, you said that patients who cannot find help through the provider directories often end up in the emergency department with little to no access to follow-up care. Do you agree that inaccurate provider directories directly contribute to decreasing quality of care and increased cost for patients and the government?

Answer. Yes. Inaccurate directories contribute to patients seeking treatment in emergency departments and can decrease quality of care as well as increase costs to the patient, the government, and the overall health-care system. Inaccurate directories are extremely demoralizing for patients seeking treatment that can lead to a deterioration of their illness. Clinically, it is imperative for patients with mental illness and/or SUD to start treatment protocols as soon as possible or risk a deterioration of their illness. Having inaccurate directories delays care for patients who may end up in the emergency room requiring more intensive and costly services.

Moreover, inaccurate directories increase the cost and burden for clinicians and practices that can also divert time and resources from patients. At Carilion, keeping our credentialing updated with insurance plans is time-consuming and expensive.

We have multiple full-time employees doing nothing but maintaining our credentialing with insurance companies and public payers, including Medicaid and Medicare Advantage. The national administrative burden for physician practices to send directory updates to insurers via disparate technologies, schedules, and formats costs $2.76 billion annually.

Question. Is the issue of inaccurate provider directories more significant for the youth and young adult population, who may have limited resources and knowledge of accessing care?

Answer. Inaccurate provider directories delay treatment for both adult and youth populations, with serious implications. The impacts on our youth and most vulnerable populations are magnified as patients struggle to find treatment and often with limited resources. The workforce shortage in behavioral health is projected to grow and for children, the shortage is even worse. This is also the case for rural and vulnerable populations where access is limited and there is a lack of culturally competent clinicians. Therefore, it is critical that provider directories be accurate especially for our youth and vulnerable populations, to ensure timely access to behavioral health care.

In addition, we recommend that Congress consider enacting policies that increase the effective behavioral health workforce. This includes incentivizing primary care to adopt and implement the Collaborative Care Model (CoCM) and integrate behavioral health into their practices, which is why APA strongly supports S. 1378, the COMPLETE Care Act introduced by Senators Cortez Masto and Cornyn. The CoCM is an evidence-based model, developed at the University of Washington's AIMs Center, which provides early identification and treatment for mental health and substance use disorders in the primary care setting while saving our health-care system money and measuring patient improvement. The APA also strongly encourages the committee to take further action to fund additional GME slots for psychiatry and support loan repayment for behavioral health clinicians practicing in rural and underserved areas.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

MEDICARE ADVANTAGE PROVIDER DIRECTORY REQUIREMENTS

Question. Senate Finance Committee staff recently conducted a secret shopper survey of Medicare Advantage (MA) plans to understand responsiveness and appointment availability.[1] Their results were similar to other studies conducted over the last decade.[2] The staff selected the two largest non-employer MA plans in Denver and called a total of 20 providers posing as the adult child of a parent with the given MA plan, seeking treatment for the parent's depression. Of the 20 calls, five went unanswered. The calls that were answered, 50 percent of them were not successful either because the provider was out-of-network (despite being listed in the plan's directory), the provider was not accepting new patients, or the provider required a referral to set an appointment. The results of this study are troubling for Coloradans.

While the Senate Finance Committee's secret shopper study targeted major cities, the results are also concerning for access to mental and behavioral health services in rural areas. In my State, 22 of the 64 counties don't even have a psychologist or psychiatrist.[3]

Could you describe how ghost networks affect rural America?

Answer. Ghost networks exacerbate the challenges patients have accessing care in rural and underserved areas. My department is in rural Virginia and delivers over 90,000 care visits per year for individuals living with a broad range of complex mental illnesses and substance use disorders. Rural areas are generally physician shortage areas to begin with, and patients can be required to travel 2 hours or more to find psychiatric care. Finding anyone who is accepting new patients can be nearly impossible. Furthermore, ghost networks exacerbate health disparities by providing false or outdated provider information and often lack culturally competent clinicians

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[1] *https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.*

[2] *https://pubmed.ncbi.nlm.nih.gov/25354035/.*

[3] *https://coruralhealth.org/wp-content/uploads/2013/10/2022-Snapshot-of-Rural-Health-February-final-release.pdf.*

to provide care to patients. The Carilion Clinic is our region's only tertiary referral center, and we function as the public health point of access for many people. My clinic is in almost all networks and our waiting list currently includes over 800 people.

MENTAL AND BEHAVIORAL HEALTH INTEGRATION

Question. In order to access care, a patient first needs to be able to find a provider. In 2020, a third of adults aged 18 or older reported having a mental illness but not receiving care because they did not know where to go for services.[4] Primary care providers are often more accessible for patients, and studies have shown that patients with mental health illnesses are more likely to discuss them with a primary care doctor than with psychiatrists or other health professionals.[5] But our current system is not designed for collaboration to coordinate a patient's care. Mental health illnesses are often diagnosed and treated separately from physical health services. other health professionals.

Given how frequently individuals bring up mental health concerns in primary care settings, could a behavioral health integration model work to increase services in rural areas?

Are there other models that could increase access to mental and behavioral health services?

Answer. Yes. The integration of behavioral health with primary care can increase access to timely treatment of mental health and SUD in rural and underserved areas. The first time many patients demonstrate a MH/SUD need is in the primary care setting, and primary care practices may not have the clinical training or resources to treat patients with MH/SUD needs. Some patients may prefer the convenience and privacy of treatment from their primary care physician instead of a behavioral health specialist. It may be incredibly difficult, especially for patients in rural and underserved areas, to access specialty care due to lack of clinicians or the time it takes to travel.

Specifically for the integration of behavioral health, we recommend the Collaborative Care Model (CoCM) that provides early identification and treatment of mental health and SUD needs in the primary care setting. The evidence- and population-based CoCM can help improve outcomes and alleviate existing workforce shortages by enabling a primary care provider (PCP) to leverage the expertise of a psychiatric consultant to provide treatment recommendations for a panel of 50–60 patients in as little as 1–2 hours per week. CoCM reduces health inequities, is proven to substantially improve MH/SUD clinical outcomes in a primary care setting and allows a psychiatrist to positively impact care of three times as many patients, in comparison to traditional "one-on-one" sessions between a psychiatrist and a patient (Fortney et al., 2021). By treating more people and getting them better faster, the CoCM is a proven strategy that enhances the efficient use of existing clinicians and in turn helps address the behavioral health workforce crisis in real time. The CoCM also utilizes psychiatric services via telehealth and does not necessarily require the psychiatric consultant to be in network when primary care is billing for the services, which is important for those living in rural and underserved areas.

The APA thanks you for your leadership in introducing S. 923, the Better Mental Health Care for Americans Act, which proposes waiving the cost sharing for patients within integrated care models, and other strategies to increase access to mental health and SUD treatment. We recommend that the committee advance this legislation expeditiously. We also recommend that the committee incentivize primary care to adopt and implement the Collaborative Care Model (CoCM) by passing S. 1378, the COMPLETE Care Act introduced by Senator Cortez Masto and Senator Cornyn. S. 1378 would facilitate adoption of the model by temporarily increasing payment under the Medicare codes for CoCM and general integration for 3 years and facilitating technical assistance to help primary care practices adopt the CoCM.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. What is the impact of prior authorization requirements on access to mental health care?

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[4] *https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care.*

[5] *https://www.aamc.org/media/62886/download.*

Answer. As more Americans seek help for mental health challenges, widespread discriminatory practices, such as frequent and more arduous prior authorization practices, more interference in medical decision making, and improper denials of claims, have resulted in psychiatrists, particularly those in solo or small practices, spending an inordinate amount of time on uncompensated tasks, leaving far less time for treating patients. APA members routinely report burdens such as having to use a fax machine (when fax machines have not been in use in most systems for years) to secure prior approval for a patient's medication, the plan providing them with incorrect phone numbers for seeking approval and waiting on hold for up to 40 minutes when trying to get approval for patient care.

These practices are designed to discourage physicians from providing necessary treatments and reduce the time psychiatrists are available to treat patients. The result is less time to engage in appropriate treatment activities which reduces patient access and psychiatrist participation in networks. Notably, the impact of prior authorization on patients can be life-threatening. According to a recent American Medical Association survey, over 90 percent of doctors report that prior authorization delayed access to care and negatively impacted patient outcomes. Four in five doctors report that it can lead patients to abandon their recommended course of treatment entirely. For individuals living with mental health conditions, gaps in treatment due to denials can lead to relapse and devastating effects for them and their families.

Question. What are the largest sources administrative and payment-recovery costs for mental health providers, and how do these affect their ability to serve patients and communities?

Answer. As I detailed in my written testimony, insurers frequently and purposefully make it difficult for psychiatrists and other mental health professionals to participate in their networks, which enables them to avoid paying for mental health care. At Carilion, keeping our credentialing updated with insurance plans is time-consuming and expensive. We have multiple full-time employees (FTE) doing nothing but maintaining our credentialing with insurance companies and public payers, including Medicaid and Medicare Advantage. My team of 35 psychiatrists and a dozen psychologists and nurse practitioners requires close to one-half FTE just to work with payers to be sure someone is in-network. The administrative burden of sending directory updates to insurers via disparate technologies, schedules, and formats costs physician practices a collective $2.76 billion annually. Not all mental health clinicians practice in settings like mine that are willing and able to invest the resources needed to participate in the networks. Private practitioners make up a significant portion of the psychiatric workforce and many do not participate in the networks because of the burdensome requirements imposed by the plans.

Further, the frequency of health plan audits has risen, as have fears around "clawbacks," in which plans demand the return of reimbursement for previously approved and paid claims, often amounting to tens of thousands of dollars paid for care provided years earlier. These audits are disruptive to patient care and often require production of large quantities of documents. Psychiatrists want to serve and help patients. We want to join insurance networks and ensure that all people, regardless of income, will have access to quality care for MH/SUD. These administrative practices, many of which violate Mental Health Parity and Addiction Equity Act (MHPAEA), preclude them from doing so. As a result, as the demand for mental health-care increases, the supply of accessible psychiatric care for insured populations decreases.

Question. What payment reforms have reduced these administrative costs, and which models hold the greatest promise to reduce the administrative burden on mental health providers?

Answer. To date, payment reforms have done little to address the increased administrative burden faced by psychiatrists. Plans' reimbursement rates for psychiatric care have not been raised for decades. Meanwhile, unreimbursed time spent on administrative tasks has risen exponentially. When psychiatric doctors attempt to negotiate contract provisions, including their rates, plans typically respond "take it or leave it." Demand for care is skyrocketing. In-network provider availability is scarce yet plans refuse to raise reimbursement rates for psychiatrists. The basic economics of supply and demand suggest the predictable result that is desired by the plans: lack of access to care. Low reimbursement rates, burdensome credentialing, and excessive documentation requirements, all work collaboratively to discourage psychiatrists from contracting with health plans. Increasing reimbursement for psy-

chiatrists, especially those in shortage areas, could help to address these barriers and to improve networks.

The Collaborative Care Model (CoCM) is a behavioral health integration model that enhances primary care by including behavioral care management support, regular psychiatric inter-specialty consultation, and the use of a team that includes the Behavioral Health Care Manager, the Psychiatric Consultant, and the Treating (Billing) Practitioner. The evidence- and population-based CoCM can help improve outcomes and alleviate existing workforce shortages by enabling a primary care provider (PCP) to leverage the expertise of a psychiatric consultant to provide treatment recommendations for a panel of 50–60 patients in as little as 1–2 hours per week. By treating more people and getting them better faster, the CoCM is a proven strategy that enhances the efficient use of existing clinicians and in turn helps address the behavioral health workforce crisis in real time. One advantage of the CoCM is the psychiatric consultant typically need not be in-network since reimbursement goes directly to the PCP, reducing some of the existing administrative burdens associated with network adequacy and described above.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

Question. Are government regulations or policies preventing the private sector from solving the problem of inaccurate provider directories?

Answer. We are not aware of any government regulations that prevent the private sector from improving the accuracy of provider directories.

Question. In your written testimony, you stated the financial and administrative burdens as a result of inaccurate provider directories. Do you know the cost of inaccurate provider directories to the patient? What's the total out-of-pocket costs patients pay for delayed care or for costly out-of-network care?

Answer. The costs of inaccurate providers to patients manifest themselves in two ways: impacts to their health and their pocketbooks. As I described in my testimony, the process of going through an inaccurate provider directory to find an appointment with someone who can help them is at best demoralizing and at worst set up to precipitate clinical deterioration and a preventable crisis. When this process results in further deterioration of a patient's condition, the treatment required as a result can be more lengthy and costly regardless, even before considering the added costs of having to seek care out of network. Patients who have delayed or foregone needed care because they could not find clinician through the provider directory often experience acute mental health crises that are treated in an emergency room.

I am not aware of any studies that have looked at the cost of inaccurate provider directories to patients. When patients cannot find an in-network provider, they have two choices: go out of network or go without care. Patients are five times more likely to go out of network for MH/SUD care than for other types of medical care.[6] Out-of-pocket costs for out-of-network MH/SUD care are higher than for other medical services.[7] These costs increase when needed treatment is delayed and symptoms worsen.[8]

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[6] Kyanko K.A., Curry L.A., Busch S.H. "Out-of-network provider use more likely in mental health than general health care among privately insured." *Med Care.* 2013;51(8):699–705, *https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx.*

[7] Pelech D., Hayford T. "Medicare Advantage and commercial prices for mental health services." *Health Affairs* (Millwood). 2019;38(2):262–7, *https://doi.org/10.1377/hlthaff.2018.05226.*

[8] Drake R.J., Husain N., Marshall M., Lewis S.W., Tomenson B., Chaudhry I.B., Everard L., Singh S., Freemantle N., Fowler D., Jones P.B., Amos T., Sharma V., Green C.D., Fisher H., Murray R.M., Wykes T., Buchan I., Birchwood M. "Effect of delaying treatment of first-episode psychosis on symptoms and social outcomes: A longitudinal analysis and modeling study." *Lancet Psychiatry.* 2020 Jul;7(7):602–610. doi: 10.1016/S2215–0366(20)30147–4. PMID: 32563307; PMCID: PMC7606908, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7606908/*.

SUBMITTED BY HON. ELIZABETH WARREN,
A U.S. SENATOR FROM MASSACHUSETTS

May 3, 2023 Senate Committee on Finance

Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks

Executive Summary

Ghost networks occur when a health plan's provider directory is filled with inaccurate provider listings or unavailable providers. Academic research has examined ghost networks across many provider specialty types within group and nongroup health plans and Medicare Advantage (MA). However, it is not known how pervasive ghost networks are for mental health-care providers within the MA program. Senate Committee on Finance's Majority staff conducted a brief secret shopper study to examine the extent of mental health provider ghost networks in the MA program.

Staff reviewed directories from 12 different plans in a total of 6 States, calling 10 systematically selected providers from each plan, for a total of 120 calls. Of the total 120 provider listings contacted by phone, 33 percent were inaccurate, nonworking numbers, or unreturned calls. Staff could only make appointments 18 percent of the time. Appointment rates varied by plan and State, ranging from 0 percent in Oregon to 50 percent in Colorado. More than 80 percent of the listed, in-network, mental health providers staff attempted to contact were therefore "ghosts," as they were either unreachable, not accepting new patients, or not in-network.

It is particularly troubling to consider how this report's findings may acutely affect an individual struggling with a mental health condition and attempting to navigate the process of identifying an in-network provider in a directory where 80 percent of the listed providers are inaccurate or unavailable. CMS should increase its oversight efforts to audit health plan directories to ensure they hold MA plans accountable for these directories and for accurately documenting their networks. Congress can also require additional steps to ensure provider directory accuracy including regular audits, transparency, and financial penalties for non-compliance.

Introduction

In the United States, approximately one in five adults suffer from a diagnosable mental health illness. In 2021, it was estimated that less than half of the 57.8 million adults living with a mental illness received mental health services in the past year.[1] Delayed access to mental health care and inadequate treatment results in suffering, lost productivity, worsening of other health conditions, and even death. Therefore, access to timely and quality mental health care is imperative and lifesaving. Tragically, many Americans experience the complete opposite.

To ensure that consumers are aware of and able to seek care from in-network providers, health plans publish "provider directories." These documents list the health plan's in-network providers, usually by specialty, and their contact information. Health insurers typically also provide online searchable versions of this information. These directories are supposed to help consumers both understand a plan's network when shopping for a plan—that is, prior to enrolling—as well as help enrollees find in-network providers when seeking care. However, consumers experience many challenges when using these provider directories, including providers not accepting new patients, long wait times to see providers, and/or plans having inaccurate or out-of-date provider information.[2]

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[1] National Institute of Mental Health. "Mental Illness." National Institute of Mental Health Office of Science Policy, Planning, and Communications, *https://www.nimh.nih.gov/health/statistics/mental-illness.* Accessed April 24, 2023.

[2] Government Accountability Office, "Mental Health Care; Access Challenges for Covered Consumers and Relevant Federal Efforts" (2022), *https://www.gao.gov/assets/gao-22-104597.pdf.*

Previous government audits[3] and academic reports[4,5,6,7,8] have identified widespread provider directory inaccuracies, referred to as "ghost networks." Ghost networks occur when a health plan's provider directory is replete with inaccurate information or unusable provider listings, such as when the provider is either (i) not taking new patients or (ii) not in a plan's network.[9]

Academic research has examined the presence of ghost networks across many provider specialty types within group, non group, and Medicare Advantage (MA) plans. A March 2022 Government Accountability Office (GAO) report to the Senate Committee on Finance, described the prevalence of ghost networks for mental health providers in Medicaid and employer group health plans.

However, it is unclear how pervasive ghost networks are for mental health providers within the MA program. Additionally, although the Centers for Medicare and Medicaid Services (CMS) requires MA plans to keep provider directories up to date,[10] CMS does not currently audit these directories on a regular basis. This suggests that provider directory inaccuracies go unnoticed by regulators and therefore unaddressed.

Approach

Building on Chairman Wyden's existing work to crack down on ghost networks,[11] the United States Senate Committee on Finance's Majority staff conducted a brief secret shopper study to examine the extent of mental health provider ghost networks in the MA program. Staff contacted in-network providers with the goal of securing an appointment for an older adult family member with depression who moved to the area. Staff used a secret shopper methodology commonly used in academic studies. Staff reviewed directories from 12 different plans in 6 States, calling 10 systematically selected providers from each plan, for a total of 120 calls (see Appendix for additional details).

Findings

In total, more than 80 percent of the identified listings for mental health providers were inaccurate or unavailable. Of the total 120 provider listings contacted: 39 (33 percent) were nonworking numbers, incorrect numbers, or unreturned calls (Figure 1). Staff could only make appointments if the provider was in-network and accepting new patients for 22 (18 percent) of the listings (Figure 1). Appointment rates varied by plan and State (see Appendix for additional details). More than 80 percent of the listed providers staff attempted to contact were therefore "ghosts," as they were either unreachable, not accepting new patients or not in-network. In other words, for every 10 calls where staff attempted to make an appointment to a listed, in-network mental health provider, only two calls resulted in an possible appointment.

When staff were able to connect with a working telephone number, on multiple occasions the number listed was for an entirely different entity. Using one plan's directory, mental health specialists listings led staff to a high school student health cen-

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[3] Government Accountability Office, Report to the Chairman, Committee on Finance, U.S. Senate, "Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts," March 2022. Available at: *https://www.gao.gov/assets/gao-22-104597.pdf.*

[4] Cama, S., Malowney, M., Smith, A.J.B., Spottswood, M., Cheng, E., Ostrowsky, L., Rengifo, J., Boyd, J.W. "Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities." *Int J Health Serv.* 2017 Oct;47(4):621–635. doi: 10.1177/0020731417707492. Epub 2017 May 5. PMID: 28474997.

[5] Malowney, M., Keltz, S., Fischer, D., Boyd, J.W. "Availability of outpatient care from psychiatrists: A simulated-patient study in three U.S. cities." *Psychiatr Serv.* 2015 Jan 1;66(1):94–6. doi: 10.1176/appi.ps.201400051. Epub 2014Oct 31. PMID: 25322445.

[6] Butala, N.M., Jiwani, K., Bucholz, E.M. "Consistency of Physician Data Across Health Insurer Directories." *JAMA.* 2023 Mar 14;329(10):841–842. doi: 10.1001/jama.2023.0296. PMID: 36917060; PMCID: PMC10015301.

[7] Resneck, J.S., Jr., Quiggle, A., Liu, M., Brewster, D.W. "The accuracy of dermatology network physician directories posted by Medicare Advantage health plans in an era of narrow networks." *JAMA Dermatol.* 2014 Dec;150(12):1290–7. doi: 10.1001/jamadermatol.2014.3902. PMID: 25354035.

[8] Zhu, J.M., Charlesworth, C.J., Polsky, D., McConnell, K.J. "Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid." *Health Aff* (Millwood). 2022 Jul;41(7):1013–1022. doi: 10.1377/hlthaff.2022.00052. PMID: 35787079; PMCID: PMC9876384.

[9] Government Accountability Office, "Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts," GAO–22–104597, March 2022. Available at: *https://www.gao.gov/assets/gao-22-104597.pdf.*

[10] 42 CFR 422.2267(e)(11).

[11] S. 5093, "Behavioral Health Network and Directory Improvement Act," 117th Congress (2021–2022); S. 923, "Better Mental Health Care for America Act," 118th Congress (2023–2024).

ter, the nursing station at an in-patient psychiatric facility, and a nonprofit organization that manages logistics for peer support groups. A different plan directory mental health specialist listing led to a mental health specialist located in a different State. In this instance, the receptionist at the facility explained that the providers have notified the health plan on multiple occasions that they are not located in the health plan's contracted State and do not have licensed providers there. These are examples of the types of challenges staff ran into while attempting to secure appointments.

In six instances, calls were routed to a national third-party provider matching service. In these cases, the services indicated that there were providers available, but staff were asked to submit additional information about the patient's health needs (*e.g.,* date of birth, condition to be treated, modality of treatment—therapy or medications) and insurance information in order to receive an appointment date, time, and provider name. In these instances, we counted these calls as successful appointments under the assumption that an appointment would be secured if the required additional information was submitted. If this was not true, our overall success in obtaining appointments would have been reduced to 16/120 (13 percent).

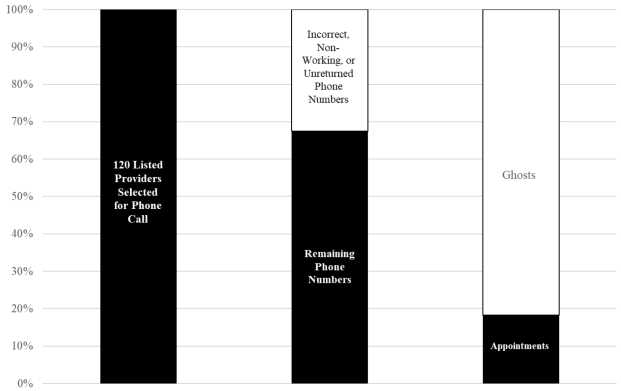

Figure 1. Overall Share of Ghosts in 120 Contacts in MA Health Plan Provider Directories

Reasons for not being able to secure an appointment included: not accepting that insurance (even though a provider was listed on that plan's directory indicating that they are in-network); not accepting new patients; or requiring a referral to see a mental health provider (sometimes requiring a primary care provider referral from within the same system).

Furthermore, time required for staff to reach providers varied widely across plans. Call times ranged from 1–3 hours to contact 10 listings per plan. Of the appointments committee staff were ultimately able to make, some were offered within a month. However, several providers offered an appointment months in the future. In one instance, the earliest available appointment was in 10 months.

Limitations

The goal of this study was to replicate a family member's experience in seeking care for a loved one with depression. This was a brief secret shopper survey and, as a result, our findings are subject to limitations. Staff surveyed a sample of mental health specialists listed by two plans each in six urban counties, but did not survey all mental health providers in the plan's network or all plans. The sample was limited per plan to examine a number of plans and areas. Furthermore, the analysis included certain mental health specialists (psychiatrists, social workers, nurse practitioners, and psychologists) and may not generalize to other specialties.

Discussion

In this secret shopper study, majority staff found it challenging to secure mental health care for an older adult with depression who is enrolled in an MA plan. These results are consistent with previous studies of provider directory accuracy for psy-

chiatrists: 26 percent in Malowney et al and 17 percent in Cama et al.[12, 13] While health plans are responsible for building and maintaining a network of providers, these findings suggest that plans are not accurately representing who is actually in their network and/or able to deliver care and/or available to deliver care.

To the extent that consumers are relying on health plan provider directories when selecting a plan to enroll in, either as a measure of network breadth or to confirm participation by a particular provider, these findings suggest that relying on provider directories would be misleading. Because of this, some experts have suggested that consumers should not rely on health plan provider directories and should call their providers prior to enrolling in a plan to confirm their participation.[14] However, this suggested workaround puts the burden on beneficiaries. It requires seniors to invest significant time in calling all of their providers who they currently see and anticipating any health needs they may have in the future.

If a health plan does not have accurate providers listed in their directories, patients seeking care will struggle to find a provider. It is particularly troubling to consider how this report's findings may acutely affect an individual struggling with a mental health condition and attempting to navigate the process of identifying an in-network provider in a directory where 80 percent of the listed providers are inaccurate or unavailable.

CMS is responsible for overseeing the implementation of MA program requirements. However, it is clear that more needs to be done to ensure MA plan provider directories are accurate and usable for getting care. MA plan directories have not been audited since 2018. CMS should increase its oversight efforts to regularly audit health plan directories to ensure they hold MA plans accountable for these directories and for accurately documenting their networks. Congress can also require additional steps to ensure provider directory accuracy including regular audits, transparency, and financial penalties for non-compliance.

Appendices

Study Methods

To assess provider directory accuracy for mental health care across Medicare Advantage (MA) plans, we conducted a "simulated patient" secret shopper study. We selected six counties with major U.S. cities across six States to ensure geographic diversity. Using State County Plan enrollment public use files provided by the Centers for Medicare and Medicaid Services (CMS), we selected the two largest non-employer Medicare Advantage plans in each county from different parent organizations.

Using the online provider directories for each plan available as of April 2023, we selected a sample of 10 mental health providers for each plan by selecting a ZIP code for the city center then sorting by distance. We selected the first five providers listed at unique office locations and then selected the next five providers of professional background not represented in the first five, again at unique offices to ensure representation of the mental health workforce (*e.g.*, psychiatrist, psychologist, nurse practitioner, and social worker). This approach did not appear to sort providers alphabetically.

Two staff members, one physician and one with a master's degree, called the phone number listed in the provider directory, posing as the adult child of a parent with the given MA plan, seeking treatment for the parent's depression. Staff used the following script: "My mom recently moved to the area and has [XXX] MA plan. She used to see a mental health specialist for her depression. I reviewed the online directory for the plan which says you are an in-network provider for mental health. Do you accept this insurance and if so, when is the earliest my mom would be able to get an appointment?"

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[12] Malowney, M., Keltz, S., Fischer, D., Boyd, J.W. "Availability of outpatient care from psychiatrists: A simulated-patient study in three U.S. cities." *Psychiatr Serv.* 2015 Jan 1;66(1):94–6. doi: 10.1176/appi.ps.201400051. Epub 2014Oct 31. PMID: 25322445.

[13] Cama, S., Malowney, M., Smith, A.J.B., Spottswood, M., Cheng, E., Ostrowsky L., Rengifo, J., Boyd, J.W. "Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities." *Int J Health Serv.* 2017 Oct;47(4):621–635. doi: 10.1177/0020731417707492. Epub 2017 May 5. PMID: 28474997.

[14] Based on majority staff conversations with an independent broker and consumer advocates.

When appropriate, staff members left voicemails with the relevant questions and a request for a call back or to leave a message addressing those questions. Staff members tried to contact each listed provider a second time if the voicemail was not returned. Unreturned voicemails were defined as an unsuccessful contact. When put on hold, we defined hold times greater than 60 minutes as an unsuccessful contact.

We defined a successful appointment as being told there was an appointment available to schedule for the simulated patient. Staff members did not actually make an appointment.

Appendix Table 1. Overall and By State Call Results

State	No Contact	Yes Contact	Successful Appointments	Ghost Listings
OH	35%	65%	25%	75%
PA	10%	90%	15%	85%
OR	30%	70%	0%	100%
MA	45%	55%	10%	90%
CO	25%	75%	50%	50%
WA	50%	50%	10%	90%
Total	33%	68%	18%	82%

Appendix Table 2. Overall and By Plan and State Call Results

Plan	State	Listings Contacted	No Contact (# Not Functional)	Yes Contact	Successful Appointments
Plan A	OH	10	5	5	2
Plan B	OH	10	2	8	3
Plan C	PA	10	0	10	2
Plan D	PA	10	2	8	1
Plan E	OR	10	0	10	0
Plan F	OR	10	6	4	0
Plan G	MA	10	5	5	1
Plan H	MA	10	4	6	1
Plan I	CO	10	1	9	6
Plan J	CO	10	4	6	4
Plan K	WA	10	2	8	1
Plan L	WA	10	8	2	1
Totals		120	39/120 (33%)	81/120 (68%)	22/120 (18%)

*Totals may not add up to 100% due to rounding.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This morning the Finance Committee gathers to discuss ghost networks, which are provider directories maintained by insurance companies that are often inaccurate and unusable by American families who need mental health care.

I want to be clear from the outset what I mean: when insurance companies host ghost networks, they are selling health coverage under false pretenses, because the mental health providers advertised in their plan directories aren't picking up the phone or taking new patients. In any other business, if a product or service doesn't meet expectations, consumers can ask for a refund.

In my view, it's a breach of contract for insurance companies to sell their plans for thousands of dollars each month while their product is unusable due to a ghost network. I'm going to use all resources at my disposal as chairman of the Senate Finance Committee to get some real accountability.

In a moment of national crisis about mental health, with the problem growing exponentially during the pandemic, the widespread existence of ghost networks is unacceptable. When someone who's worried about their mental health or the mental health of a loved one finally works up the courage to pick up the phone and try to get help, the last thing they need is a symphony of "please hold" music, nonworking numbers, and rejection.

Just take a moment and think about the impact that might have on an individual who's already in a challenging situation. It's not hard to imagine how many Americans simply give up and go on struggling without the help they need.

This is not a hypothetical matter. Just last month, my staff conducted a secret shopper study: they made over 100 phone calls to make an appointment with a mental health-care provider for a family member with depression across 12 Medicare Advantage insurance plans in six States.

The results were clear. Our secret shoppers were only able to get an appointment 18 percent of the time. That means more than 8 in 10 mental health-care providers listed in the insurance companies' directories were inaccurate or not taking new appointments. A third of the time the phone number was a dead end altogether. In one instance, staff trying to reach a mental health provider were instead connected to a high school student health center. In another, they were connected to a mental health specialist in another State. And in my State of Oregon, the results are especially troubling—my staff could not make one successful appointment.

Other secret shopper studies looking at commercial health insurance found similar results. In 2017, researchers posing as parents seeking care for a child with depression were only able to obtain an appointment 17 percent of the time. Another from 2015 resulted in an appointment only 26 percent of the time after 360 calls. It is clear that ghost networks are a persistent, widespread problem in the health-care system.

The Finance Committee has been looking closely at this issue, and in my view there are reasons to be optimistic that Congress can take action. A little over a year ago the committee first heard the term "ghost networks" used in this room when the Government Accountability Office shared their findings about the prevalence of inaccurate provider directories.

Since then, the committee has put a lot of sweat equity into developing legislation to improve mental health care for all Americans, from telehealth, to youth mental health, to workforce, to care integration and parity. Some of our policies were passed into law in the last Congress, including a policy to strengthen provider directory standards in Medicaid, but there is still more to be done. I look forward to working with Ranking Member Crapo and every member of the committee to get more of our hard work across the finish line so more families can get mental health care when they need it.

In my view, eliminating ghost networks is going to require a three-legged approach: more audits, greater transparency, and stronger consequences for insurance companies that don't keep their directories up to date.

Today, Medicare performs regular audits of plans offering coverage to seniors to ensure they meet minimum standards. However, CMS does not regularly audit Medicare Advantage provider directories, and the results speak for themselves. It's time for that to change.

I'm always an advocate for greater transparency that allows consumers and advocates to compare plans. That's why last year the committee put forward a bipartisan proposal to improve the accuracy of provider directors in Medicaid and to require Medicare to publish plan provider directories on a central website. That will help consumers, advocates, and researchers dig into this information and make informed choices about their care.

We got started by passing the Medicaid ghost network provision into black letter law last year. This year I want consensus on how to address ghost networks in Medicare.

I want to conclude by talking about accountability. My view is that insurance companies have gotten a free pass for too long letting ghost networks run rampant. If a student were writing an essay and 80 percent of their citations were incorrect or made up, they'd receive an "F." If a business gave the SEC false or incorrect information, it would face extremely severe consequences. So in my view, insurance companies should face strict consequences if their products don't live up to the billing. That's the least that should be done, and I'll keep pushing for the necessary accountability so families across the country aren't getting lost in these ghost networks.

This issue needs to be addressed across the board, not just in Medicare and Medicaid. Many of my colleagues have expressed interest in applying these policies to commercial insurance like employer-sponsored plans. I look forward to working with this committee and the entire Senate to find consensus that will consign ghost networks to the dustbin of history.

There's a lot for us to talk about today. I want to thank our witnesses for joining the committee. I look forward to our discussion.

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Every American deserves access to effective, affordable, and equitable mental health support and counseling. Health insurance providers are committed to lowering barriers to care for mental health and substance abuse disorders (SUD). That commitment includes ensuring provider networks of mental health professionals are as robust as possible.

As the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day, our member plans work consistently with care professionals, and government agencies to make certain that provider directories are up-to-date and accurate as possible, so patients can get the mental health care services, care, and support they need at a price they can afford.

AHIP appreciates the Committee's focus on these important issues. Maintaining accurate provider directories is a shared responsibility that requires a joint commitment from health plans and providers to ensure patients have the information they need, and that the information is updated in a timely and accurate fashion. We look forward to working with providers and policymakers to address the current provider directory challenges, particularly for patients seeking mental health support.

Ensuring Accurate Provider Directory Information: A Shared Responsibility

Since the COVID–19 pandemic, more Americans of all ages are seeking mental health care—stretching capacity to its limits. While more people are receiving the treatment they need, still more work needs to be done. If an individual seeks help and can't answer key questions about their mental health care, such as which providers to see or whether a specialist is in their plan's network, no one benefits.

It is more critical than ever that patients are able to access the mental health care they need. One in five adults in the United States lived with mental illness, according to the National Institute of Mental Health.[1] To that end, it is essential that all stakeholders work together, including care professionals, federal and state policymakers, community organizations, health insurance providers, and other health leaders.

Late last year, the AHIP Board of Directors noted the crucial role of collaboration in their commitment and vision to improve access to mental health care.[2] As such, maintaining accurate provider directories is a shared responsibility that requires a joint commitment from health plans and providers to ensure patients have the information they need, and it is updated in a timely and accurate fashion.

Health Plans Work to Provide Patients with Essential Information

Every American should be able to easily find a clinician or facility skilled in the type of care they seek, that is convenient to access, and with whom they are comfortable. Health plans are committed to ensuring provider directories reflect the

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[1] *https://www.nimh.nih.gov/health/statistics/mental-illness.*
[2] *https://www.ahip.org/news/press-releases/ahip-board-reinforces-commitment-to-improved-access-to-mental-health-care-with-new-principles-and-advocacy-priorities*.

most current and accurate information, so that individuals can maximize the value of their coverage for both physical and mental health.

Provider directories offer essential information for patients on providers in-network, such as their contact information, practicing specialties, board certifications, hospital affiliations, and ability to speak languages other than English. Provider directories also usually include information on hospitals, and non-hospital facilities.

In addition to our commitment to ensure that Americans have accurate information, federal laws have imposed provider directory requirements across various types of coverage (*e.g.,* Medicare, Medicaid, and the commercial health insurance markets). To supplement those requirements, at least 39 states impose their own state-specific provider directory requirements. Regulations implementing provider directory provisions under the Consolidated Appropriations Act of 2021 are also forthcoming from the Administration.

Health plans use a variety of approaches to maintain and update provider directory information, including regular phone calls, emails, online reminders, and in-person visits. This multi-faceted outreach effort is reinforced by contractual requirements between health plans and providers to ensure provider directory information is accurate and up to date.

Provider Engagement and Accountability

Given the breadth and diversity of providers in health plans' networks and the frequency of changes, information can quickly become out of date. Moreover, not all providers rely on the same method of communicating information to health plans. This often leads to delays in updating pertinent provider information. These challenges are further complicated by the fact that providers contract with multiple health plans and may be part of multiple medical groups or independent physician associations.

Maintaining accurate and up-to-date provider directory information has been a longstanding issue for the health care industry. In 2016, AHIP launched a Provider Directory Initiative to identify opportunities to improve the process of developing and maintaining accurate and timely provider directory information.[3] During the project, AHIP worked with two vendors to contact over 160,000 providers, testing different ways to coordinate with them to update key directory data.

The results of the project found that while providers indicated that they were familiar with directories and were aware that they are used to help consumers find clinicians who are in-network, and accepting new patients, they and/or their staff:

- Expressed a general lack of awareness regarding the need to proactively alert plans of changes to their information.
- Did not understand the purpose of, or need for, responding to plan requests to validate or update their information.
- Felt overwhelmed with responsibility and therefore prioritized activities that were required of them by regulation or to secure payment for the provider.
- Were not necessarily aware of state and federal regulations requiring health plans to have accurate, up-to-date provider directory information.

Health plans have worked with their provider partners for many years to improve the accuracy of directory data for patients. These efforts include regular outreach to clinicians to ensure their information is accurate; collaborating to streamline information updates; using advanced analytics and artificial intelligence methods to identify information that should be updated; and validating directories to ensure they are correct. Further, third-party vendors have developed innovative products to improve provider directories, and health insurance providers are contracting with those companies as valuable partners.

While health plans are committed to making accurate and up-to-date provider directory information available to consumers, a strong partnership and active participation with health care providers is essential to achieving this goal. Enhancing provider responsibility for ensuring accurate directory information would also lead to a more collaborative process and a more useful tool for patients, avoiding the inconvenience of inaccurate office locations, incorrect phone numbers, and non-acceptance of new patients.

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[3] *https://www.ahip.org/resources/provider-directory-initiative-key-findings.*

Greater Standardization to Reduce Provider and Plan Burden

Despite private-sector initiatives and government actions, provider directory data challenges remain. One key barrier to ensuring accurate provider directory information is that there is no single source-of-truth for provider information that can be leveraged to verify provider directory submissions without direct engagement of the clinician themselves.

To address these challenges, Americans would benefit from a public-private partnership between the federal government, clinicians, payers, and vendors to streamline and simplify collection of this information and improve its accuracy and completeness. Greater standardization and harmonization in the technical aspects of the information validation process would reduce provider and plan burden and make it easier to update directory information.

To that end, the Centers for Medicare and Medicaid Services (CMS) sought feedback in an October 2022 request for information (RFI) on developing a cohesive, national approach to building a technology-enabled infrastructure, such as the National Directory of Healthcare Providers and Services (NDH).[4] This approach could serve to promote better accuracy of directories, reduce provider burden, and improve efficiency. It also could serve as a source of truth that health insurance providers could leverage to inform more accurate directories, as AHIP noted in our response to the RFI.[5]

Especially as digital technologies become a more essential part of health care delivery, improved provider directory accuracy that could be developed through a national streamlined infrastructure would reduce the burden on patients and would allow them to access the most up-to-date and accurate information about providers and identify an appropriate in-network provider and is a good fit for their specific needs.

Multi-stakeholder engagement is critical to the success of such an effort. AHIP urges the Committee to explore ways to leverage existing initiatives and support additional ways to standardize data elements to build on what is currently working. AHIP also encourages the Committee to work towards solutions that increase the efficiency and adoption of scalable technological solutions for improving the accuracy of provider directories. For example, we recommend that Congress provide adequate funding to support CMS' approach to building the NDH through a public-private partnership.

Addressing Systemic Challenges to Meet Growing Mental Health Care Demands

AHIP acknowledges and recognizes the important role health plans play in provider networks; effective mental health support depends upon accessible and affordable robust networks. Unfortunately, systemic barriers, such as workforce shortages and growing treatment demands, have also contributed to challenges with mental health access.

Health plans are working to address these challenges, such as integrating mental health care with primary care, providing access to telehealth, and broadening access to a wider range of mental health professionals in order to better meet the needs of patients where they are and offer care that is more coordinated, holistic, and effective.

Workforce Shortages

Health insurance providers recognize the need to address widely acknowledged workforce shortages and a growing demand for treatment where the supply of providers is insufficient to serve local needs. A recent analysis found that 47% of the U.S. population—158 million people—live in an area where there is a mental health workforce shortage.[6] But addressing this ongoing issue can only be accomplished by all health care stakeholders working together.

Health insurance providers are working to improve mental health workforce issues by bringing more high-quality clinicians into their networks, training and supporting primary care physicians (PCPs) to care for patients with mild to moderate mental health conditions, expanding tele-behavioral health, and helping patients

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[4] *https://www.govinfo.gov/content/pkg/FR-2022-10-07/pdf/2022-21904.pdf.*

[5] *https://www.ahip.org/resources/directory-ahips-response-to-cmss-request-for-information-on-the-creation-of-a-national-directory-of-health-care-providers-and-services-2.*

[6] *https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/.*

find available mental health appointments. In fact, among commercial health plans, the number of in-network mental health providers has grown by an average of 48% in 3 years.[7] Nonetheless, longstanding mental health provider shortages persist and are exacerbated by many providers choosing not to participate in health plan networks.

Strengthening the Mental Health Workforce

Action is urgently needed to expand the number of mental health providers of all types—from psychiatrists and psychologists to social workers and mental health professionals.

AHIP supports legislative policies that provide incentives for individuals to enter the mental health field. These could include:

- Increasing funding for loan repayment programs for providers who enter the mental health field. If government resources are used to encourage people to enter the mental health field, AHIP supports requirements that those providers participate in health plan networks, particularly in public programs such as Medicare and Medicaid.
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include mental health care professions with an additional emphasis on promoting workforce diversity.

In addition to expanding the number of providers, AHIP member organizations believe that every provider should receive training and be able to deliver culturally competent care. We support training of providers and staff on cultural competency, cultural humility, unconscious bias, and anti-racism in order promote empathy, respect, and understanding among provider networks and between providers and their patients.

Moreover, AHIP members believe in promoting diverse provider networks that reflect the communities they serve so that people can find providers who meet their needs and preferences. This includes provider and practitioner demographic diversity as well as diversity of staff and care team members. Improved directories where providers can more easily disclose demographics—such as race/ethnicity and languages spoken—would also help patients seek the type of provider that best meets their needs. Furthermore, a public-private partnership for a national directory infrastructure that could be leveraged to collect both provider and payer digital addresses to advance health data interoperability would also help improve the patient experience related to quality, equity, and affordability of care.

Mental Health Integration

Because the front door to health care for most individuals is their PCP, making that primary care practice a one-stop shop for people's physical and mental health needs can help with early identification of mental health issues, reduce the wait time to treatment, and improve access to mental health services for everyone.

That's why health insurance providers are exploring multiple ways to integrate mental health care with primary care—leveraging collaborations with PCPs as an effective way to enhance access to mental health support and improve overall health results. Integrated mental health care blends care for physical conditions and mental health, including mental health conditions and substance use disorders, life stressors and crises, or stress-related physical symptoms that affect a patient's health and well-being.[8]

Because many patients already have existing relationships with PCPs, integration of physical and mental health can provide multiple benefits to patients, including earlier diagnosis and treatment, better care coordination, timely information sharing, improved results, and improved patient and provider satisfaction. Many people with mental health conditions also have other chronic medical conditions. Integrating mental health with primary care can allow for earlier diagnosis and better coordination of care for patients with multiple complex physical and mental health conditions. This approach has also been identified by many stakeholders as a strategy not only to improve access and quality, but also to reduce disparities and promote equity.[9, 10]

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[7] *https://www.ahip.org/news/press-releases/new-survey-shows-strong-action-by-health-insurance-providers-to-growing-mental-health-care-demands.*

[8] *https://www.integrationacademy.ahrq.gov/about/integrated-behavioral-health.*

[9] *https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf.*

[10] *https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices.*

The Collaborative Care Model (CoCM) is one such model.[11] This model of integration includes care management support for patients receiving mental health treatment and psychiatric consultation. In addition to the CoCM, many health insurance providers have promoted integration and team-based care through other effective approaches, including enhanced referral, expanded case management specific to mental health conditions, and value-based arrangements.

The range of approaches currently underway underscores the importance of flexibility and recognition that physician practices are at varying stages of readiness in their ability to deliver fully integrated physical and mental health care. Health insurance providers see firsthand the vital role that mental health plays in overall health care and are committed to working with their provider partners to promote whole-person care through mental health integration.

The Role of Telehealth

Patients, health care professionals, and health insurance providers all appreciate the value of telehealth. Many patients can access telehealth from wherever they are, making it a vital tool to bridge health care gaps nationwide. Patients now accept—and often prefer—digital technologies as an essential part of health care delivery, including the delivery of mental health and substance use disorder services. Those accessing mental health services via telehealth can do so from the privacy of their own homes and free from concerns about the potential stigma associated with seeking care in brick-and-mortar settings for mental health conditions.

For patients in rural communities and other underserved areas with fewer practicing providers, telehealth can make mental health care more convenient, accessible, efficient, and sustainable. Patients who access care remotely can also avoid challenges associated with taking time off from work, arranging transportation, or finding childcare. For providers, telehealth also substantially reduces the number of no-shows, assuring that the time made available for patient care is spent delivering services to the patients who need it.

Health insurance providers are committed to ensuring that the people they serve, regardless of where they live or their economic situation, can access high-quality, safe, and convenient care. That is why they embrace telehealth solutions that help increase access to care. The telehealth flexibilities put in place during the COVID–19 public health emergency, such as waiving originating site requirements for telehealth services under Medicare and allowing reimbursement of more video-enabled telehealth and audio-only telehealth services, have proven critically important to the delivery of care throughout the pandemic.

The collective actions taken by Congress and the Administration, many of which were adopted across Federal programs and in commercial plans, allowed for increased access to telehealth for both patients and providers, leading to exponential growth in use especially for those in need of mental health services. Data show that over 60% of telehealth use is for mental health care.[12]

However, legislation is required to permanently authorize key evidence-based reforms under Medicare. We support legislative action and encourage Congress to act to permanently protect health insurance providers' flexibilities in creating telehealth programs and other virtual care solutions that will best serve the needs of their members and can provide convenient access to high-quality mental health services in an equitable manner across all populations and communities.

Conclusion

Mental health is an essential part of a person's overall health and well-being. Health insurance providers are working everyday with patients, providers, and communities to ensure access to mental health care and support—including making accurate and up-to-date provider directory information available to patients.

We are making progress, but we must recognize the multi-faceted nature of the challenges facing our nation's mental health care system and acknowledge the need for all stakeholders to do much more. AHIP believes that a strong partnership and active participation among both health plans and providers is essential to achieving the goal of maintaining timely, accurate provider directories so patients have the information they need and the information is up to date.

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[11] *https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf.*

[12] *https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/nov-2021-national-telehealth.pdf.*

AHIP and its members are committed to working with the Committee to improve provider directory information and therein help patients access care more quickly and reduce administrative burden and costs for everyone, helping make coverage and care more affordable while also permitting clinicians to spend more of their time caring for patients.

AHIP appreciates the Committee's increased focus on these important issues. We look forward to working with you to further develop solutions to improve long-standing provider directory issues and enhance mental health care access and affordability.

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May 12, 2023

The Honorable Ron Wyden
Chairman
U.S. Senate
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Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the 100 members of the American Association of Payers Administrators and Networks (AAPAN), we would like to share our thoughts on ways to improve the accuracy of provider directories. AAPAN members strive to provide our beneficiaries with the most up-to-date and accurate information on the providers in our networks. We understand the frustrations people face when their ability to seek care is hampered by incorrect provider information. However, the responsibility of ensuring this information is accurate lies with both the plans as well as the providers. While your recent hearing on "ghost networks" focused on the deficiencies with respect to mental health care, AAPAN believes these issues are not limited to mental health care.

AAPAN provides a unified, integrated voice for payers, third-party administrators, networks, and care management in the group/government health and workers' compensation markets. The association serves as an advocate that respects and balances the unique business needs of its members so that both may more effectively provide patient access to appropriate, quality health care.

Provider directories are an important resource and tool given to enrollees to help them determine which providers are in-network. The directories provide market opportunities for both plans and providers. However, inaccurate directories could potentially result in unforeseen costs for enrollees as well as frustrations finding care. While the hearing highlighted the challenges faced by patients and the burdens and costs borne by providers, the costs to plans and payers were overlooked and are significant. Plans need to comply with both federal and state provider directory laws and invest significant amounts of money to do so. The costs associated with ensuring provider directory accuracy include data acquisition which can be in the millions of dollars, the costs of engaging a third-party vendor to scrub the data which can cost hundreds of thousands of dollars, and the costs of hiring employees to work on the internal processes necessary to ensure the data are current. However, at the end of the day plans are hamstrung by the information, or lack of information, from the providers.

Our members have found that providers often omit or neglect to include certain data when submitting this information to plans, such as whether they are accepting new patients, their hours of operation, or the accessibility of their office setting (*i.e.,* handicap accessibility, languages spoken, etc). While it is incumbent on the plan to verify and ensure this information, AAPAN believes that providers need to be a willing partner. Anecdotally, our members have reported that some providers are less forthcoming and responsive if they believe they have a less favorable reimbursement rate as compared to other networks/plans.

One example that was raised in the hearing was of a patient with schizophrenia being unable to find a provider. Our members were particularly concerned about this example because when providers are credentialed plans determine that pro-

viders have the proper qualifications and licensing to perform their jobs. While specialty is often part of the data included in a provider directory, plans would not know a provider's preference for treating certain conditions within their scope of practice. There are health equity issues that this example raised that are not confined to just the mental health care field. Patients with disabilities face similar challenges, according to a report published in *Health Affairs* in October 2022.[1] These attitudes and biases would not be captured in a directory.

AAPAN supports efforts to alleviate this burden. We believe that having standardized data elements and definitions around those elements could go a long way in ensuring that provider directories are accurate. Having a common language and expectations around the elements included in the directory will not only help plans and providers, but will help patients. AAPAN believes that some ideas that have been proposed, such as a National Directory, may create their own issues and additional burdens.

Under such a National Directory model, the directory information could be maintained in a standardized and interoperable way which could serve as an important resource for plans. This would allow all plans to update their own directories without requiring providers to submit multiple data collections from their plans, reducing burdens for both plans and providers. However, AAPAN members have raised concerns about how such a model would account for directory requirements imposed at the state level. A majority of states have legislated the items plans are required to collect and include on directories. AAPAN also believes for a National Directory to be successful all states must agree to the data elements being collected. If plans have to submit to 50 different state requirements because states continue to mandate their own data elements for provider directories, then it would ultimately be an additional burden on plans and providers.

While it is incumbent on plans to ensure the accuracy of their provider directories, AAPAN believes that accurate directories are a shared responsibility between plans and their in-network providers. Plans can establish processes to update provider data but providers themselves need to inform plans when they have changes to their practices. AAPAN believes that a National Directory would have similar difficulties ensuring accurate information unless providers are willing and active participants. The Committee should consider opportunities to increase provider accountability, including consequences for failure to update data changes in a timely manner. As part of California's law on provider directories plans are permitted to delay payments to providers who fail to respond to the plans' attempt to verify their information. While plans are also able to terminate provider contracts for failure to inform plans of changes in the directory information, AAPAN believes this course of action could ultimately harm patients by leaving existing patients of that provider vulnerable and searching for a new provider.

As the Committee considers its next steps it should keep in mind that the No Surprises Act (NSA) included provisions that require health plans and issuers to verify and update provider directory information at least once every 90 days, process updates within two business days of receiving updated information, and remove providers from the directory if their information has not been verified during a period specified by the health plan. It also requires certain elements to be included such as the name of the provider, address, phone number, specialty, and digital contact information. However, to date, the Administration has not yet issued any rulemaking to implement these requirements of the NSA, despite these provisions going into effect on January 1, 2022. AAPAN members are making good faith efforts to comply, but further guidance is needed to ensure providers fulfill their requirements.

While there are requirements and enforcement mechanisms imposed on plans to ensure the accuracy of directories, these mechanisms are not imposed on providers. Congress should consider both incentives and penalties to ensure providers participate and they do so with the frequency needed to keep their information current. Earlier versions of the NSA included penalties for both providers and plans, but this language did not make it into the enacted version.

As the Committee looks for ways to improve the accuracy of directories, it should consider convening listening sessions with all stakeholders included to develop a meaningful solution that works for all parties. AAPAN believes the unique perspec-

[1] "I Am Not the Doctor for You": Physicians' Attitudes About Caring for People With Disabilities; Tara Lagu, Carol Haywood, Kimberly Reimold, Christene DeJong, Robin Walker Sterling, and Lisa I. Iezzoni; *Health Affairs* 2022 41:10, 1387–1395.

tives of all these types of payers within its membership should be included in the debate. However, before undertaking any new legislation, Congress should allow for time to ensure the NSA provisions are fully implemented. The Committee could encourage CMS to move forward with guidance or rulemaking.

AAPAN supports your effort to reduce the compliance burden for providers and payers with respect to the accuracy of provider directories. We would like to be a resource to the Committee as your work on this vital issue continues. If you have any questions regarding our comments, please contact Julian Roberts at jroberts@aapan.org or 404–634–8911.

Sincerely,

Julian Roberts
President and CEO

AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity 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."

As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA understands 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, Jack Resneck, MD (the AMA's current President and witness for this hearing) published a study with several colleagues in the *Journal of the American Medical Association Dermatology.*[1] He and his colleagues specifically studied Medicare Advantage (MA) plan directories of participating dermatologists and the appointment availability of those dermatologists listed. Their "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, they 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, it was 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 they were seeking care (*e.g.,* an itchy rash), they were subspecialists, dermatologic surgeons, pediatric dermatologists, etc. In the end, it was found that about 26.6 percent of the individual directory listings were unique, accepting the patient's insurance, and offering a medical dermatology appointment. However, the average wait time to get that appointment was 45.5 days.

Since that study was published, the situation has, unfortunately, 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 Committee[5] highlighted patient challenges with accessing mental health care. Stakeholders reported inaccurate or out-of-date information; these inaccuracies where mental health providers appear to be in a health plan's network contributes

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[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).

[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," Power Point summary, American Medical Association, 2018.

[4] K.A. Kyanko, S.H Busch, "Surprise Bills from Outpatient Providers: A National Survey," *Journal of General Internal Medicine* 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.*

to ongoing access issues for consumers and may lead consumers to obtain out-of-network care at higher prices.

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 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

Achieving provider directory accuracy is not easy and we 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 paper[8] 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. 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.

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[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).

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 our research with CAQH, we 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, we suggest 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 our 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 Senator Sherrod Brown (D–OH) and Senator 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 urges CMS to promptly finalize and implement these changes to increase transparency and improve the prior authorization process for patients, providers, and health plans. We also urge 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) requir-

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

ing that plans respond to prior authorization requests within 24 hours for urgently needed care; and (3) requiring detailed transparency metrics. We 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 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, the AMA urges 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. We are 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. The AMA is 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.

In conclusion, the AMA stands ready to work with Congress 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.

ASSOCIATION FOR BEHAVIORAL HEALTH AND WELLNESS
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Chair Wyden and Ranking Member Crapo,

The Association for Behavioral Health and Wellness (ABHW) appreciates the Committee's support and leadership in addressing mental health (MH) and substance use disorder (SUD) issues. ABHW is the national voice for payers that manage behavioral health insurance benefits. ABHW member companies provide coverage to approximately 200 million people, both in the public and private sectors, to treat MH, SUD, and other behaviors that impact health and wellness. In administering these benefits, ABHW members maintain extensive networks and associated provider directories on behalf of their members, providers, and health benefit plan sponsors.

We appreciate the opportunity to submit a statement for the record supporting the Committee's efforts to identify solutions and opportunities to improve provider directories. Our plans have heavily invested in ensuring complete and accurate provider directories of available in-network provider resources. We agree that discrepancies in provider directories can be frustrating for consumers and are an issue that directly impacts accessing care in a timely manner.

Over the past several years, ABHW member plans have dedicated significant resources to ensuring that their directories are accurate. They have taken several steps to validate the external data and information used to populate these directories, improving outreach to providers, and simplifying the processes for providers to update their information with plans. These activities include monthly provider communications, direct provider outreach programs, streamlining updates based on provider-initiated correspondence, and claims submission reviews to identify provider changes. Despite these efforts, some of our member plans report a less than 50 percent response rate from providers, and one plan indicates that only 11 percent of providers responded to their requests to update information. For provider directories to be the most accurate, health plans and providers have a role to play. There must be appropriately aligned incentives for providers to fulfill their obligations to plans and patients by maintaining timely, accurate information updates.

We are dedicated to finding solutions to provider directory inaccuracies that work for plans, providers, and consumers. ABHW members are working to comply with the more recently developed provider directory standards and requirements set forth by Congress in the Consolidated Appropriations Act (CAA) of 2021; however, we note that the required rulemaking and guidance have yet to be issued on this por-

tion of the CAA. We highlight this because the CAA provisions establish a solid model for improving provider directories that has yet to be tested due to the delay in rulemaking and implementation of to-be-issued guidance. In addition, Congress should ensure that the standards for provider directories, and by extension, network adequacy and access, should not vary by payer or program to ensure health equity and avoid disparities in access. Accordingly, we urge the Committee to work with the Centers for Medicare and Medicaid Services (CMS) to release the guidance.

In addition, as you are aware, in December 2022, CMS issued a request for information (RFI) on establishing a centralized repository for healthcare providers and services data. ABHW and many of our members responded to this RFI, sharing that a national directory could help enhance accuracy and access provided it is designed, established, and operated thoughtfully, and addresses the points above about the need for aligned incentives and responsible participation by both plans and providers. While there are many details to examine before implementing a national directory, we urge the Committee to explore solutions that engage health plans and providers to ensure accurate provider directories.

To further help alleviate provider directory issues, we urge the Senate Finance Committee to continue addressing behavioral health workforce shortages and ensuring access to services via telehealth. Provider directory issues are a symptom, not the disease. The real challenge, the workforce, is one of the most pressing issues facing the behavioral health industry. We urge Congress to consider approaches to help mitigate existing shortages to utilize our existing workforce and expand it simultaneously. ABHW recommends the Committee work to:

- Increase psychiatry residency positions,
- Allow advanced psychologist trainees to practice without direct supervision,
- Cover peers in all Medicare settings, not limited to integrated care,
- Examine proposals that increase loan repayment incentives, such as S. 462, *Mental Health Professionals Workforce Shortage Loan Repayment Act of 2023,* and
- Identify opportunities to advance integrated care solutions, such as the Collaborative Care model.

We also urge the Committee to focus on making the COVID–19 telehealth flexibilities permanent. Telehealth is an emerging strategy to help fill in gaps in the workforce.[1] We recommend that the Committee make permanent the COVID–19 telehealth flexibilities that are currently extended until December 2024. The Drug Enforcement Agency (DEA) recently extended controlled substances telehealth prescribing flexibilities available during the COVID–19 pandemic until November 11, 2023. It gave an additional year of safe harbor until November 11, 2024, for an established telemedicine relationship. Continued access via telehealth is vital to maintaining care, particularly considering the opioid and fentanyl crisis our nation is grappling with, and we encourage the Committee to work with the DEA to release the special registration rule, as previously mandated by Congress, before these flexibilities expire. We also recommend the following:

- Repealing the 6-month in-person Medicare requirement for telemental health visits,
- Fostering cross-state licensure, and
- Covering telehealth in high deductible plans.

We look forward to working with the Committee and other stakeholders to identify solutions to improve the accuracy of provider directories. We thank the Committee for the opportunity to submit ABHW's comments for the record. If you have any questions, please contact Maeghan Gilmore, Vice President of Government Affairs, at gilmore@abhw.org or 202–449–2278.

Sincerely,

Pamela Greenberg, MPP
President and CEO

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[1] *https://www.healthcareitnews.com/news/staffing-expert-shows-how-telehealth-stepping-fill-staffing-shortage.*

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Statement of David Merritt, Senior Vice President of Policy and Advocacy

Every American deserves access to accurate and up-to-date information about in-network providers so they can easily find the health care professionals that best meet their needs. The Blue Cross Blue Shield Association (BCBSA) commends Chairman Wyden, Ranking Member Crapo, and members of the Senate Finance Committee for holding this important hearing on how to improve the accuracy of provider directories to achieve this critical, shared goal.

BCBSA is a national federation of 34 independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS companies serve those who purchase coverage on their own as well as those who obtain coverage through an employer, Medicare and Medicaid and contract with 96% of providers nationally. We are committed to delivering affordable access to high-quality care for every American.

BCBS companies are working aggressively to improve the accuracy of provider directories to provide those we serve with the most current provider information when they are seeking medical care. However, we know that improving provider directories alone will not resolve the challenges many Americans face in accessing timely, quality health care. That is a particular challenge for patients to find support for mental and behavioral health services. In fact, studies show more than one third of Americans live in areas with far fewer mental health providers than the minimum needed to meet the need.1 We thank the Committee for its ongoing bipartisan work to improve patients' access to mental health services.

Specifically, we applaud the Committee for its part in securing passage of key provisions within the Consolidated Appropriations Act (CAA 2023) to help improve access to behavioral health services. This includes meaningful steps to expand access to professional counselors and marriage and family therapists in Medicare, creating additional Graduate Medical Education slots for mental health providers, and extending current telehealth flexibilities. Those flexibilities to expand telehealth has been critical for millions of Americans to access the mental health support they need, especially during the COVID-19 pandemic. We look forward to working further with the Committee on ways to bolster the mental and behavioral health workforce to support robust access across the country.

Improving Access to Providers

We applaud the Committee's interest in evaluating all avenues for improving mental health access but encourage Congress to consider approaches that will help mitigate existing significant workforce capacity challenges in the mental and behavioral health fields. Addressing these issues will have the most meaningful impact in improving access for patients. To expand existing capacity as we work to address the longer-term workforce challenges, we encourage policymakers to consider actions such as:

- Work to promote the use of care integration and non-clinical support personnel by investing in providers who are seeking to integrate care and supporting payment models that promote care integration.
- Expand the use of telehealth to help expand access to care and augment local practitioners.
- Address underlying workforce pipeline challenges by increasing the number of residency spots in medical programs and expanding incentives to encourage students to enter the behavioral health workforce.

BCBS Companies' Commitment to Improving Provider Directory Accuracy

We understand the impact outdated provider information has on patients. Inaccurate information is frustrating, confusing, and inefficient. That is why we continue to commit significant resources and conduct regular outreach to make it easier for providers to submit and update their information to be displayed in provider directories. We also understand that challenges remain for both providers and health plans in keeping directory information accurate on a timely and consistent basis, and we have committed to serving as an industry partner in working to build a common repository for directory information.

Challenges in Verifying Provider Directory Information

For provider directories to be most accurate, health plans and providers must work together to keep information current and accurate for patients. Based on a BCBSA survey of Plans, provider response rates to Plan requests for information are well below 50%. We understand that providers regularly receive requests from all their contracted health plans, so it is understandable that many providers—especially smaller practices—struggle to keep up with these requests, and often fail to respond on a timely basis. Unfortunately, ignoring consistent outreach and regular requests is not a solution to deliver timely, accurate, and updated information to patients.

While the Consolidated Appropriations Act of 2021 (CAA 2021) requires commercial health plans to verify provider directory information every 90 days, no corresponding legislative or regulatory requirement is placed on providers to confirm or update this demographic information when plans request it. As a result, for the many providers who do not consistently update their information, they will end up being removed from health plan directories as required by the CAA 2021. BCBSA continues to recommend that states and HHS consider this challenge when issuing regulations and enforcing these provider directory requirements.

Moving Forward

Plans are still awaiting regulations from HHS implementing the provider directory requirements included in CAA 2021. Being overly aggressive on provider directory standards could impair patients' access to needed care, particularly in the behavioral health space where the supply of providers is not able to meet the demand for services. While accuracy of the directories is critical, we urge caution in considering any policies that would further require removing providers from directories if they are delayed in responding to data requests—but who are still practicing, in-network and accepting patients. BCBS Plans comply with both state and CMS network adequacy standards and Plans continue to engage with regulators to ensure networks meet the needs of their customers.

Additionally, we urge the Committee to require additional oversight of providers to improve the timeliness and accuracy of the information they provide to Medicare Advantage (MA) plans and to CMS in the National Plan and Provider Enumeration System (NPPES). MA plans are making a good faith effort to obtain accurate and timely provider information and should not be held solely accountable when providers do not send timely information to their requests or give inaccurate information. Updated, accurate information is the responsibility of both plans and providers.

Lastly, CMS, health plans, providers, technology vendors, and other stakeholders are currently in the process of standardizing the data and transactions to make it possible for providers and health plans to transmit more real-time information about their availability and network participation. BCBSA and stakeholders agree, as evidenced by shared comments on CMS' proposed National Directory of Health, that the more that manual processes can be streamlined and standardized, the more accurate and patient-friendly provider directories will be. We urge members of Congress to avoid any legislative measures that would set back this important work.

Conclusion

Ensuring accurate provider directories is a shared responsibility between health plans and health care clinicians. We look forward to continuing to work with Congress, the Administration and our provider partners to identify and implement meaningful solutions that will improve provider directory accuracy while reducing burden on all stakeholders.

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Statement of Michael G. Bindner

Chairman Wyden and Ranking Member Crapo, thank you for the opportunity to submit these comments on the problem of ghost networks. We thank Senator Smith for bringing attention to this issue.

The problem of ghost networks varies, depending upon one's health plan. If one enters mental health care through Medicaid, state departments of health generally have up-to-date listings for programs that provide both psychiatric and social worker services. This was my experience as a patient in the District of Columbia. I did

not choose a health plan when I was in the DC system, which made finding a primary care physician interesting. After moving to Maryland, I chose Kaiser for medical care, but could not do so for mental health services.

Participants in a Psychiatric Rehabilitation Program include access to a nurse practitioner (which is usually what Medicaid pays for). PRPs have case managers who will do the searching for you when a therapist is needed—although this may take some time, precisely because of the problem of ghost networks. Medicaid patients have access to certified counselors and licensed marriage and family therapists, but not to Licensed Clinical Social Workers. LCSWs were only covered by Medicare, while the other therapists were not.

Starting in 2024, the counselors available with Medicaid are added to Part B coverage. This makes ghost networks a problem for more people—although wider availability may help individuals find care.

In my case, my relationship with my nurse practitioner in my PRP proved toxic, so I had to find a new provider. In reality, there was not much choice—only one was open—even though more were listed.

Before moving to Medicare after two years of Medicaid after my SSDI began, I could no longer meet the asset test of Medicaid when I received assets from my divorce (although I probably did not have to take this step). At this time, I signed up for the Affordable Care Act Silver Plan. The coverage was too expensive and the copays too high for care when I fell and broke a rib. Luckily, at the two-year mark, I moved to Medicare Parts B/D and a Psychiatrist and LCSW. A year later, I signed up for Part C.

Shifting from Medicaid to the Affordable Care Act to Medicare was seamless with my Primary Care Physician, unlike my mental health services. Of late, I was offered the ability to go out of the HMO for services due to regulatory changes. None were as convenient as what Kaiser provided.

I had previously been a Kaiser member fifteen years prior to this as a government contract employee. During this time, I noted that the DC Government, where I had been working a few years earlier, had shifted to Kaiser as well for their employees.

The point of my tale of coverage is that, once I chose Kaiser, my relationship with my PCP was unchanged, although details of copayments and prescription coverage did vary, especially regarding the pharmaceuticals.

For those who sign up for managed care, we have achieved fusion in some aspects, but not in others—although this will change in 2024 as far as therapists are concerned. One can work for a company, get an individual policy under the ACA at a later time, get Medicaid when disabled and full Medicare without changing doctors. What is complicated is what is covered and what is not with the same provider network.

The real antidote to ghost networks is the kind of network care that is provided through community healthcare in Medicaid and to managed care participants (regardless of funding). Getting to single payer funding is not an issue as much as is seamless coverage *within the same provider network* regardless of which government or employer plan one uses.

Professional employees always get good coverage, as do unionized employees. Others need to rely on some sort of governmentally funded care. For those in this situation, the care package should be the same, with providers getting the same level of support in each setting.

If this sounds like an endorsement of Medicare for All, which is essentially Dual Eligibility for all (meaning Medicare reimbursement with Medicaid copays) for all seniors, then you have been listening.

There are other options, however, like Medicare Part E coverage replacing dual eligibility for seniors in long-term care (taking these patients off of state Medicaid rolls) and a public option added to Affordable Care Act coverage (which could replace Medicaid—at least for non-retirees—and be more heavily subsidized than current coverage). The other option is to have employers offer direct care.

I have addressed these options in more detail previously in comments regarding Single Payer coverage, which I have attached.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment—Single-Payer, June 12, 2019

There is no logic in rewarding people with good genes and punishing those who were not so lucky (which, I suspect, is most of us). Nor is there logic in giving health insurance companies a subsidy in finding the healthy and denying coverage for the sick, except the logic of the bottom line. Another term for this is piracy. Insurance companies, on their own, resist community rating and voters resist mandates—especially the young and the lucky. As recent reforms are inadequate (aside from the fact of higher deductibles and the exclusion of undocumented workers), some form of single-payer is inevitable. There are three methods to get to single-payer.

The first is to set up a **public option** and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs when

The second option is Medicare for All, which I described in an attachment to yesterday's testimony and previously in hearings held May 8, 2019 (Finance) and May 8, 2018 (Ways and Means). Medicare for All is essentially Medicaid for All without the smell of welfare and with providers reimbursed at Medicare levels, with the difference funded by tax revenue.

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying "Don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. Much of this is now managed care, as is Medicare Advantage (Part C).

Obamacare has premiums with income-based supports and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value-added tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All.

The third option is an **exclusion for employers,** especially employee-owned and cooperative firms, who provide medical care directly to their employees without third party insurance, with the employer making HMO-like arrangements with local hospitals and medical practices for inpatient and specialist care.

Employer-based taxes, such as a subtraction VAT or payroll tax, will provide an incentive to avoid these taxes by providing such care. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid or Medicare for All. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. The employee ownership must ultimately expand to most of the economy as an alternative to capitalism, which is also unstable as income concentration becomes obvious to all.

The key to any single-payer option is securing a funding stream. While payroll taxes are the standard suggestion, there are problems with progressivity if such taxes are capped and because profit remains untaxed, which requires the difference be subsidized through higher income taxes. For this reason, funding should come through some form of value-added tax.

Timelines are also a concern. Medicare for All be done gradually by expanding the pool of beneficiaries, regardless of condition. Relying on a Public Option will first serve the poorest and the sickest, but with the expectation that private insurance will enlarge the pool of those not covered until the remainder can safely be incorporated into a single-payer system through legislation or bankruptcy in the health insurance marketplace.

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May 9, 2023

Senator Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

Senator Michael Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20150

Dear Chairman Wyden and Ranking Member Crapo,

Thank you for your bipartisan leadership on the Senate Finance Committee regarding mental health issues, particularly for children, youth and young adults. I am writing to you regarding the recent hearing titled "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks."

First Focus on Children is a bipartisan advocacy organization dedicated to making children and families a priority in federal and budget decisions. Since the release of the U.S. Surgeon General's report on youth mental health in December 2021[1] we have been pleased to see Congress shine a light on the array of major behavioral health system issues that need to be addressed, including network adequacy. We appreciate the invitation to share our thoughts on the issue of "ghost networks" as it impacts children, youth and young adults.

Mr. Chairman, we agree with the comments you made in your opening statement. "In a moment of national crisis about mental health, with the problems growing at such a rapid rate, the widespread existence of ghost networks is unacceptable." This Committee is already familiar with the range of issues facing our nation's youth.

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[1] U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID–19 Pandemic, December 7, 2021, *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

The February 15, 2022 hearing, "Protecting Youth Mental Health: Part II—Identifying and Addressing Barriers to Care" and the subsequent white paper on mental health and youth[2] laid out many of the staggering statistics of the increased demand for mental health services among children, teens and young adults. It is widely agreed that while COVID–19 exacerbated the crisis, our teens were in crisis before the pandemic. The current statistics are alarming. Roughly 42% of high school students felt so sad or hopeless almost every day for at least two weeks in a row that they stopped participating in their usual activities.[3] One in ten high school students attempted suicide one or more times during the past year.[4] A statistic that hits at the heart of the ghost network problem, and a statistic that you have noted in previous hearings, is that typically 11 years pass between the onset of symptoms in our children and adolescents and when they first receive treatment.[5] Nationwide, more than 60% of children who experience a severe depressive episode do not receive treatment.[6] This is simply unacceptable and we can do better.

While Congress passed and President George W. Bush signed the Mental Health Parity and Equity Act (MHPAEA) into law in 2008 (which addresses the disparities between general and behavioral health care and seeks to create equal access to behavioral health services), millions of children and their families have not enjoyed the benefits of this important law. Insurance companies have skirted the universal benefits guaranteed by the MHPAEA law, and enforcement of the law is lacking, meaning no one, including children and youth, has achieved equitable access over the past 14 years. Even the 2010 passage of the Affordable Care Act did not force all insurance companies to offer parity in behavioral health services. While patients have the legal right to equal access and coverage of behavioral health treatment services, coverage still remains restrictive.

What a Lack of Parity Means to Children and their Families

When a child or teenager has a behavioral health crisis (mental health issue, eating disorder, substance use disorder, etc.), a parent's first instinct is to seek immediate and appropriate care so their child can receive a timely, proper diagnosis and treatment. In other words, their response is exactly the same as if their teen had just broken their arm in a bike accident or experienced a seizure. Unfortunately, when children and teens experience a behavioral health crisis—even if they are covered by health insurance (private insurance or Medicaid)—help may not be on the way.

For families with health insurance, the lack of adequate networks or the existence of so-called "ghost networks" is a brick wall or a frustrating exercise fraught with emotional turmoil for the child and the entire family. As we heard in your hearing and from many stories in the press, families often encounter outdated or severely limited provider network directories. Some providers are no longer in their network. Or parents are told that the waiting lists are weeks—or months—long. Providers may be so overburdened that they are not accepting new patients. In addition to barriers from ghost directories, insurance companies may impose limits on the number of behavioral health visits a child can have in a calendar year. Families may also have to pay much higher co-pays for behavioral health care visits than for traditional physical health visits.

When children cannot access home and community-based services in real time, they go without proper care and risk experiencing a crisis. They may contemplate suicide or harm someone else. At the point of a true crisis, a hospital emergency room may be the only viable option for the child or teen to receive immediate care—a route into the system that is traumatic for the child and family, chaotic, and costly. Sometimes, even emergency room care for behavioral health issues requires prior authorization before hospital treatment which can result in several days of delay—yet an-

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[2] U.S. Senate Finance Committee, Youth Mental Health Discussion Draft. June 15, 2023, *https://www.finance.senate.gov/chairmans-news/wyden-crapo-carper-cassidy-unveil-youth-mental-health-discussion-draft.*

[3] "Youth Risk Behavior Survey Data Summary and Trends Report," Centers for Disease Control and Prevention, February 2023, *https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm.*

[4] "Youth Risk Behavior Survey Data Summary and Trends Report," Centers for Disease Control and Prevention, February 2023, *https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm.*

[5] U.S. Surgeon General Issues Advisory on Youth Mental Health Crisis Further Exposed by COVID–19 Pandemic, December 7, 2021, *https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.*

[6] Youth Ranking 2022. Mental Health America, *https://www.mhanational.org/issues/2022/mental-health-america-youth-data.*

other barrier to care. Ideally, children and youth should receive care in the early stages when symptoms first appear so that they never have to experience a crisis.

Solutions

Solving the multifaceted problem of achieving parity will require government, providers, group health plans, states, and other entities to work better together. Congress and the relevant agencies must strengthen and enforce the existing 2008 MHPAEA law, and must provide states with adequate support to oversee, monitor, and enforce parity at the state level. First Focus on Children supports lifting the voices of children and youth and empowering parents who face barriers in finding and paying for care for their children. Efforts to investigate consumer complaints about denials of services and/or network adequacy issues are important to children and families.

Our ability to address the youth mental health crisis in this country hinges in part upon parity. Achieving parity will require: network adequacy; a diverse and increased number of workforce professionals and non-professionals; fair reimbursement rates; consumer empowerment and education; and better oversight and enforcement of insurance companies.

We agree with Chairman Wyden on a three-pronged approach of oversight, greater transparency and enforcement to ensure these network directories are more accurate and reliable for consumers. Only when our nation's children and youth can access affordable, high-quality behavioral health services in a timely fashion—a standard we apply to the rest of their health care—will we reduce their rates of anxiety, depression, suicide, and substance use and offer them a brighter, healthier future.

Thank you for your leadership on mental health issues and for your commitment to ensuring the good health and well-being of all children. First Focus on Children looks forward to working with you and your staff. Please feel free to contact me at BruceL@firstfocus.org, or Elaine Dalpiaz at ElaineD@firstfocus.org, or Averi Pakulis at AveriP@firstfocus.org with any questions.

Sincerely,

Bruce Lesley
President

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May 17, 2023

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

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

The Legal Action Center, Center for Medicare Advocacy, and Medicare Rights Center commend the Senate Finance Committee for its leadership on improving access to mental health care and for convening the May 3rd hearing on "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks."

The Legal Action Center (LAC) is a non-profit organization that uses legal and policy strategies to fight discrimination, build health equity, and restore opportunity for people with arrest and conviction records, substance use disorders, and HIV or AIDS. LAC works to expand access to substance use disorder and mental health care through enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act) in public and private insurance, including our Medicare Addiction Parity Project, which seeks to improve access to substance use disorder treatment in Medicare in a comprehensive and equitable manner.[1] The Center for Medicare Advocacy (the Center) is a national, non-profit, law organization that works to advance access to comprehensive Medicare coverage, health equity, and quality health care for older people and people with disabilities. Founded in 1986, the Center focuses on the needs of people with longer-term and chronic conditions. The organization's

[1] "Medicare Addiction Parity Project," Legal Action Center, *https://www.lac.org/major-project/mapp.*

work includes legal assistance, advocacy, education, analysis, policy initiatives, and litigation of importance to Medicare beneficiaries nationwide. Our systemic advocacy is based on the experiences of the real people who contact the Center every day. Headquartered in Connecticut and Washington, DC, the Center also has attorneys in CA and MA. The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Our organizations appreciate the opportunity to provide a statement for the record.

A. Ghost Networks and Provider Directories

Our organizations strongly agree with the Chairman's remarks, that "when insurance companies host ghost networks, they are selling health coverage under false pretenses." We further agree that eliminating ghost networks will require more audits, greater transparency, and stronger consequences for insurance companies that are providing false or incorrect information to their enrollees. We urge Congress to **pass Senator Wyden and Senator Bennet's "Mental Health Care for Americans Act," which would require accuracy and transparency in Medicare Advantage provider directories and audits by the Secretary,** in addition to other critical provisions to require Parity in Medicare Advantage and Part D plans as well as fee-for-service Medicaid.

As noted in the testimony by Mental Health America, provider directory requirements alone are not enough. We recommend the Committee establish strong compliance and enforcement provisions for maintaining accurate provider directories. Respectfully, we believe incentives should not be needed for Medicare Advantage plans for this purpose. Our government is paying these private health plans billions of dollars to provide medically necessary care to older adults and people with chronic disabilities, they are failing to do so, and they should not be given incentives to do the job they are contracted to do. As noted by each of the witnesses, inaccurate provider directories prevent consumers from making informed decisions about which health plan to select, lead to a delay in care—that may result in abandoning care altogether—that is disproportionately harmful to people with mental health conditions and substance use disorders, and result in unnecessary additional costs to consumers who are forced to go out-of-network because the networks are inadequate to meet their needs. Our organizations urge Congress and the Centers for Medicare and Medicaid Services (CMS) to **hold Medicare Advantage plans accountable through sufficient penalties when they both fail to provide medically necessary services to their enrollees and when they misrepresent or falsify information to individuals and the federal government by putting forth inaccurate network directories.**[2]

The Senate Finance Committee majority staff and witnesses highlighted findings from secret shopper surveys, demonstrating their usefulness in assessing the accuracy of provider directories and determining whether patients are truly able to get appointments in a timely manner. As noted by Senator Menendez, CMS recently proposed a rule that would require an independent entity to conduct annual secret shopper surveys of Medicaid managed care organizations for provider directory accuracy for outpatient mental health and substance use disorder providers, as well as several other provider types.[3] We applaud CMS for this proposal and urge Congress **to establish consistency across health plans and financing systems and require comparable independent secret shopper survey requirements in Medicare Advantage and commercial insurance plans.**

We appreciate Ranking Member Crapo's and many of the Senators' comments on the importance of telehealth in expanding access to mental health and substance use disorder care. We concur that telehealth offers a critical opportunity to bring culturally and linguistically effective treatment to more people, especially during the ongoing workforce crisis. We strongly urge Congress to **make permanent the telehealth flexibilities that were established during the COVID–19 pandemic,** especially where telehealth can be used to fill in gaps in mental health professional shortage areas and counties in which consumers have limited or no access to prescribers of medications for opioid use disorder and other substance use disorder providers. However, we believe telehealth should supplement in person care, not re-

[2] *See* 42 U.S.C. 1395w–27(g)(1)(A) and (E).

[3] "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," Centers for Medicare and Medicaid Services (CMS), 88 Fed. Reg. 28092, 28101–02 (proposed May 3, 2023).

place it. Many individuals still prefer in-person care, a hybrid model of care, or telehealth only when it is delivered by an in-state provider who is familiar with all the local resources and referrals. With this in mind, CMS has articulated in its proposed rule for Medicaid that it is "appropriate to prohibit managed care plans from meeting appointment wait time standards with telehealth appointments alone," as doing so would mask whether the appointments being offered by providers are "consistent with expectations and enrollees' needs."[4] Thus, as Congress considers provider directory and network adequacy standards, we recommend **requiring all Medicare Advantage provider directories to identify the delivery modality providers use and limit the counting of telehealth visits to meet appointment wait time standards or, at a minimum, report telehealth utilization separately, consistent with Qualified Health Plans and with CMS's proposal for Medicaid managed care organizations.**[5]

B. Network Adequacy

Our organizations also concur with the American Medical Association's testimony and Senator Warren's statements that provider directory inaccuracies often mask another significant problem: inadequate networks that are unable to serve the needs of the plan's enrollees. Medicare Advantage plans must be required to meet network adequacy standards for outpatient mental health and substance use disorder care—both geographic time and distance standards as well as appointment wait time standards—and they must be held accountable for failing to do so. While CMS has developed strong geographic time and distance network adequacy standards for mental health care, it has failed to do so for substance use disorder care.[6] Yet, over 50,000 Medicare Part D beneficiaries experienced an overdose in 2021 at a time when fewer than 1 in 5 of the over 1 million Medicare beneficiaries with an opioid use disorder received medications for opioid use disorder.[7] Furthermore, CMS's recent final rule for Medicare Advantage set an appointment wait time standard for routine visits at 30 business days for mental health and substance use disorder care, even though the final standard in Marketplace plans and the proposed standard in Medicaid managed care plans is 10 business days. Once more, we urge Congress to establish consistent standards across payment systems and **require Medicare Advantage plans to comply with these more appropriate wait time standards to ensure networks are adequate for beneficiaries to access mental health and substance use disorder care.**

As part of improving network adequacy, Congress must consider the payment rates of Medicare Advantage plans and how offering low payment rates or failing to negotiate contributes to the insufficient networks and lack of access to mental health and substance use disorder services. CMS's recently proposed Medicaid/CHIP rule would continue to allow Medicaid managed care organizations to get exceptions from the State for failing to meet timely appointment wait time standards, but it would also add a requirement that States consider the payment rates offered by the managed care organization when granting exceptions, recognizing that these "plans sometimes have difficulty building networks that meet network adequacy standards due to low payment rates."[8] The agency also proposed requiring managed care plans to conduct and submit to the State a payment analysis including paid claims data to assess and compare rates for critical services, including mental health and substance use disorder services, because "a critical component of building a managed care plan network is payment, low payment rates can harm access to care," and "provider payment rates in managed care are inextricably linked with provider network sufficiency and capacity."[9] Our organizations recommend Congress **improve data collection, transparency, and oversight of the payment rates and credentialing processes of Medicare Advantage organizations and ensure that these plans are not using policies and practices that intentionally or**

[4] *Id.* at 28102–03.
[5] *Id.*
[6] "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program," Centers for Medicare and Medicaid Services (CMS), 88 Fed. Reg. 22120, 22168–71 (April 12, 2023).
[7] U.S. Department Health and Human Services, Office of the Inspector General, "Opioid Overdoses and the Limited Treatment of Opioid Use Disorder Continue to be Concerns for Medicare Beneficiaries" (September 2022), *https://oig.hhs.gov/oei/reports/OEI-02-22-00390.pdf.*
[8] "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," Centers for Medicare and Medicaid Services (CMS), 88 Fed. Reg. 28092, 28100 (proposed May 3, 2023).
[9] *Id.* at 28104–05.

in practice limit networks or access to medically necessary care for enrollees.

C. Mental Health Parity and Addiction Equity

The significant access gaps for mental health and substance use disorder care highlighted at this hearing would also be ameliorated by another provision of the Mental Health Care for Americans Act: applying the Parity Act to Medicare Advantage and Part D plans and to Medicaid fee-for-service plans. Among Americans ages 65 and over in 2021, approximately 6.5 million individuals had a mental health condition and over 4.3 million individuals had a substance use disorder.[10] It is unacceptable that millions of Americans lack the anti-discrimination protections in their insurance that are afforded to those in other commercial insurance plans and Medicaid managed care plans. Lack of parity protections translate to inequitable networks of mental health and substance use disorder providers, insufficient coverage of the full scope of needed services, and greater barriers to services including prior authorizations and other utilization management practices. **Our organizations strongly urge Congress to use every available strategy to address America's mental health crisis and the opioid public health emergency by applying the Parity Act to all parts of Medicare and to fee-for-service Medicaid.**

Thank you for your work to reduce barriers to mental health and substance use disorder care. If you have any questions about our statement, please contact Deborah Steinberg at dsteinberg@lac.org.

Sincerely,

Deborah Steinberg	Kata Kertesz	Julie Carter
Senior Health Policy Attorney	Senior Policy Attorney	Counsel for Federal Policy
Legal Action Center	Center for Medicare Advocacy	Medicare Rights Center

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Improving Medicare Advantage Network Accuracy and Adequacy

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to submit a statement for the record on the May 3, 2023, Senate Finance Committee hearing, "Barriers to Mental Health Care: Improving Provider Directory Accuracy to Reduce the Prevalence of Ghost Networks." Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to nearly three million people with Medicare, family caregivers, and professionals.

Based on this experience, we understand the toll inaccurate provider directories can have on people with Medicare and the program. They shift not only a core Medicare Advantage (MA) plan responsibility—network identification—onto enrollees, but also expenses. Affected plan members may have little choice but to pay higher out-of-network rates. While this may come at a substantial personal cost, plans stand to gain. Most policies cover such care less generously than in-network services. Medicare's finances are also impacted, since enrollees who forego care may need more costly interventions later, such as hospital and acute services paid for by Medicare Part A.

From worsening health outcomes to derailing economic security, inaccurate provider directories put enrollees at risk. For many, the challenges begin as early as their Medicare enrollment.

On our National Consumer Help line, we frequently hear from people struggling to navigate the complex Medicare enrollment process. Regardless of whether they choose Original Medicare (OM) or MA, they may need help paying for and accessing

[10] Substance Abuse and Mental Health Services Administration (SAMHSA), "2021 National Survey on Drug Use and Health (NSDUH) Detailed Tables," Table 5.4A and 6.1A (January 4, 2023), *https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables.*

care. In our experience, these challenges are more pronounced for MA enrollees. The MA plan landscape is cluttered, and the stakes are high. Often, there is no quick fix if a beneficiary finds their MA plan does not meet their needs because of unexpected or extreme costs, inferior quality, or networks that are too narrow or exclude their chosen providers.

To reduce these risks, MA plans must be high-quality and easy to compare, and beneficiaries must be empowered to select the best plan for their circumstances. We therefore recommend the following reforms to **(I) End Ghost Networks, (II) Support Beneficiary Decision-Making, and (III) Improve MA Networks.**

I. End Ghost Networks

Among MA's network accuracy and adequacy problems are so-called "Ghost Networks," in which plans tout access to providers that are not in-network, accepting patients, clinically active, or otherwise meaningfully available.

MA ghost networks are typically the result of inaccurate provider directories. Though intended to be a useful decision-making resource, directories are frequently incorrect. For example, a 2018 CMS report found that 52% of physician listings in MA provider directories contained at least one inaccuracy. Typical errors included wrong phone numbers, errantly listing in-network providers as accepting new patients when they were not, and omitting in-network providers from directories.[1]

Provider directory inaccuracies thwart informed decision-making by obscuring the reality of MA plan networks, undercutting beneficiaries from the start. MA enrollees are advised to review their coverage each year. Some use CMS's primary consumer-facing tool, Medicare Plan Finder, to search for available plans, while others may work with brokers or plan entities. These searches can yield a dizzying number of options. For 2023, on average, beneficiaries had access to 43 MA plans, more than twice as many as in 2018.[2] Plans can vary on everything from costs to coverage, sometimes in subtle but important ways. For most beneficiaries, this makes close analysis both critical and impracticable.

Inaccurate provider directories only compound these comparison difficulties. As discussed during the hearing, directories may list providers who are in-network but not accepting new patients promptly or at all, as well as those who are not meaningfully available due to geographic or transportation barriers. They may also make contacting potential providers impossible due to outdated information, such as incorrect phone numbers and addresses. Uncovering and verifying the truth can take significant time and cause considerable stress. It also forces providers to field time-sensitive consumer inquiries about network participation and availability, creating additional administrative burdens.

When beneficiaries make good faith coverage choices in reliance on incorrect provider directories, the effects can be devastating. Some enrollees discover too late that their plan's network is too small, of low quality, or geographically distant—making care difficult to find, access, and afford. Others may enroll in a plan thinking their preferred provider is in-network or that needed care will be covered, only to learn otherwise after receiving a higher-than-expected bill.

Consider a recent Medicare Rights client, Ms. P, a 32-year-old Medicare enrollee with cardiac issues. Ms. P had a high-risk pregnancy. Since her MA plan's network did not include the cardiac specialists she needed, it was required to cover these services from out-of-network providers. After confirming this and seeing the specialists, her plan refused to pay. This caused Ms. P significant stress, leading to a panic attack while pregnant. Further, because she was unable to afford the excessive medical bill, it was sent to collections, saddling her with debt.

Another client, Ms. M, is 73 and has two stage 4 cancers. Seeking a mental health provider for assistance with end-of-life issues, she called every provider listed in her MA plan's network directory but could not contact many. Of those, few were accepting new patients, willing to see her, or otherwise available. She finally found a therapist and got the help she needed—until that doctor was suddenly no longer in the plan's network. Unable to afford the more costly out-of-network rates, Ms. M had to stop seeing her mental health provider. She has not yet found a new doctor.

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[1] Michael S. Adelberg, et al., "Improving the Accuracy of Health Plan Provider Directories," The Commonwealth Fund (June 7, 2019), *https://www.commonwealthfund.org/publications/journal-article/2019/jun/improving-accuracy-health-plan-provider-directories.*

[2] Meredith Freed, et al., "Medicare Advantage 2023 Spotlight: First Look" (November 10, 2022), *https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.*

These problems are widespread. As Chairman Wyden highlighted during the hearing, Senate Finance Committee staff operating as "secret shoppers" could successfully make appointments only 18% of the time.[3] More than 80% of the listed providers "were either unreachable, not accepting new patients, or not in-network." Similarly, Dr. Robert Trestman's written testimony previews a forthcoming *Psychiatric Services* investigation in which secret shoppers could schedule appointments with psychiatrists 11% of the time.[4] Nearly 20% of the phone numbers were wrong and over a quarter of the doctors were not accepting new patients.

Typically, there is little recourse available. Impacted enrollees may be stuck with their ill-fitting plan until the next open enrollment window. And because provider directory errors persist in the interim, finding care may remain a struggle.

Recommendation

- *Make MA Provider Directories Accurate*—The Medicare Rights Center urges immediate action to address the long-standing problem of inaccurate MA provider directories.[5] This misinformation derails thoughtful coverage choices and access to care. It also prevents the Centers for Medicare and Medicaid Services (CMS) from conducting proper oversight, as insufficient data may hide non-compliance with network adequacy and other requirements. We recommend requiring accurate provider directories without delay, imposing financial penalties on plans for non-compliance, and holding beneficiaries harmless for any enrollment decisions they may make in reliance on provider directory-contained misinformation.

II. Support Beneficiary Decision-Making

Most people new to Medicare are automatically enrolled because they are receiving Social Security when they become eligible, but a growing number are not.[6] These individuals must enroll on their own, considering specific timelines, intricate Medicare rules, and any existing coverage. Mistakes are common and carry serious consequences, including lifelong financial penalties, high out-of-pocket health care costs, disruptions in care continuity, and gaps in coverage.

People who choose MA face an additional hurdle: the plan selection process. As noted above, it is recommended that enrollees review their coverage options annually. But doing so can be complicated and intimidating, deterring engagement. Identifying and comparing dozens of plans and their exponential deviations, year after year, is a challenging and time-consuming task that few people with Medicare perform;[7] even fewer switch plans from one year to the next.[8] This inertia, and any underlying sub-optimal plan choices, can have detrimental and unanticipated results, like higher costs and problems accessing preferred providers. Enrollees who arguably have the most at stake—those who are older, have lower incomes, or have serious health needs—are also the least likely to review and change their coverage.[9]

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[3] Senate Finance Committee, "Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), *https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.*

[4] Robert Trestman, "Statement to the 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), *https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf.*

[5] *See, e.g.,* Centers for Medicare and Medicaid Services, "Online Provider Directory Review Report" (March 2018), *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf*; Centers for Medicare and Medicaid Services, "Online Provider Directory Review Report (January 2018), *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf.*

[6] *See, e.g.,* Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), *http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

[7] *See, e.g.,* Meredith Freed, et al., "More Than Half of All People on Medicare Do Not Compare Their Coverage Options Annually," Kaiser Family Foundation (October 29, 2020), *https://www.kff.org/medicare/issue-brief/more-than-half-of-all-people-on-medicare-do-not-compare-their-coverage-options-annually/;* Wyatt Korma, et al., "Seven in Ten Medicare Beneficiaries Did Not Compare Plans Past Open Enrollment Period," Kaiser Family Foundation (October 13, 2021), *https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/.*

[8] *https://www.kff.org/medicare/issue-brief/medicare-beneficiaries-rarely-change-their-coverage-during-open-enrollment/.*

[9] *Id.*

Recommendations

- *Update Medicare Plan Finder*—Beneficiaries are often confused about the differences between plans or how to compare them and lack sufficient tools and support for confident decision-making.[10] CMS can begin to address this by improving Medicare Plan Finder. Priority upgrades should include integrating accurate plan network information to enable beneficiaries to search by provider, individual claims history, more realistic and predictive estimated costs, and more information about supplemental benefits, like coverage and eligibility limits.[11]
- *Ensure Beneficiary-Centered Materials*—We also support updates to materials explaining the differences between OM and MA, and the trade-offs of each, to better reflect beneficiaries' primary considerations. For example, one of the most vital decision points for many is provider choice. Most MA plans have ever-shifting networks that may exclude one's provider at any given time, but this may not be well or widely understood. Even when it is, as discussed, discovering what providers are in network can be difficult.[12] As a result, MA enrollees are at risk of losing—or never even having—access to their preferred provider. Few resources make this plain, or that post-enrollment relief is limited.
- *Individually Tailor the Annual Notice of Change*—CMS should require MA plans to provide all enrollees a tailored Annual Notice of Change (ANOC). The individualized notice should be based on claims data and clearly describe how the enrollee's plan and costs will change, if at all, in the coming year. This includes listing any of the individual's providers who will no longer be in network, any prescription drugs that will no longer be on the plan's formulary (for MA–PD plans), and new applications of utilization management tools.
- *Support Enrollment Counselors*—We urge greater investments in State Health Insurance Assistance Programs (SHIPs). For many beneficiaries, SHIP counselors are their sole source of objective, highly trained, one-on-one, Medicare counseling. Despite surging Medicare enrollment and an increasingly complex coverage landscape, the SHIP program remains woefully underfunded. The FY 2023 level of $55.2 million is out of step with growing needs. If this investment had kept pace with population shifts and inflation over the past decade, it would exceed $80 million. We support increasing funding to at least this amount ($80 million) in FY 2024.
- *Modernize Notification and Outreach*—CMS and the Social Security Administration (SSA) should alert people approaching Medicare eligibility about important rules and deadlines. As documented by MedPAC, such notice could help prevent harmful enrollment errors, like lifetime financial penalties[13] and harmful gaps in coverage.[14] But today, no such notice exists. The bipartisan BENES 2.0 Act would correct this.[15] In so doing, it would advance the goals of the original BENES Act. Also bipartisan, CMS finalized its implementing rules this year, updating Medicare enrollment for the first time in over 50 years to end lengthy waits for coverage and align Special Enrollment Period (SEP) flexibilities across the program.[16] We similarly support strengthening remedies for mistaken enrollment delays, including through access to these SEPS and equitable relief.

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[10] National Council on Aging, "The Modernizing Medicare Plan Finder Report" (April 2018), *https://www.ncoa.org/public-policy-action/health-care/better-coverage-choices/medicare-plan-finder-report/*.

[11] Medicare Rights Center, "2019 Medicare Plan Finder Review" (September 18, 2019), *https://www.medicarerights.org/policy-documents/comments-2019-medicare-plan-finder-review.*

[12] Centers for Medicare and Medicaid Services, "Online Provider Directory Review Report," (November 28, 2018), *https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf.*

[13] In 2021, nearly 800,000 people were paying a Part B Late Enrollment Penalty. The average amount increased their monthly premium by nearly 30%. *See* Congressional Research Service, "Medicare Part B: Enrollment and Premiums" (May 19, 2022), *https://www.everycrsreport.com/files/2022-05-19_R40082_143a23f28239eec6ef87bac952856d5a14d0a22e.pdf.*

[14] Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2019), *http://www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.*

[15] S. 3675, *https://www.congress.gov/bill/117th-congress/senate-bill/3675?s=1&r=43.*

[16] Medicare Rights Center, "Medicare Rights Center Welcomes Passage of Key BENES Act Provisions" (December 22, 2020), *https://www.medicarerights.org/media-center/medicare-rights-welcomes-passage-of-key-benes-act-provisions.*

- *Update Enrollment Infrastructure*—Medicare Rights strongly supports the recently proposed Medicare enrollment improvement pilot. This initiative would also further the goals of the BENES Act, by allowing SSA and CMS to work together to identify enrollment barriers and solutions, including for those who are not already collecting Social Security, and to explore opportunities to eliminate remaining post-enrollment coverage lags, such as the requirement to wait for a mailed Medicare card before connecting with one's earned benefits.[17]

III. Improve MA Networks

Even the best provider directory is only as effective as the network it captures. Here too, reforms are needed. Overly narrow MA networks can make care harder to find, access, and afford. This is especially true for mental health and substance use disorder (SUD) treatment.[18] On average, MA plan networks included only 23% of psychiatrists in a county—a smaller share than for any other physician specialty—and nearly 40% of plans had less than 10%.[19] By comparison, though psychiatry has the highest opt-out rate from OM of all medical specialties, only 7.5% of psychiatrists have done so.[20]

More broadly, a 2015 U.S. Government Accountability Office (GAO) report found "CMS's oversight did not ensure that MAO networks were adequate to meet the care needs of MA enrollees."[21] In June 2022, GAO testified that its recommendations to address these issues "had not yet been fully implemented."[22] Rule changes in the intervening years further diluted this critical protection.[23]

Recommendations

- *Strengthen Network Adequacy Rules*—We support rescinding the May 2020 rule changes that weakened network adequacy requirements and further improving consumer protections by requiring MA plans to demonstrate they can meet enrollee care needs before they are permitted to offer plans in the area.[24] If a plan does not have enough providers in network to realistically serve enrollees in a geographic area, then CMS should not allow the plan to operate in that region. The solution to inadequate plan networks is not for CMS to lower the bar.
- *Address Supplemental Benefits*—We also recommend establishing network adequacy requirements for supplemental benefits. Without this basic guardrail, there is no way to measure plan capacity to deliver promised benefits.
- *Ensure Meaningful Provider Availability*—Network adequacy standards must consider a provider's in-network status and their meaningful availability. We specifically support the adoption of two additional quantitative metrics: (1) the number of providers and facilities within a given specialty that have submitted a claim over a certain period, such as six months; and (2) the number of providers that are accepting new patients. Plan submission and CMS verification of these data points would better protect enrollee access to care.
- *Capture Timeliness*— Similarly, the existing metrics for MA network adequacy fail to capture whether timely care is available. To address this, we support aligning MA wait time standards with those that will apply to Marketplace plans beginning in 2024; similar timelines were recently proposed for Medicaid

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[17] *See, e.g.,* U.S. Department of Health and Human Services, "Fiscal Year 2024 Budget in Brief," page 8, *https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf;* and The Office of Management and Budget, "Budget of the U.S. Government Fiscal Year 2024," page 52, *https://www.whitehouse.gov/wp-content/uploads/2023/03/budget_fy2024.pdf.*

[18] Daria Pelech, et al., "Medicare Advantage and Commercial Prices for Mental Health Services," *Health Affairs* (February 2019), *https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05226.*

[19] Gretchen Jacobson, et al., "Medicare Advantage: How Robust Are Plans' Physician Networks?", Kaiser Family Foundation (October 5, 2017), *https://www.kff.org/report-section/medicare-advantage-how-robust-are-plans-physician-networks-report/.*

[20] Nancy Ochieng, "Most Office-Based Physicians Accept New Patients, Including Patients With Medicare and Private Insurance," Kaiser Family Foundation (May 12, 2022), *https://www.kff.org/medicare/issue-brief/most-office-based-physicians-accept-new-patients-including-patients-with-medicare-and-private-insurance/.*

[21] U.S. Government Accountability Office, "Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy" (August 31, 2015), *https://www.gao.gov/products/gao-15-710.*

[22] U.S. Government Accountability Office, "Medicare Advantage: Continued Monitoring and Implementing GAO Recommendations Could Improve Oversight" (June 28, 2022), *https://www.gao.gov/products/gao-22-106026.*

[23] 85 FR 33796, 33855.

[24] *Id.*

managed care plans.[25] Accordingly, we were disappointed that in the 2024 C&D rule, CMS instead set a wait time standard at 30 business days for routine mental health and SUD care—well beyond the 10 business day standard for Marketplace plans and under consideration in Medicaid.[26] Once more, we urge policymakers to establish consistent standards across payment systems and to require MA plan compliance.

- *Promote Network Stability*—MA enrollees must be able to count on stability in their plan networks and the knowledge that their doctors will be there when they need them. We urge CMS to work with plans to minimize the practice of dropping doctors without cause in the middle of the plan year. When such changes are necessary, affected enrollees must receive adequate notice and relief, including access to a Special Enrollment Period.
- *Reduce Provider Burden*—As Dr. Jack Resneck noted in his testimony, providers face significant administrative burdens, most notably compliance with MA prior authorization requirements: "Practices are completing 45 prior authorizations per week per physician, adding up to two business days per week spent on prior authorization alone." He further explains this requires "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."[27] We urge a reduction in the services subject to prior authorization—such as prohibiting repeated prior authorization during a course of treatment—as well as better oversight and enforcement to ensure existing guardrails—like the requirement to cover all OM services—are effective. These reforms would improve enrollee access to care by minimizing unnecessary waits for coverage and reducing provider burdens in a way that could lead to increased network participation.

Thank you for your bipartisan consideration and leadership. These are critical issues for millions of Americans. The Medicare Rights Center looks forward to continued collaboration on improving health care access and affordability.

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May 1, 2023

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Bldg.
Washington, DC 20510–6200

Dear Chairman Wyden and Members of the Senate Committee on Finance:

For the first time in my life, I needed mental health treatment and could not get it. In May of 2020, at the onset of the pandemic, I began to lose ground in my recovery from clinical depression. Work became more difficult. I could not taste food, feel music, sleep soundly, or experience pleasure. Life lost its color again and returned to shades of gray. Like most people who need healthcare, I consulted my insurer's provider directory to find a psychiatrist. One by one, going down the list, I called

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[25] 87 FR 27208, 27329.
[26] 88 FR 22120.
[27] Jack Resneck, "Statement to the 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), *https://www.finance.senate.gov/imo/media/doc/Jack%20Resneck%20MD%20Statement%20to%20Finance%20Cmt%20on%20Behalf%20of%20AMA%20Re%20Provider%20Directories%202023-5-3.pdf.*

office after office. Some were no longer accepting my insurance or new patients. Others were booking six months out. Hoping to address the depression before it worsened, I booked a telemedicine appointment with my primary care physician (PCP), who gave me a prescription for an antidepressant.

It worked out for the most part. Six months later, when I was finally able to see a psychiatrist, he changed the dosage and timing of my medication to improve my sleep. PCPs are well intentioned, but they are not mental health experts. If this were my first episode of depression, or if I had a complicated illness or more than one mental illness, my PCP might not have been able to accurately diagnose and treat me. Just as patients with heart conditions see cardiologists, people with mental illness need a psychiatrist who understands the complexities of mental illness and psychotropic medications.

My experience is not unique. Many patients face similar barriers when trying to access care. It is common practice for insurers to assemble "ghost networks" of providers who are licensed to practice in the state but are not actually part of the insurance network, or are in-network but are not taking new patients. Inadequate networks are caused by multiple factors. One significant and correctable factor is stagnant and low reimbursement rates, which make it difficult for providers to keep up with the rising costs of keeping their practices or centers open. As a result, providers move their practices out of state where rates are higher, switch jobs frequently, or stop participating in insurance networks. Some have permanently closed their doors.

Insurance companies have tremendous power in our country. They typically threaten to raise the cost of premiums whenever the government attempts to rein them in. Requiring insurers to pay reimbursement rates that keep up with the cost of inflation is not likely to drive up the cost of premiums. The cost of commercial insurance premiums is influenced by a number of factors, such as the utilization rate of outpatient services, inpatient hospitalization, and emergency departments (the last two being the most expensive levels of care); the rising cost of prescription medications; pharmacy benefit managers; hospitals' administrative costs; insurers' administrative costs; and more. It is unfair to single out providers who want to be paid fairly, or consumers who want timely access to care, as the main cost drivers in a complicated system.

On the contrary, raising reimbursement rates may, in fact, reduce the cost of premiums. Higher rates will help insurers attract and retain providers in their networks. A robust provider network will increase access to timely outpatient mental and behavioral health services. Early intervention improves patient outcomes and saves money in the long term. When patients access treatment in a timely fashion, their conditions stabilize or improve, thus decreasing the utilization of restrictive and expensive emergency departments, inpatient hospitals, and residential treatment centers. This, in turn, reduces insurers' costs, and that reduction in their costs should be reflected in lower premiums.

The Kaiser Family Foundation reports that in the spring of 2022, 19.9% of adult Rhode Islanders had symptoms of depression and anxiety and an unmet need for counseling and or therapy.[1] Patients suffer when there are not enough providers. As we wait for care, our conditions worsen sometimes to the point of a life-threatening crisis.

We respectfully urge this Committee to prevent insurers from assembling "ghost networks." We encourage you to examine the role of unfairly low reimbursement rates on patients' access to care.

Thank you for your consideration.

Respectfully,

Laurie-Marie Pisciotta
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[1] *https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/rhode-island/*.

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I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly NABIP, a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NABIP help millions of individuals and employers of all sizes purchase, administer, and utilize health plans of all types.

The health insurance agents and brokers that NABIP represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that are best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees [1] and 84 percent of people shopping for individual exchange plans found brokers helpful—the highest rating for any group assisting consumers.[2] During the 2023 open enrollment period, agents and brokers assisted 71 percent of those who enrolled through *HealthCare.gov* or a private direct enrollment partner's website. Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.[3] Consequently, the NABIP membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

Access to mental health services is a crucial component of healthcare. National discussion has addressed mental healthcare for years, but often focuses more on physical health. The COVID–19 pandemic has reminded us of the importance of adequate mental healthcare and exposed a mental health crisis: About 4 in 10 adults in the U.S. reported symptoms of anxiety or depressive disorder during the pandemic, a share that has been largely consistent, up from one in ten adults who reported these symptoms from January to June 2019.[4] For these reasons it is more vital than ever that consumers can access and afford mental and behavioral health services.

Unfortunately, a lack of network adequacy has proven a substantial barrier for consumers seeking mental and behavioral health services. While attempts have been made to make improvements in this area, there is still a significant amount of ground to cover. Often it is difficult for patients to locate a provider that accepts insurance at all, much less participates in their insurer's network. If a provider does participate, that participation may not be consistent. For example, it is possible that an insurer's in-network provider directory implies a specific plan is accepted by the provider in question, when in reality the provider accepts only certain iterations of the plan (such as the PPO and not the HMO).

Directories that appear accurate only to include providers that are not actually in-network or are not accepting new patients are commonly referred to as "ghost networks." Inaccurate or out-of-date information on which mental health providers are in a health plan's network contributes to ongoing access issues for consumers and often compels consumers to obtain out-of-network care at higher costs. A 2020 survey of privately insured patients found that 53 percent of consumers that used provider directories found inaccuracies in their insurer's provider directory, often leading them to receive care from out-of-network providers.[5] Additionally, the GAO reported in 2022 that the problem of ghost networks in mental healthcare worsened

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[1] Kaiser Family Foundation. Employee Health Benefits Annual Survey. October 2013, *https://www.kff.org/wp-content/uploads/2012/09/8465-employer-health-benefits-2013.pdf.*

[2] Blavin, Fredric, et al. Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources. Urban Institute. June 2014, *https://hrms.urban.org/briefs/obtaining-information-on-marketplace.html.*

[3] Karaca-Mandic, Pinar, et al. The Role of Agents and Brokers in the Market for Health Insurance. National Bureau of Economic Research. August 2013, *https://www.nber.org/papers/w19342.*

[4] Kaiser Family Foundation. Adults Reporting Symptoms of Anxiety or Depressive Disorder During COVID–19 Pandemic. 27 September 2021, *https://www.kff.org/other/state-indicator/adults-reporting-symptoms-of-anxiety-or-depressive-disorder-during-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[5] Busch, S. and Kyanko, K. Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills. *Health Affairs.* June 2020, *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.*

during the pandemic, as providers left their positions or stopped taking new patients due to overload.[6]

With these statistics in mind, it is crucial that Congress address the prevalence of ghost networks and create stronger enforcement standards to protect those seeking mental health services. NABIP believes that the maintenance of reliable network directories should be a shared responsibility between the providers and the insurance carriers, as both entities have the information required to properly preserve the list and prevent networks from becoming ghost networks. However, while the employer is often lumped into regulatory conversations regarding mental health services, it is important to note that they do not have direct control over plan networks and should not be burdened with additional compliance concerns.

The relevant regulatory bodies have already erroneously encumbered employers with mental health parity standards. The Consolidated Appropriations Act of 2021 (CAA) mandated that employers offering medical, surgical, and mental health and substance use disorder coverage provide comparative analyses and relevant supporting documentation demonstrating compliance with mental health parity requirements to the Department of Labor upon request. Both fully insured and self-funded ERISA plan sponsors are required to comply with the quantitative treatment limits imposed by the Mental Health Parity Act. Complying with the CAA mandates and in particular the non-quantitative treatment limits reporting is challenging for many employers, who, because of their size, must rely on their intermediaries such as third-party administrators to monitor and comply with network adequacy requirements for access to mental and behavioral health care.

In the event of a Department of Labor request, these employers often will need to work with legal counsel to identify treatment limitations and contact multiple providers to request information necessary to complete comparative analyses. This makes compliance particularly difficult for employers who already face other compliance requirements relating to the plans they sponsor for employees. In 2022, the Department of Labor, Department of Health and Human Services, and Department of the Treasury released the first Annual Report to Congress on the Mental Health Parity and Addiction Equity Act. Out of the 216 NQTL analyses reviewed by DOL and 21 NQTL analyses reviewed by CMS, none were found to meet regulators' expectations—highlighting the difficulty that employers have in their efforts to comply.[7]

While action must be taken to ensure that carriers' mental health provider directories are accurate, placing the regulatory obligation on employers when they do not have direct control over the directories would be in error and prove as burdensome as mental health parity requirements. Small employers in particular would struggle to be in compliance with new mental health network adequacy requirements, as they would still rely on third-party administrators to monitor and comply with these network requirements as well. NABIP supports proposals that better enforce mental health network adequacy without needlessly penalizing employers who are working to provide such benefits to their employees.

Mental health services are up to six times more likely than other medical services to be delivered by an out-of-network provider, in part because so many mental health providers do not accept commercial insurance.[8] NABIP recommends that Congress consider incentives to encourage providers to participate in network plans including plans that use mental health carve-outs, as well as increase incentives for plans with mental health carve-outs to contract with willing mental health providers. We also recommend increasing incentives for carriers with mental health carve-out plans to expedite the contracting process and prioritize updating provider lists. The contract negotiation process between carriers and providers is a source of inefficiency, as the process can take a significant amount of time and can add yet another barrier to receiving care.

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[6] Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. March 2022, *https://www.gao.gov/assets/gao-22-104597.pdf.*

[7] 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage. January 2022, *https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf.*

[8] Busch, S. and Kyanko, K. Incorrect Provider Directories Associated with Out-of-Network Mental Health Care and Outpatient Surprise Bills, *Health Affairs.* June 2020, *https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501.*

Switching focus from network adequacy to the shortage of mental health providers themselves, 119 million Americans live in areas designated as mental health professional shortage areas—despite the clear need for mental health services across the country.[9] In addition to contributing to challenges consumers face in finding in-network providers, representatives from 17 of the 29 stakeholder organizations that the GAO interviewed in 2022 indicated that workforce shortages have contributed to constraints on overall capacity of the mental health system.[10] Recent American Academy of Pediatrics data also shows that there are, on average, just 9.75 child psychiatrists per 100,000 children, and child psychiatrists are disproportionately located in larger urban centers; more than two-thirds of U.S. counties don't have even a single child psychiatrist.[11] According to the Health Resources & Services Administration, an additional 6,586 providers would be needed to bridge the gap for consumers living in these shortage areas.[12]

The workforce shortage is not only an issue in the mental and behavioral health sphere. The United States could see an estimated shortage of between 37,800 and 124,000 physicians by 2034, including a shortfall of between 17,800 and 48,000 primary care physicians.[13] Prior to the COVID–19 pandemic, physician shortages were already evident, with 35 percent of voters in 2019 saying they had trouble finding a doctor in the previous 2 or 3 years; this was a 10-point jump from when the question was asked in 2015.[14] To enhance Americans' access to mental and behavioral health care, strengthening both the mental health and primary care workforce must be a top priority. NABIP supports workforce development and training programs that aim to increase the amount of mental health and primary care professionals.

Strengthening the workforce of both mental health and primary care providers is vital, as a further source of inefficiency impeding Americans' access to mental and behavioral health is the lack of communication between behavioral health and primary care providers. Approximately two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services.[15] Since mental and behavioral health is often not integrated with primary care, this leaves patients with undiagnosed or poorly managed mental and behavioral health conditions, even though mental and behavioral health conditions often initially appear in a primary care setting. Currently, primary care clinicians provide mental health and substance use care to many people with mental and behavioral disorders and prescribe most psychotropic medications.

Outside of workforce issues, state licensure requirements and cross-state-border restrictions also remain some of the largest, most complex barriers within the mental health space as well as the telemedicine space broadly. Due to the COVID–19 pandemic CMS, along with a handful of states, decided to relax regulations around telehealth and state-licensure requirements, temporarily waiving requirements for licensure in the state where the patient was located. This added flexibility was of great benefit to patients across the country, particularly mental healthcare consumers. For these reasons, NABIP recommends that Congress look at ways to facilitate reciprocity of state-provided licenses and other ways to ease cross-state-border restrictions on tele-behavioral health and telehealth generally.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NABIP can be of assistance as you move for-

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[9] Kaiser Family Foundation. Mental Health Care Health Professional Shortage Areas (HPSAs). 30 September 2022, *https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[10] Government Accountability Office. Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts. March 2022, *https://www.gao.gov/assets/gao-22-104597.pdf.*

[11] McBain, Ryan, et al. Growth and Distribution of Child Psychiatrists in the United States: 2007–2016. American Academy of Pediatrics. 1 December 2019, *https://publications.aap.org/pediatrics/article/144/6/e20191576/77002/Growth-and-Distribution-of-Child-Psychiatrists-in?autologincheck=redirected.*

[12] Health Resources and Services Administration. Health Workforce Shortage Areas. 1 May 2023, *https://data.hrsa.gov/topics/health-workforce/shortage-areas.*

[13] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. Association of American Medical Colleges. June 2021, *https://www.aamc.org/media/54681/download?attachment.*

[14] *Ibid.*

[15] Cunningham, Peter. Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care. *Health Affairs.* 2009, *https://www.healthaffairs.org/doi/10.1377/hlthaff.28.3.w490.*

ward, please do not hesitate to contact me at either (202) 595–0639 or jtrautwein@nabip.org.

Sincerely,

Janet Stokes Trautwein, CEO

ZOCDOC

https://www.zocdoc.com/

On behalf of the millions of patients and tens of thousands of providers that use Zocdoc every month, thank you for holding this hearing to discuss a barrier to patients' access to care: the prevalence of inaccurate provider directories and ghost networks. We appreciate the Committee's commitment to investigating the issue and learning from experts in the field regarding scalable solutions. As a company that operates an intuitive, accurate, and functional provider directory, our product can offer insight into how we can work together to improve the patient experience.

In particular, through Zocdoc's healthcare marketplace, **we have solved the ghost network problem.** In addition, we have increased provider availability through advanced inventory management that unlocks a hidden capacity for patients to receive care. As the Senate Finance Committee continues its deliberation and considers initiatives to increase access to healthcare, we have the following recommendations:

1. **The proposed CMS National Directory of Healthcare Providers and Services should be an accurate data hub accessible by Application Programming Interface (API) so that third parties can effectively leverage and build upon it.**
2. **Ensure standardization of data requirements, form, and functionality to make it easier for providers to comply.**
3. **Ensure regulatory policies and incentives are aligned to encourage providers to have the most accurate information (not just insurance, but availability, specialty, visit reasons, etc.) and to update that information in an efficient, scalable way.**

About Zocdoc

Zocdoc was founded in 2007 with a mission to give power to the patient. In furtherance of this mission, we operate an online marketplace that enables millions of Americans each month to independently find in-network doctors, see their real-time availability, and instantly book appointments online for in-person or telehealth visits. Our user-friendly service is free to patients, available in all 50 states, and facilitates in-network scheduling for 200+ different specialties across +12,000 different insurance plans.

The Zocdoc Marketplace

By building a true healthcare marketplace over the last 15 years, we are bringing choice, competition, and transparency to the largest and most important consumer service in our country: healthcare. We are building this because the fragmented healthcare industry needs a unifier—a connective tissue that brings together all the participants, technologies, and applications. Unlike other technology-focused entrants in the space, we are not trying to replace the provider, the payor, or the EHR, but rather wrangle all of the underlying complexity in those players to make it easy for patients to find and book in-network care. Users can intuitively research options based on what is most important to them (insurance, reviews,[1] location, availability, etc.), independently select the provider who best suits their needs, and instantly book an appointment online.[2]

In addition to simplifying Americans' healthcare experience, Zocdoc also accelerates access to care. As noted in the hearing, unnecessarily long wait times have a real and lasting impact on patients, especially when they might be experiencing an acute mental health crisis. Overall, the national wait time to see a primary care provider

[1] Zocdoc, "How Reviews Work on Zocdoc," *https://www.zocdoc.com/about/verifiedreviews/*.
[2] Zocdoc, "How Zocdoc Search Works," *https://www.zocdoc.com/about/how-search-works/*.

is 26 days on average when booked over the phone,[3] and these wait times continue to rise.[4]

Zocdoc dramatically expedites patients' access by uncovering the "hidden supply of care," meaning the 20% to 30% of appointments that become available last minute due to cancellations and rescheduled appointments, that would otherwise go to waste.[5] Our marketplace surfaces this hidden appointment inventory in real-time to users who are actively seeking care. In doing so, we accelerate access to care: the typical appointment booked through Zocdoc takes place within 24–72 hours—an order of magnitude sooner than the national average wait.

Beyond reducing wait times for patients, the convenience of booking an appointment at any time of the day is vital to ensuring access to care. On Zocdoc, 37% of all appointments are booked between 5pm and 9am, when a doctor's office is typically closed.[6] Plus, 17% of all appointments are booked on a Saturday or Sunday.[7] The popularity of after-hours booking makes intuitive sense, especially in healthcare, where the impulse to book care often strikes the moment a patient decides they need to see a doctor. Those moments don't always happen during a provider's relatively narrow office hours, and without this access to after-hours booking, families might seek care in ERs for immediate relief, or delay care entirely.

Easy access to healthcare appointment scheduling enables patients to get last-minute care in an appropriate, and often lower-cost setting. Nearly one in five Zocdoc users (19%) who booked a same-day appointment said they may have gone to the emergency room had Zocdoc not facilitated timely access to care.[8] According to a study in the Harvard Health Policy Review, 45% of patients cited access barriers to primary care as their reason for using the emergency room, while only 13% of patients had conditions that required it.[9] Zocdoc enables timely access to care, which is crucial, as emergency room over-utilization has costly impacts on families, providers, and the healthcare system alike.

Zocdoc for Developers

Today, more than a third of patients in the U.S. are referred to a specialist each year, but the vast majority are scheduled over the phone, which is inefficient and untrackable.[10] Providers and payors typically have the choice between a 20+ minute three-way-call or simply passing on a provider's phone number to the patient, which removes the trackability of the encounter and puts the onus on the patient to follow up, creating blind spots for care outcomes and gaps in continuity of care.

With the recent launch of Zocdoc for Developers, Zocdoc's first-ever API, developers can build on top of the same standardized, scalable technology that powers Zocdoc's Marketplace.[11] This has the potential to transform the way providers make and receive referral appointments, close patient care gaps, and more. Our first use case, Care Navigation, empowers physician groups and care coordinators to build tools using our API that allow them to search for availability and directly book a referred patient into a provider's schedule. We look forward to building additional use cases with new partners over time, and having reliable information accessible through the National Directory of Healthcare Providers and Services, as proposed by CMS earlier this year, would be a tremendous boon to those efforts.[12]

As the Committee explores solutions to eradicate ghost networks for the betterment of the patient experience, we urge you to look at private sector

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[3] Merritt Hawkins. Survey of Physician Appointment Wait Times, 2022, *https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Articles/mha-2022-wait-time-survey.pdf.*

[4] *Ibid.*

[5] McKinsey and Company. "Revisiting the access imperative," May 2018, *https://healthcare.mckinsey.com/revisiting-access-imperative.*

[6] Between August 2021 and August 2022

[7] *Ibid.*

[8] Zocdoc. Study: Nearly 3 in 4 Americans Say It's Easier to Go to the ER Than to Get a Doctor's Appointment. September 2019, *https://www.zocdoc.com/about/news/2019-er-report/.*

[9] Harvard Health Policy Review, "Targeting National Emergency Department Overuse: A Case for Primary Care, Financial Incentives, and Community Awareness." 2014, *https://scholar.harvard.edu/files/christinaangienguyen/files/targeting-national-emergency-department-overuse-nguyen.pdf.*

[10] The Milbank Quarterly, Dropping the Baton: Specialty Referrals in the United States. March 2011, *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594/.*

[11] Zocdoc, "Zocdoc for Developers," *http://developer.zocdoc.com/.*

[12] CMS, "Request for Information; National Directory of Healthcare Providers and Services," December 2022, *https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services#footnote-5-p61018.*

solutions that have aligned incentives and continuous accountability structures. We applaud the Committee's bipartisan investigation into the issue and appreciated hearing from the witnesses about the impact of ghost networks on patients, providers, and health systems. We concur that there should be more auditing and penalties for bad actors. We especially agree with Dr. Resnick's comments that standardization of data elements will go a long way in reducing the administrative burdens on providers. Herein we detail how we might be able to work together to build a better patient experience.

Ghost Networks have a negative impact on the patient experience

As the witnesses discussed, accessing healthcare is often a frustrating experience for patients. One of patients' biggest hurdles is not only finding a doctor but also finding one that is in-network and available. When patients search through the years-old provider directories (many of which are stagnant downloadable .pdf files) listed on insurers' sites and start the process of calling around only to find that most providers listed are either no longer in-network or not accepting new patients, they can become disheartened and delay care.

Delayed care is bad for the patient and bad for the economy. According to a study by Harvard Public Health Review, faster care reduces healthcare costs by 51%.[13] When healthcare costs are outpacing rampant inflation, faster access to in-network providers is more important than ever.

Ghost networks do not exist on Zocdoc

We are proud of the fact that ghost networks do not exist on Zocdoc, and the reason is quite simple: Zocdoc incentivizes providers to maintain accurate information. Providers join Zocdoc to reach new patients and they pay a new patient booking fee each time a new patient finds and books an appointment with them through our marketplace. Because they pay a fee for each new patient booking, providers have an interest in advertising themselves accurately to prospective patients. When a provider joins the marketplace, we help them through the process of accurately listing all of their insurances as part of the onboarding process, and have regular touchpoints with providers thereafter to ensure that the information stays accurate.

As discussed at the hearing, ghost networks are able to proliferate because publishers have no incentive to update information, and there is no efficient system to update a stagnant document at the scale and volume needed to be useful for patients. In contrast, Zocdoc's marketplace is more like Wikipedia than Encyclopedia Britannica in that it evolves by the minute, versus being out of date the moment it is published. Providers regularly engage with their Zocdoc account to update insurance information, visit reasons, availability, etc. **This means that providers are not only incentivized to have the most accurate information (not just insurance, but availability, specialty, visit reasons, etc.), but also able to update it in an efficient, scalable way.** A provider's time is valuable, as is each appointment booking, and that's why we make it as easy as possible to list and update accurate information.

Additionally, because we maintain a direct relationship with the provider, we have regular opportunities to double-check the accuracy of the information they've listed. We also have a team dedicated to maintaining the accuracy of this information, so that if a patient reports to us that a provider's information was not correct, we can quickly follow up with the practice to address the discrepancy.

Standardizing data requirements, form, and functionality

Last year, Zocdoc joined hundreds of other organizations to comment on an RFI from CMS seeking input on the potential creation of a National Directory of Healthcare Providers and Services (NDH).[14] We were particularly interested in the types of data that should be publicly accessible from an NDH (either from a consumer-facing CMS website or via an API). As a company that has unique expertise in this space, we strongly recommend that CMS mandates the fewest data inputs required to make this both feasible for providers and useful to stakeholders. The information we recommend mandating to collect is:

- Name
- NPI (if applicable) or Specialty from a dropdown list by license type

[13] Harvard Public Health Review, "The Effect of Delays in Acute Medical Treatment on Total Cost and Potential Ramifications Due to the Coronavirus Pandemic." 2021, *https://hphr.org/26-article-haque/*.

[14] *See* Zocdoc's comments here: *https://www.regulations.gov/comment/CMS-2022-0163-0377.*

- Mailing address for the physical location of the provider's office (rather than billing address)
- Email address
- Phone number for the physical location of the provider's office (rather than billing office)
- Board certifications (if any)

As discussed above, the tens of thousands of providers that utilize Zocdoc are incentivized to have all of their information accurately listed on Zocdoc, as they are leveraging our platform to advertise their services to new, in-network patients they are able to treat. We invest significant capital in making sure this information is accurate to ensure the best experience for both patients and providers. Because the NDH, as described, does not present the same incentives for accurate information from providers, we urged them to operate with a "less is more" approach to the information required. **To help mitigate the preponderance of ghost networks, the focus should be on making the NDH an accurate data hub accessible by API, so that third-parties can effectively leverage and build upon the available information.**

A consolidated directory of provider information can solve fragmentation and inaccuracy of disparate data sources, but only if it is limited to the lowest common denominator of information needed. That way, developers, like Zocdoc, can build on that core, accurate data set.

The creation of an NDH as an open API would allow innovators to build useful tools from accurate, validated data, eliminating the ghost network effect. With that in mind, creating an NDH *without* mandating compliance perpetuates the same problems we are facing today with both the National Plan and Provider Enumeration System (NPPES) and outdated insurance directories that result in the proliferation of the very ghost networks the Committee is investigating.[15] Providers are not incentivized to voluntarily update their information at a national level, but there is an opportunity to leverage the current state-based licensing systems to create a "superset" of data at a national level. **This way, the federal government can play a vital role in building upon and improving the tools that already exist.**

As noted by witnesses, payor penalties for noncompliance and consistent audits can serve as a "stick" to push insurance companies to maintain accurate directories. But Zocdoc offers a model of how policymakers can learn from a "carrot" approach, which incentivizes providers to maintain up-to-date information.

Zocdoc shares the goal of achieving true transparency for patients, empowering them to make informed choices about their care, free from the trap of ghost networks. We remain committed to building tools to get us there. In fact, this is at the core of our daily work pursuing our mission to give power to the patient.

Thank you for the opportunity to provide comments on a potential solution to ghost networks. We would be delighted to expand on our comments or provide any additional information that might be helpful.

Links:

https://developer.zocdoc.com/?utm_medium=organicpro&utm_routing=API_Sender

https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services#p-1

https://hphr.org/26-article-haque/

[15] Testimony of John E. Dicken, Director, Health Care of GAO before the U.S. Senate Committee on Finance, March 30, 2022. "Mental Health Care: Consumers with Coverage Face Access Challenges," *https://www.gao.gov/assets/gao-22-105912.pdf.*