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% were inaccurate, non-working numbers, or unreturned calls. Staff could only make appointments 18% of the time. Appointment rates varied by plan and state, ranging from 0% in Oregon to 50% in Colorado. More than 80% 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% 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 life-saving. 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

[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.

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]

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, nongroup, 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.

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[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

[3]United States 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 AJB, Spottswood M, Cheng E, Ostrowsky L, Rengifo J, Boyd JW. 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 JW. 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 2014 Oct 31. PMID: 25322445.

[6] Butala NM, Jiwani K, Bucholz EM. 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 JS Jr, Quiggle A, Liu M, Brewster DW. 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 JM, Charlesworth CJ, Polsky D, McConnell KJ. 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).

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% of the identified listings for mental health providers were inaccurate or unavailable. Of the total 120 provider listings contacted: 39 (33%) were non-working 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%) of the listings (Figure 1). Appointment rates varied by plan and state (see Appendix for additional details). More than 80% 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 center, 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%).

[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)

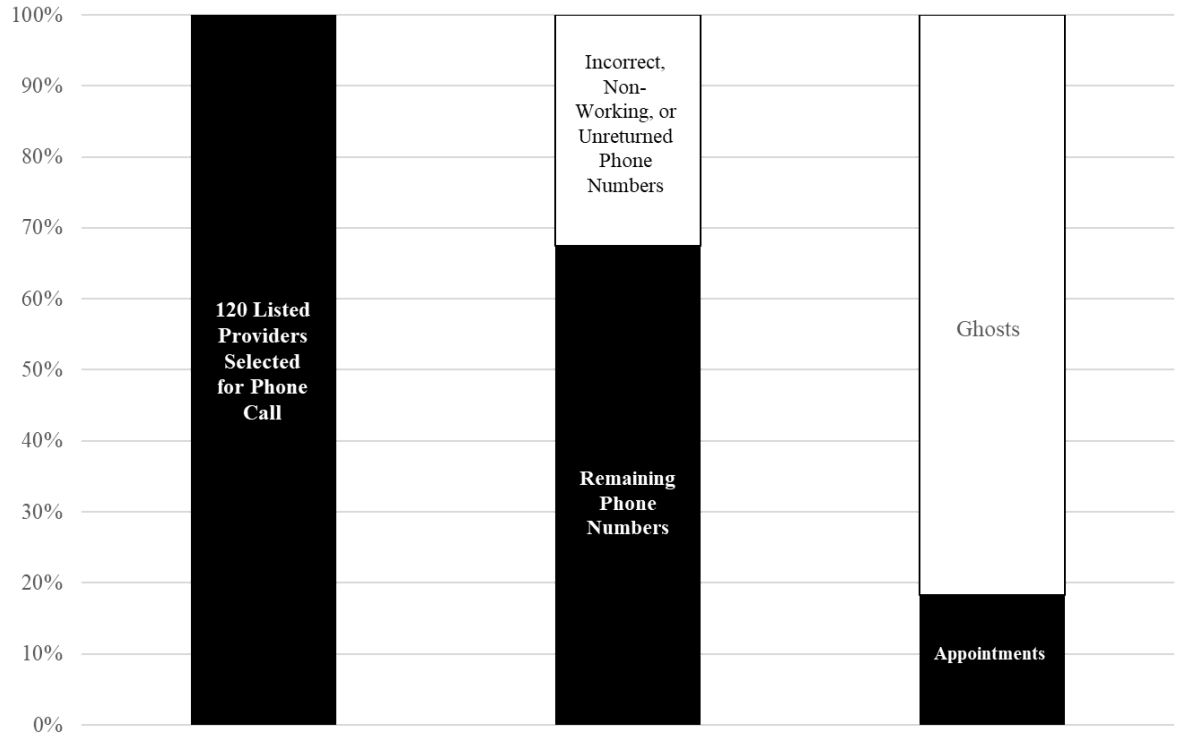

Figure 1. Overall Share of Ghosts in 120 Contacts in MA Health Plan Provider Directories

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 psychiatrists: 26% in Malowney et al and 17% 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% 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.

[12] Malowney M, Keltz S, Fischer D, Boyd JW. 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 2014 Oct 31. PMID: 25322445.
[13] Cama S, Malowney M, Smith AJB, Spottswood M, Cheng E, Ostrowsky L, Rengifo J, Boyd JW. 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.

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 US 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 ten 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?"

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