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On Behalf of the

American Psychiatric Association

May 3, 2023

Before the

U.S. Senate Committee on Finance

For a Hearing Entitled

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

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

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

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 percent 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

[2] Butala NM, BTech KJ, Bucholz EM. 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 (healthaffairs.org)

[4] Zhu J, Charlesworth CJ, Polsky D, McConnell KJ. 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

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 six years ago. My former colleagues at the University of Connecticut Health Center told me that patients were calling for two 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 eight to ten 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 out-patient 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 co-payments 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 two 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 five percent of our ambulatory psychiatric care via video 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. Schoolteachers 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 credentialling 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 ½ 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

[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

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 becomes 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

[6] Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement (milliman.com)

[7] Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories, YALE LAW & POLICY REVIEW Microsoft Word - 2_Burman_PE_final_11-30.docx (yale.edu)

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 antidiscrimination 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 reimbursement 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 that we continue work to remove unnecessary

[8] Projected Workforce of Psychiatrists in the United States: A Population Analysis - PubMed (nih.gov)

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.