



*Office of the New York State
Attorney General Letitia James*

Inaccurate and inadequate:

*Health plans' mental health provider
network directories*

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I. Executive Summary

As New York continues to experience a mental health crisis, millions of New Yorkers struggle to access and afford mental health treatment. The Attorney General's recent mental health hearings, complaints filed with the Health Care Bureau Helpline, and survey data show a significant unmet need across the state for mental health services.

New Yorkers rely on health plan provider directories to access affordable, quality health care services. However, when provider directories contain inaccurate listings or unavailable providers — known as “ghost networks” — consumers often cannot access treatment using their health insurance benefits. As a result, they are forced to choose between paying out of pocket if they can or going without treatment, which can harm their health.

Using secret shopper surveys, numerous published studies have confirmed the existence of mental health provider ghost networks. To determine the scope of the problem in New York State, the Office of the Attorney General (OAG) conducted a statewide secret shopper survey of 13 health plans: Aetna, CDPHP, Cigna, Emblem, Empire BlueCross BlueShield, Excellus, Fidelis, Healthfirst, Independent Health, MetroPlus, Molina, MVP, and UnitedHealthcare. Staff reviewed directories from the plans, calling at least 20 providers in major cities served by the plans (New York City, Albany, Buffalo, and for one plan, Rochester). Callers attempted to schedule an appointment for an adult or child with a mental health provider who was listed in the directory as accepting new patients.

The success rate for the 13 health plans surveyed ranged from 0 percent to 35 percent. Of the total 396 providers called across all plans, callers were offered appointments with only 56 providers (14 percent).

Therefore, 86 percent of the listed, in-network mental health providers staff called were ghosts, as they were unreachable, not in-network, or not accepting new patients.

These results are shocking but not surprising, as they confirm what testimony, complaints, and surveys suggest: in-network mental health care is inaccessible to many New Yorkers who need it. The process of navigating a health plan provider directory filled with ghosts is confusing, time-consuming, and often ends in frustration. Expending a great deal of time and effort trying to find an in-network provider in a directory that is 86 percent inaccurate undoubtedly has a negative impact on a person suffering from a mental health condition.

Ghost networks are illegal. New York and federal laws require that health plans maintain accurate provider directories. Ghost networks also suggest violations of laws requiring health plans to maintain adequate provider networks and cover mental health treatment the same way as physical health (“mental health parity”).

This report first describes the enormous unmet need for mental health treatment in New York. More than one million adults and children need mental health treatment but are not getting it. It then briefly summarizes the directory accuracy, network adequacy, and mental health parity laws that are intended to ensure access to treatment. Then it explains how the OAG conducted its secret shopper survey and presents the deeply troubling results. Finally, it provides recommendations.

The OAG's survey confirms the need for regulatory changes, increased enforcement, and significant actions by health plans. New York should:

- » Require health plans to conduct regular audits of their provider networks (including secret shopper studies) to verify compliance with directory accuracy, network adequacy, and mental health parity requirements, and to report the results to regulators, who would make them available on a public website.
- » Mandate robust appointment wait time standards for mental health treatment, so that consumers can promptly get the services they need.
- » Require health plans to analyze and submit to regulators data regarding key network adequacy indicators.
- » Require health plans to improve inadequate networks, ensure that network providers are culturally and linguistically competent, and improve consumer complaint mechanisms.
- » Vigorously enforce the law and impose consequences for violations, including monetary penalties.
- » Explore the possibility of a centralized provider directory for all health plans, which may improve compliance with regulations and access to treatment.

Health plans must also proactively improve their practices, including by recruiting more mental health providers into their networks, especially providers of color, increasing provider reimbursement rates, and decreasing administrative burdens on providers.

Only a multifaceted approach can effectively address the unmet need for mental health treatment in New York. Although the supply of mental health providers and other social factors may create challenges, health plans — which are often the gateway to treatment — are obligated under New York and federal law to ensure access. By doing so, they can improve the lives of millions of New Yorkers.

II. Introduction

Three million adult New Yorkers — one in five — live with mental illness.¹ In February 2023, 31 percent of New Yorkers reported symptoms of anxiety or depression.² The COVID-19 pandemic dramatically increased the need for mental health services,³ but access to treatment remains out of reach for many. More than half of insured adults who do not get needed mental health treatment cite lack of coverage by their health plans as the reason.⁴ In 2022, 28.7 percent of New Yorkers with anxiety or depression reported an unmet need for counseling or therapy,⁵ which continues a disturbing trend. In 2019, 850,000 adults in New York (5.6 percent) had reported an unmet need for mental health treatment, including nearly 300,000 who reported not receiving care because of cost.⁶

The COVID-19 pandemic exposed and exacerbated disparities in New Yorkers' access to mental health care. Youth mental health was especially devastated. Between 2016 and 2020, there was a 22.5 percent increase in the number of children with anxiety or depression in New York.⁷ In 2022, 196,000 (40 percent) of New York children aged three through 17 with a behavioral health condition did not receive treatment or counseling.⁸

1. Kaiser Family Found. (KFF), *New York: Mental Health & Substance Abuse*, <https://www.kff.org/state-category/mental-health/?state=NY>, (last visited Nov. 14, 2023) (indicating that 2,972,000 (19.5 percent) adults in New York reported mental illness from 2018-19).

2. Kaiser Family Found. (KFF), *Mental Health in New York* (last visited Nov. 14, 2023), <https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/new-york>.

3. See N.Y. State Health Found., *Mental Health Impact of the Coronavirus Pandemic in New York State* (2021), <https://nyshealthfoundation.org/wp-content/uploads/2021/02/mental-health-impact-coronavirus-pandemic-new-york-state.pdf>; NYC Dep't of Health and Mental Hygiene, *Impacts of COVID-19 on Mental Health in New York City, 2021* (2021), <https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief130.pdf>.

4. Kaiser Family Found. (KFF), *Proposed Mental Health Parity Rule Signals New Focus on Outcome Data as Tool to Assess Compliance* (Sept. 29, 2023), <https://www.kff.org/mental-health/issue-brief/proposed-mental-health-parity-rule-signals-new-focus-on-outcome-data-as-tool-to-assess-compliance/>.

5. KFF, *New York: Mental Health & Substance Abuse*, *supra* note 1.

6. *Id.*

7. The Annie E. Casey Found., *2022 Kids Count Data Book: State Trends in Child Well-Being 7* (2022), <https://assets.aecf.org/m/resourcedoc/aecf-2022kidscountdatabook-2022.pdf>.

8. Child and Adolescent Health Measurement Initiative, *2022 National Survey of Children's Health*, <https://www.childhealthdata.org/browse/survey/results?q=10029&r=34> (last visited Nov. 15, 2023).

The reality of the crisis is on display in New York’s emergency rooms, often the last resort for individuals unable to access outpatient treatment. During the OAG’s June 2022 and January 2023 mental health hearings, we heard alarming testimony from multiple witnesses about emergency room boarding, in particular youth who “end[] up stuck for days and weeks and months in the emergency departments without effective places for [them] to go safely in the community.”⁹ In written testimony in June 2022, Albany Medical Center Hospital reported that the number of children coming to the hospital with suicidal ideation had more than doubled in three years.¹⁰ Their experience was consistent with a study that found much higher rates of youth mental health-related visits to New York City emergency rooms compared to the years before the pandemic.¹¹

Tamara Begel, a parent who tried repeatedly to get care for her nine-year-old son after he attempted suicide, testified at the Attorney General’s June 2022 mental health hearing that “the system of care on Long Island in general has completely collapsed. There are not [enough] psychologists to treat kids after they have suicid[e] attempts. Kids who had swallowed large numbers of pills are waiting six months to a year to see a psychiatrist . . . [and] everyone from the psychiatrist to the family peer advocates . . . are not paid appropriately.”¹²

9. New York State Attorney General Public Hearing on Access to Mental Health Care in Western New York Transcript 89 (Office of the N.Y. State Att’y Gen. ed., Jan. 18, 2023), <https://ag.ny.gov/sites/default/files/2023-02/buffalopublichearing-transcript.pdf> [hereinafter Jan. 2023 OAG Mental Health Hearing Tr.] (Testimony of Laura Kelemen, Director of Niagara County Department of Mental Health & Substance Abuse Services). See also New York State Attorney General Public Hearing on Access to Mental Health Care in New York Transcript 65-69 (Office of the N.Y. State Att’y Gen. ed., June 22, 2022), https://ag.ny.gov/sites/default/files/2022-12/hearing_pdftran.pdf [hereinafter June 2022 OAG Mental Health Hearing Tr.] (Testimony of Alice Bufkin, Associate Director of Policy for Citizens’ Committee for Children) (“The reality is that children struggle to access care at any level which only leads to an escalation of need and a reliance on RTFs and psychiatric beds which as this hearing as established are deeply inadequate to meet the need . . . the children’s system has been starved for years and we have a lot of ground to make up.”).

10. OAG Hearing on Mental Health Access in New York State: Submitted Written Testimony 34 (N.Y. State Office of the Att’y Gen. ed., 2022), <https://ag.ny.gov/sites/default/files/mentalhealthhearing-writtentestimony.pdf> [hereinafter June 2022 OAG Mental Health Hearing Written Testimony].

11. Deborah A. Levine et al., *Pediatric Mental Health Emergencies During 5 COVID-19 Waves in New York City*, *Pediatrics*, Oct. 2023.

12. June 2022 OAG Mental Health Hearing Tr., *supra* note 9, at 186.

Resolving the mental health crisis requires affordable, accessible, and quality services. Consumers depend on their health insurance to access and afford mental health treatment for themselves and their family members. To enable consumers to find in-network treatment and to shop for insurance, health plans publish provider directories. But consumers experience many challenges when using these directories, including providers not accepting new patients, long wait times to see providers, and inaccurate or out-of-date provider information. During the past few years, federal audits¹⁴ and academic studies¹⁵ have identified widespread inaccuracies in health plans' mental health provider directories. These are referred to as “ghost networks” — providers who are listed in a provider directory as being in-network but are not taking new patients or are not in a health plan's network.¹⁶

The OAG previously brought enforcement actions to remedy inaccurate provider directories and network inadequacy. In 2006 and 2011, the OAG entered into settlement agreements with affiliates of UnitedHealthcare regarding their inaccurate directory listings, including for behavioral health providers.¹⁷ The settlements required UnitedHealthcare to verify the accuracy of its provider directories in New York by conducting outreach to confirm participation and to reimburse consumers who paid more than they should have after they went to providers who were erroneously listed as in-network. In 2015, the OAG executed a settlement with Carelon,¹⁸ which administers behavioral health benefits for a number of New York health plans, in which the company agreed to ensure network adequacy and the accuracy of its online provider directory.¹⁹

13. John E. Dicken, Gov't Accountability Off., GAO-22-104597, Mental Health Care; Access Challenges for Covered Consumers and Relevant Federal Efforts 12 (2022), <https://www.gao.gov/assets/gao-22-104597.pdf>.

14. Ctrs. for Medicare & Medicaid Servs., Online Provider Directory Review Report 6 (Nov. 21, 2018), https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/226504_OY2%20Provider%20Directory%20Review%20Industry%20Report_11-21-2018.pdf.

15. See, e.g., Shireen Cama et al., *Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities*, 47 Int'l J. Health Servs. 621, 630 (2017); Monica Malowney et al., *Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities*, 66 Psychiatr. Serv. 94, 95 (2015); Jane M. Zhu et al., *Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid*, 41 Health Affs. 1013, 1019-20 (2022).

16. Dicken, *supra* note 13, at 12.

17. Press Release, Office of the N.Y. State Att'y Gen., Health Plan To Correct Inaccurate Physician Directories (Dec. 19, 2006), <https://ag.ny.gov/press-release/2006/health-plan-correct-inaccurate-physician-directories>; Press Release, Office of the N.Y. State Att'y Gen., A.G. Schneiderman Announces Settlements Requiring Health Insurers To Publish Accurate Provider Directories (Jan. 19, 2012), <https://ag.ny.gov/press-release/2012/ag-schneiderman-announces-settlements-requiring-health-insurers-publish-accurate>.

18. Formerly known as ValueOptions and BeaconHealth Options.

19. Press Release, Office of the N.Y. State Att'y Gen., A.G. Schneiderman Announces Settlement With ValueOptions To End Wrongful Denial Of Mental Health And Substance Abuse Treatment Services (Mar. 5, 2015), <https://ag.ny.gov/press-release/2015/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental>.

Despite these settlements, the OAG's Health Care Bureau continues to receive complaints about inaccurate directories and consumers' inability to access in-network mental health services.

In 2022, a New York City mother filed a complaint that she could not find an in-network psychiatrist to provide psychotherapy and medication management for her 14-year-old Black son, who suffers from major depression and attention-deficit disorder. Her health plan (Carelon) gave her a list of eight in-network providers, but none accepted new patients, provided both psychiatry and psychotherapy, or were culturally competent to treat a patient of color. Recently, even after calling an additional six psychiatrists listed in her plan directory, she has been unable to find a culturally competent psychiatrist who can treat her son. As a result, her son's condition has significantly worsened and he is having difficulty focusing on school and staying out of trouble.

During the June 2022 mental health hearing, numerous consumers submitted testimony about extreme difficulties they face accessing in-network mental health treatment in the community. For example:

Yerania Simo was treated for depression in the emergency room at Bellevue Hospital and was told that she would be referred to a therapist in a clinic that would accept Medicaid. However, she could not access treatment with any of the providers to whom she was referred, as they either did not return her calls or had long waiting lists.²⁰

Mental health providers presented testimony about the obstacles they face in participating in health plan networks, in particular low reimbursement rates, which limit the ability of consumers to access treatment.

A Rochester-area psychologist wrote that some New York health plans, such as Excellus, have actually decreased reimbursement rates for psychotherapy during the pandemic after no increases for 15 years. She stayed on insurance panels for years "out of a belief that therapy should not be only for those who are wealthy,"²² but withdrew from Excellus' network because the reimbursement was unreasonably low.²³ She (in addition to other providers) sent letters to Excellus expressing her concerns about reimbursement, but Excellus offered an increase of only 25 cents per session.²⁴ As a result, for an increasing number of patients, finding a mental health professional has become an insurmountable obstacle.²⁵

20. Submitted Written Testimony from Yerania Simo to Letitia James, New York State Attorney General (June 15, 2022); Telephone interview with Yerania Simo (Aug. 9, 2023).

21. Submitted Written Testimony from Dr. Claire McLauchlin to Letitia James, New York State Attorney General (Jun. 20, 2022).

22. *Id.*

23. Telephone interview with Dr. Claire McLauchlin, Psychologist (Jul. 11, 2023).

24. *Id.*

25. *Id.*

Dr. Christine Steerman, a psychologist in upstate New York, wrote that she has a full caseload but health insurance companies do not pay enough, deny claims due to small errors, and are difficult to contact. Thus, there is little incentive to stay in their networks. She is committed to provide treatment to low-income individuals but also needs to be paid for her time.²⁶

Nadia Chait, spokesperson for the Coalition for Behavioral Health, testified that reimbursement rates offered by commercial health plans for mental health care remain vastly inadequate as compared with the rates offered for physical health. “In our system, the commercial reimbursement rate ... doesn’t come anywhere close to covering the full cost of care.”²⁷

Through this report, the OAG seeks to raise public awareness of the need for health plans to maintain accurate directories and strengthen their mental health networks in order to address the mental health crisis in New York State. The report begins with an overview of the legal framework requiring directory accuracy, network adequacy, and behavioral health parity in New York. Then it describes the OAG’s secret shopper survey of 13 health plans and presents and discusses the results. Finally, it provides recommendations for policymakers, regulators, and health plans regarding how to improve directory accuracy and network adequacy, and thereby improve access to care.

This report is especially timely because by December 31, 2023, the New York Department of Financial Services (DFS), in consultation with the Department of Health (DOH), the Office of Mental Health (OMH), and the Office of Addiction Services and Supports (OASAS), must propose regulations for network adequacy for mental health and substance use disorder treatment services.²⁸

26. Dr. Christine Steerman, Submitted Written Testimony, in June 2022 OAG Mental Health Hearing Written Testimony, *supra* note 10.

27. June 2022 OAG Mental Health Hearing Testimony Tr., *supra* note 9, at 43-44.

28. N.Y. Ins. L. § 3241(a)(2).

III. Brief summary of legal framework

The OAG's secret shopper survey directly tested health plans' compliance with provider directory accuracy laws. Because callers simulated consumers seeking access to in-network mental health services, the survey also shed light on whether health plans have adequate mental health provider networks. This section summarizes health plans' obligations under both sets of laws and provides a baseline for recommendations that will be discussed later in this report.

A. Directory accuracy

1. New York laws and regulations

Under New York law, health plans must include in their provider directories a listing, by specialty, of the name, address, and telephone number of all participating providers, noting whether each provider is accepting new patients.²⁹ For mental health and substance use disorder treatment providers, the directories must include any affiliations with participating facilities certified or authorized by OASAS and any restrictions regarding the availability of the individual provider's services.³⁰ Insurers must maintain the provider directory on their website and revise it annually, updating the website within 15 days of the addition or termination of a provider from the insurer's network or a change in a physician's hospital affiliations. If a health plan member receives a bill for out-of-network services resulting from inaccurate network status information provided by their health plan, the plan must pay for the services and can charge the member only their in-network cost sharing, regardless of whether the member's coverage includes out-of-network services.³¹ The Insurance Law allows for penalties of up to \$1,000 per violation.³²

29. N.Y. Ins. L. §§ 3217-a(a)(17) and 4324(a)(17); N.Y. Pub. Health L. § 4408(1)(r). For physicians, the directories must also include board certification, languages spoken, and any affiliations with participating hospitals.

30. Guidance issued by DFS provides examples: "the directory may indicate whether an individual provider does not serve adults or children, or individuals with particular mental health conditions, whether the individual provider is an employee of or affiliated with a facility, or whether the individual provider provides services in a specific facility location." DFS, *Insurance Circular Letter No. 12 (2021)* (December 29, 2021), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2021_12.

31. N.Y. Ins. L. §§ 3217-b(n), 4325(o); N.Y. Pub. Health L. § 4406-c(12); 11 N.Y.C.R.R. § 52.77(a).

32. N.Y. Ins. L. § 109(c)(1). We have not identified any enforcement actions related to provider directory accuracy by DFS or DOH, which regulate health insurance plans and health maintenance organizations (HMOs) respectively.

2. Federal laws and regulations

Federal laws and regulations require commercial plans, Qualified Health Plans (QHPs) issued under the Affordable Care Act (ACA), and Medicaid plans to maintain accurate provider directories. The No Surprises Act (effective January 1, 2022), requires all private health plans to maintain accurate online provider directories, verify their directories at least every 90 days, and post any changes within two business days.³³ Plans must apply in-network cost sharing for covered services provided by providers inaccurately listed as in-network.³⁴ CMS regulations require QHPs, including those sold on the New York State of Health Marketplace,³⁵ to publish an up-to-date, accurate, complete, and accessible provider directory, noting each provider's location, contact information, specialty, institutional affiliations, and whether new patients are accepted.³⁶ Finally, effective July 1, 2025, Medicaid fee for service³⁷ and managed care³⁸ plans must maintain accurate provider directories that indicate whether providers are accepting new patients.

B. Network adequacy

1. New York laws and regulations

a) Commercial Health Insurance

The New York Insurance Law requires each commercial health insurance plan to “ensure that the[ir] network is adequate to meet the health and mental health needs of insureds and provide an appropriate choice of providers sufficient to render the services covered under the policy or contract.”³⁹ DFS has issued network adequacy guidance with some baseline requirements, including that health plans “include” outpatient providers and inpatient facilities in their behavioral health networks and that “it is preferred that” members have access to such providers within 30 minutes or 30 miles by public transportation or by car.⁴⁰ DFS, in consultation with DOH, OMH, and OASAS, must propose regulations for network adequacy for mental health and substance use disorder treatment services by December 31, 2023.⁴¹

33. 42 U.S.C. § 300gg-115(a), which is effective for plan years beginning on or after January 1, 2022. Although regulations have not yet been issued, plans must implement the requirements. Dep'ts of Labor, Health and Human Servs., and the Treasury, FAQs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 49 8 (Aug. 20, 2021), <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf>.

34. 42 U.S.C. § 300gg-115(b).

35. *N.Y. State of Health: The Official Health Plan Marketplace*, N.Y. State, <https://nystateofhealth.ny.gov> [hereinafter N.Y. State of Health].

36. 45 C.F.R. § 156.230(b)(2).

37. 42 U.S.C. § 1396a(83).

38. 42 U.S.C. § 1396u-2(a)(5).

39. N.Y. Ins. Law § 3241(a)(1).

40. Network Adequacy Standards and Guidance, DFS, https://www.dfs.ny.gov/apps_and_licensing/health_insurers/network_adequacy_oon_standards_guidance.

41. N.Y. Ins. L. § 3241(a)(2).

Where a consumer cannot access services in-network, the Insurance Law provides limited protection. If an enrollee cannot locate a provider in their region,⁴² DFS may require an insurer to make available at least one option for coverage at 80 percent of the usual and customary cost of out-of-network health care services after imposition of deductibles or benefit maximums. DFS, however, may waive this out-of-network coverage requirement if a health plan states that it would impose an undue hardship.⁴³

DOH must review each HMO's provider network at least every three years and ensure that it "maintains a network of health care providers adequate to meet the comprehensive health needs of its enrollees and to provide an appropriate choice of providers sufficient to provide services under [the insurance policy]," including a sufficient number of geographically accessible participating providers, at least three primary care providers pursuant to travel and distance time standards, and sufficient providers in each area of specialty practice.⁴⁴ DOH guidance states that for HMO plans, the time and distance from a member's residence to an available participating provider cannot exceed 30 minutes or 30 miles for primary care providers, with this standard "preferred" for all other providers.⁴⁵ Pursuant to 2023 amendments to the New York Public Health Law,⁴⁶ DOH must also consider the following during its reviews: (i) the availability of appropriate and timely care provided in compliance with the Americans with Disability Act; (ii) the network's ability to provide culturally and linguistically competent care to meet the needs of enrollees; (iii) the availability of appropriate and timely care in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), including "an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services;" and (iv) the number of grievances filed by enrollees relating to waiting times for appointments, appropriateness of referrals and other indicators of plan capacity.⁴⁷

DOH must also set network adequacy standards for mental health and substance use disorder services for HMOs, including sub-acute care in a residential facility, assertive community treatment services, critical time intervention services, and mobile crisis intervention services, and propose regulations, in consultation with DFS, OMH and OASAS, by December 31, 2023.⁴⁸ If an HMO determines that it does not have a provider with

42. DOH has established eight rating regions in New York. See DOH, *Revised Attachment C: New York Standardized Rating Regions*, <https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20C%20-%20Rating%20Regions%2C%20new%203-27-13.pdf>.

43. N.Y. Ins. L. § 3241(b)(1)(B).

44. N.Y. Pub. Health L. § 4403(5)(a).

45. Guidelines for MCO Service Delivery Networks - Version 3.0, Attachment 4, DOH, https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-v3.0.htm#att4 [hereinafter DOH Guidelines].

46. L.2023, c. 57, pt. II, subpt. F, § 2, eff. May 3, 2023.

47. N.Y. Pub. Health L. § 4403(5)(b).

48. *Id.*

appropriate training and experience in its network to meet the health care needs of an enrollee, it must make a referral to an appropriate provider at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received within the network.⁴⁹

b) Medicaid and Child Health Plus

Almost 80 percent of Medicaid enrollees in New York receive their benefits through a managed care organization (MCO),⁵⁰ which is a private entity that contracts with the state to administer Medicaid benefits.⁵¹ Under federal law, Medicaid MCOs must assure that they have capacity to serve expected enrollment in their service area and maintain a sufficient number, mix, and geographic distribution of providers.⁵² They must also make covered services accessible to enrollees to the same extent that such services are accessible to other state residents eligible for Medicaid who are not enrolled with that plan.⁵³ States that contract with MCOs to deliver Medicaid services must develop and enforce network adequacy standards, including a quantitative standard for mental health and substance use disorder, adult and pediatric providers.⁵⁴

DOH guidance specifies that each MCO serving Medicaid and Child Health Plus (CHP) members must include in its network at least one contracted outpatient facility in each county and at least one inpatient psychiatric center.⁵⁵ The network must also include the higher of 50 percent or two per county of licensed mental health practitioners and outpatient mental health clinics in a county (or per region for rural counties).⁵⁶ Through guidance and its model contract for MCOs, DOH has also established quantitative standards for Medicaid and Child Health Plus plans, including: (i) the time and distance from a member's residence to an available participating provider must not exceed 30 minutes by public transportation in metropolitan areas, and 30 minutes or 30 miles by public transportation or by car in non-metropolitan areas; (ii) each MCO network must include 15.4 psychiatrists per 100,000 population; and (iii) for urgent care, appointments must be available within 24 hours of request, for non-urgent "sick" visits, within 48 to 72 hours of request, and for routine non-urgent,

49. N.Y. Pub. Health L. § 4403(6)(a).

50. *Medicaid Managed Care Database: New York*, The Commonwealth Fund, <https://www.commonwealthfund.org/medicaid-managed-care-database#/states/NY>.

51. Elizabeth Hinton & Jada Raphael, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*, Kaiser Family Found (June 15, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes>.

52. 42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.68; 42 C.F.R. § 438.207; 42 C.F.R. § 457.1218; 42 C.F.R. § 457.1230.

53. 42 U.S.C. § 1396b(m)(1)(A)(i).

54. 42 C.F.R. §§ 438.68(b)(1)(iii), 457.1218.

55. DOH Guidelines, *supra* note 45.

56. *Id.*

preventive appointments, within four weeks of request.⁵⁷ For non-urgent mental health visits with a participating provider that is a mental health clinic, appointments must be available within one week of request, and for behavioral health specialist referrals to outpatient programs (including day treatment), appointments must be available within two to four weeks of request.⁵⁸

Federal regulations for Medicaid plans require that state network adequacy standards consider the ability of MCO network providers to communicate with limited English proficient enrollees in their preferred language, and to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with physical or mental disabilities.⁵⁹ Medicaid MCOs in New York must ensure the cultural competence of their provider networks by requiring participating providers to complete State-approved cultural competence training annually, including training on the use of interpreters, for all staff who have regular and substantial contact with enrollees.⁶⁰

2. Federal laws and regulations

In addition to regulations for Medicaid managed care plans, pursuant to the ACA,⁶¹ CMS has issued network adequacy regulations for qualified health plans (QHPs) including those sold on the New York State of Health Marketplace.⁶² Each QHP must maintain a network “that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay.”⁶³ QHPs must also include in their networks “a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP’s service area....”⁶⁴

57. N.Y. Dep’t of Health, *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract* (Mar. 1, 2019) https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv_snp_model_contract.pdf. [hereinafter DOH Model Contract].

58. *Id.*

59. 42 C.F.R. §§ 438.68(c)(1)(vii), (viii).

60. DOH Model Contract, *supra* note 57, at 15.10.

61. 42 U.S.C. § 18031(c)(1)(B).

62. N.Y. State of Health, *supra* note 35.

63. 45 C.F.R. § 156.230(a)(1)(ii).

64. 45 C.F.R. § 156.235(a)(1). DOH, Invitation and Requirements for Insurer Certification and Recertification for Participation in 2024 42, <https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%202024%20Plan%20Invitation.pdf>.

C. Mental Health and Substance Use Disorder Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA) also addresses network adequacy. Enacted in 2008, MHPAEA prohibits covered group health plans from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than the treatment limitations they apply to medical/surgical benefits.⁶⁵ The essential health benefit regulations under the ACA extend MHPAEA's requirements to small and individual plans.⁶⁶ Under New York's mental health parity law (originally enacted as "Timothy's Law"), which incorporates the requirements of MHPAEA,⁶⁷ "treatment limitations" include nonquantitative treatment limitations (NQTLs).⁶⁸ Federal regulations define NQTLs as treatment limitations "which otherwise limit the scope or duration of benefits for treatment under a plan or coverage," and provide an illustrative list.⁶⁹ Federal MHPAEA guidance states that "plan standards" such as "network adequacy" are NQTLs. For example, if a health plan takes steps to ensure it has an adequate number of in-network medical/surgical providers, the plan must take comparable steps to ensure an adequate number of in-network mental health and substance use disorder providers.⁷⁰

65. 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c).

66. 45 C.F.R. § 156.115(a)(3).

67. N.Y. Ins. L. §§ 3216(i)(31), (i)(35); §§ 3221(l)(5), (7); §§ 4303(g), (l).

68. 42 U.S.C. § 300gg-26; 45 C.F.R. § 146.136(c)(4)(i); N.Y. Ins. L. §§ 3216(i)(31), (i)(35); §§ 3221(l)(5), (7); § 4303(g).

69. 45 C.F.R. §§ 146.136(a), (c).

70. Dep'ts of Labor, Health and Human Servs., and the Treasury, FAQs About Mental Health And Substance Use Disorder Parity Implementation And The 21st Century Cures Act Part 39 n.13 (Sept. 5, 2019), <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>.

IV. OAG secret shopper study

A. Background

Secret shopper surveys, in which callers simulate the experience of consumers calling providers in a plan's network directory, are an effective tool to test directory accuracy and identify gaps in access to network providers.⁷¹ Numerous secret shopper studies conducted during the past eight years have pointed to serious inaccuracies in health plans' provider directory listings for mental health providers, including incorrect information about network status, location, and availability to accept new patients. Most recently, Senate Finance Committee staff conducted a study of Medicare Advantage plans' directories showing that appointments were available with only 18 percent of mental health providers.⁷² A study of UnitedHealthcare's New York directory found that only three percent of calls to psychiatrists in New York City resulted in being offered an appointment.⁷³ A survey of BlueCross BlueShield plans in five cities found that mental health appointments for children were obtained with only 40 percent of the pediatricians and 17 percent of the child psychiatrists.⁷⁴ A different study of BlueCross BlueShield plans in three cities found that mental health appointments with psychiatrists were obtained with only 26 percent of psychiatrists.⁷⁵ And a study of three health plans' directories in the Washington, D.C. area found that only seven percent of psychiatrists offered an appointment within two weeks.⁷⁶

71. Simon F. Haeder et al., *Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans*, 35 Health Aff. (Millwood) 1160 (2016), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1554> [hereinafter Haeder et al., *Secret Shoppers Find Access to Providers and Network Accuracy Lacking*].

72. Press Release, U.S. Senate Finance Committee, *Wyden Calls for Action to Get Rid of Ghost Networks, Releases Secret Shopper Study* (May 3, 2023), <https://www.finance.senate.gov/chairmans-news/wyden-calls-for-action-to-get-rid-of-ghost-networks-releases-secret-shopper-study#:~:text=Washington%2C%20D.C.%20%E2%80%93%20Senate%20Finance%20Committee,from%20getting%20mental%20health%20care>.

73. Nicole L. Tenner et al., *Secret Shopper Analysis Shows Getting Psychiatry Appointment in New York City is Well Kept Secret*, 59 Community Mental Health J. 290, 291 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9287131/pdf/10597_2022_Article_1006.pdf.

74. See Cama et al., *supra* note 15, at 625.

75. See Malowney et al., *supra* note 15, at 95.

76. Benzion Blech et al., *Availability of Network Psychiatrists Among the Largest Health Insurance Carriers in Washington, D.C.*, 68 Psychiatr. Serv. 962, 964 (2017), <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201600454>.

B. The OAG's approach

Using a methodology commonly used in academic studies published in peer reviewed journals, OAG staff conducted a “simulated patient” secret shopper study to examine the extent of mental health provider ghost networks in New York. Staff reviewed directories from 13 different health plans, which provide coverage for approximately 12 million New Yorkers.⁷⁷ Calls were made to listed providers in up to four cities (New York, Albany, Buffalo, and Rochester) to ensure geographic diversity, with at least 20 providers from each insurer in each city included. All calls were made to providers who were specifically listed in directories as accepting new patients, except for Excellus and Independent Health, whose directories did not include this information. For each health plan, we called different types of mental health providers, including psychiatrists, psychologists, nurse practitioners, licensed mental health counselors, and social workers, to ensure broad representation of the mental health workforce. The survey included a sample size comparable to published studies, in some cases far exceeding them.

Staff called providers posing as a family member of a person with a mental health condition, with the goal of securing an appointment for them using a specific health plan. For two-thirds of the calls, staff used Scenario A (a fictional adult patient), stating the family member is depressed and their primary care physician suggested they see a mental health provider. For one-third of the calls, staff used Scenario B (a fictional child patient), stating they are the parent of a 14-year-old who has begun having problems in school. When callers reached a voicemail they left a message with a request for a call back. When the listed phone number was incorrect but we reached someone who could direct us to another number, we followed those instructions and attempted to reach the listed provider. We measured two outcomes.

First, we assessed whether each provider was in-network. We counted a provider as “in network” when we were able to confirm that they accepted any plans under the relevant insurance. For many providers, we were unable to make an assessment of in-network status because the calls ended after the recipient of the call said that they did not know the provider, the provider was not practicing, was not accepting new patients, or their network status was unknown.

Second, we determined whether the provider offered an appointment using the named insurance. We defined an offer of an appointment as being told there was either a virtual or in-person appointment available with the listed provider using the named insurance. If providers required intake or screening sessions before making appointments for treatment and stated that an appointment could thereafter be scheduled, we counted calls as successful, as long as they provided a reasonable opportunity to obtain the necessary screening. If the provider's office could not confirm that the provider worked in the office and/or was taking new patients, we did not count the call as successful. We also did not count as successful the small number of calls where the provider required a referral in order to make an appointment or could not guarantee an appointment with the listed provider. Staff members did not actually make an appointment.

77. The health plan membership totals in this report include lines of business for which each plan reports enrollment figures to DOH and DFS.

C. Findings

Eighty-six percent of the listings for mental health providers were inaccurate or unavailable. Of the 396 providers we contacted, 93 (23 percent) were non-working numbers, incorrect numbers, or unreturned calls. Staff could only make appointments for 56 (14 percent) of the listings. Appointment rates varied by plan and location. 86 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 — ***despite being listed in health plans’ directories as in-network and accepting new patients.***

Staff encountered numerous challenges while attempting to secure appointments. On multiple occasions callers were told by receptionists that the listed provider was unknown or had retired. Additional reasons for not being able to secure an appointment included: the provider not accepting the named insurance (even though a provider was listed in a plan’s directory as in-network); not accepting new patients (even through the listing indicated they were); or requiring a referral. Several providers told callers that they had notified the health plan on multiple occasions that they are not in-network.

1. Aetna

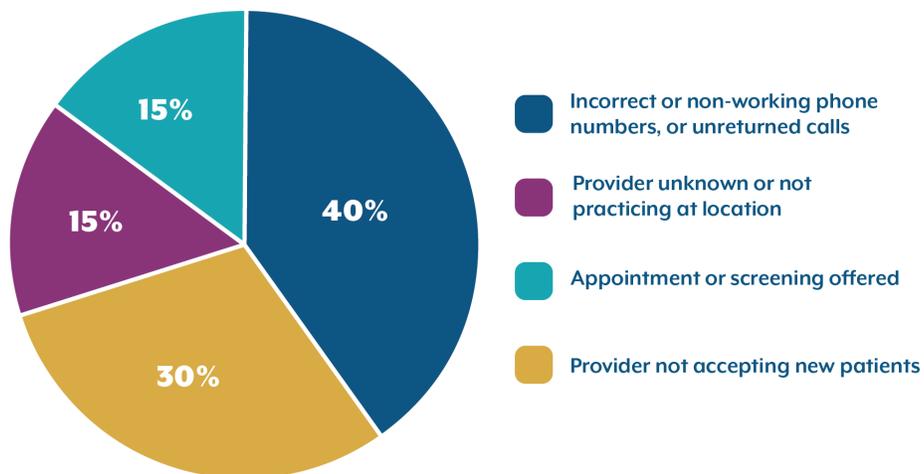
Table 1. Aetna call results

Plan: Aetna | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	5	2	0	15%	85%
Scenario B (child)	7	2	1	1	14%	86%
Aetna totals	20	7	3	1	15%	85%

Aetna has approximately 930,000 members in its New York health plans.⁷⁸ We called a mix of psychiatrists, doctoral-level psychologists, masters-level counselors, and social workers in New York City. Six providers were not taking new patients, including one psychiatrist who was not accepting new patients with Aetna insurance. One phone number for a social worker treating children turned out to be a high school and the listed provider was not included in the directory of school social workers. One child psychiatrist's office said that the practice was currently at capacity but that they were accepting intake appointments which would be scheduled based on necessity; we counted that call as a success although it was not certain that the provider would be able to take on the patient. The three appointments were offered three to 11 days after the calls.

Figure 1. Aetna call outcomes



78. DOH, Statewide EPO and PPO Plan Profiles - Health Plans Reported in eQARR 2018 - eQARR - 2021 (2021), https://www.health.ny.gov/health_care/managed_care/reports/eqarr/2020-2021/ppo_plan_profiles.htm [hereinafter 2018-2021 DOH EPO and PPO Plan Profiles].

2. CDPHP

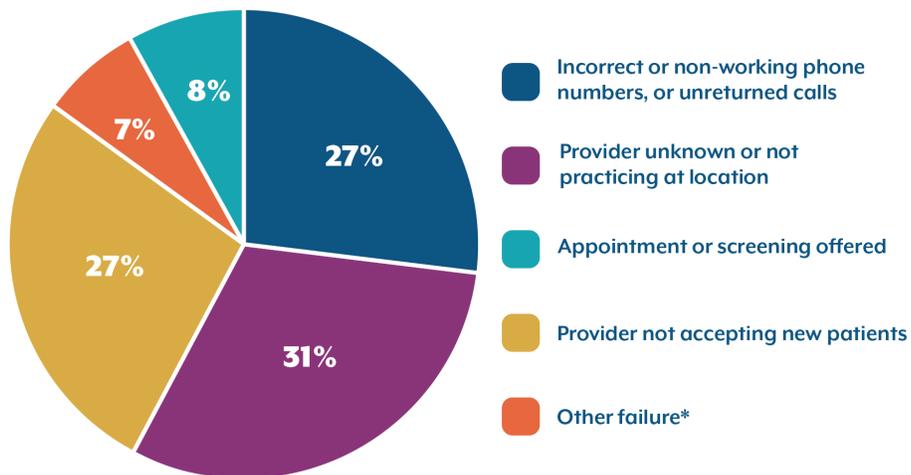
Table 2. CDPHP call results

Plan: CDPHP | Location: Albany

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	4	1	1	8%	92%
Scenario B (child)	13	2	1	1	8%	92%
CDPHP totals	26	6	2	2	8%	92%

CDPHP has approximately 330,000 members in its commercial and Medicaid plans in New York.⁷⁹ We called psychiatrists, doctoral-level psychologists, masters-level counselors, and social workers in Albany who were listed in CDPHP’s provider directory. One provider treating adults offered an appointment for a virtual visit in the same week or an in-person visit the following week, but in a different city than appeared in the listing. The only successful appointment for children – offered a month and a half later – was limited to medication management, meaning that the provider only writes prescriptions for psychiatric drugs and does not provide psychotherapy. This is problematic because, although medication can be an important part of mental health treatment, it is sometimes overused⁸⁰ and many children with mental health diagnoses need psychotherapy. Two providers we called for a child visit were incorrectly listed in the directory as providing mental health treatment although they practiced only developmental psychiatry or provided evaluations for learning disabilities.

Figure 2. CDPHP call outcomes



*Providers did not treat mental health diagnoses.

79. *Id.*; DOH, Statewide Plan Profiles - Health Plans that Reported in eQARR 2021 - eQARR - 2021 (2021) https://www.health.ny.gov/health_care/managed_care/reports/eqarr/2020-2021/plan_profiles.htm [hereinafter 2021 DOH Statewide Plan Profiles].

80. Robert E. Drake, *Overmedicating Vulnerable Children in the U.S.*, 28 *Epidemiol. Psychiatr. Sci.* 358 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6999034>.

3. Cigna

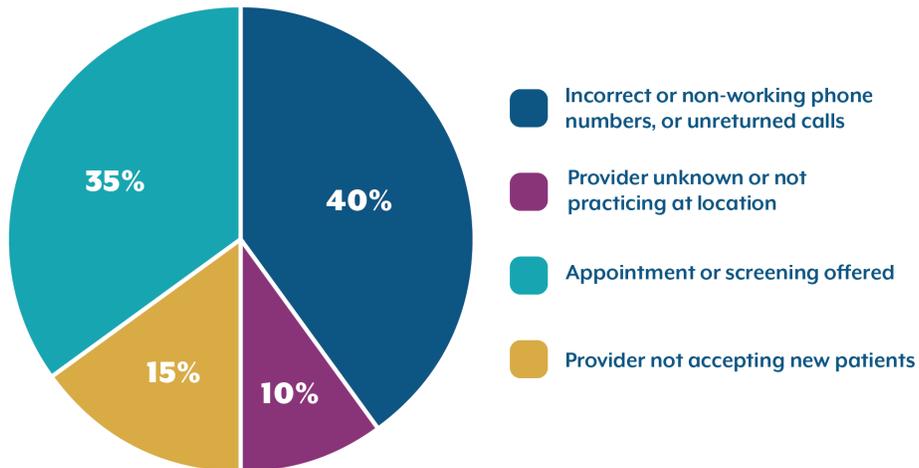
Table 3. Cigna call results

Plan: Cigna | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	7	5	4	38%	62%
Scenario B (child)	7	3	2	2	29%	71%
Cigna totals	20	10	7	6	35%	65%

Cigna has approximately 490,000 members in its New York health plans.⁸¹ We called psychiatrists, doctorate-level psychologists, licensed mental health counselors and social workers in New York City listed in Cigna’s provider directory. One social worker treating adults said she only accepted patients with substance abuse disorders and did not accept any new patients at “this time of year” (early November) because she does not work for two months in January and February. One child psychologist only treated patients with autism. For the few providers that offered appointments, the wait ranged from one day to one month.

Figure 3. Cigna call outcomes



81. 2018-2021 DOH EPO and PPO Plan Profiles, *supra* note 78.

4. EmblemHealth

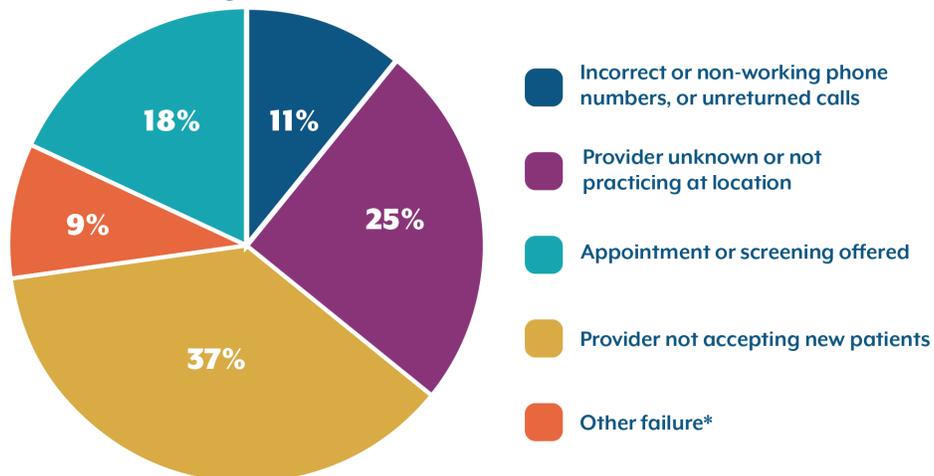
Table 4. EmblemHealth call results

Plan: EmblemHealth | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	28	9	3	3	11%	89%
Scenario B (child)	16	9	5	2	31%	69%
EmblemHealth totals	44	18	8	5	18%	82%

EmblemHealth⁸² has approximately 530,000 members in its commercial insurance and Medicaid plans in New York.⁸³ We called psychiatrists, nurse practitioners, doctoral-level psychologists, and social workers in New York City listed in EmblemHealth’s provider directory. For children, the treatment options were quite limited. The two psychiatric nurse practitioners who were accepting new child patients only offered medication management. Two providers were incorrectly listed as treating children; in fact they only worked with adults (one treated only nursing home patients). For adults, treatment options were not much better. One psychologist worked at a nursing home and did not provide any outpatient treatment. Three providers stated that even though they were in-network, they were not taking any more Emblem patients — in one case a psychologist said, “all of her Emblem slots are full.” For one call that we counted as a success, the listed provider did not treat patients themselves but only did client intakes. For the few providers that offered appointments, the wait time was up to eight weeks.

Figure 4. EmblemHealth call outcomes



*Providers were not in-network or were incorrectly listed as treating children.

82. EmblemHealth includes GHI and HIP.

83. DOH, Recipients Enrolled in Mainstream Medicaid Managed Care By County, Plan, Aid Category, and NYSoH (May 2023) https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/2023/docs/en05_23.pdf [hereinafter DOH Medicaid Managed Care Enrollment Data]; DOH, Child Health Plus Total Enrollment by County Report for May 2023 (May 2023), https://www.health.ny.gov/statistics/child_health_plus/enrollment/docs/2023-05.pdf [hereinafter DOH Child Health Plus Enrollment Data]; DOH, Recipients Enrolled in QHP or EP - March 2023 (Mar. 2023), https://info.nystateofhealth.ny.gov/sites/default/files/EP%20and%20QHP%20Total%20Enrollees%20Q1_2023.pdf [hereinafter DOH QHP and EP Enrollment Data]; DFS, Rate Applications by Company (last accessed Nov. 14, 2023), <https://myportal.dfs.ny.gov/web/prior-approval/rate-applications-by-company> [hereinafter DFS Prior Approval Rate Applications Data].

5. Empire BlueCross BlueShield

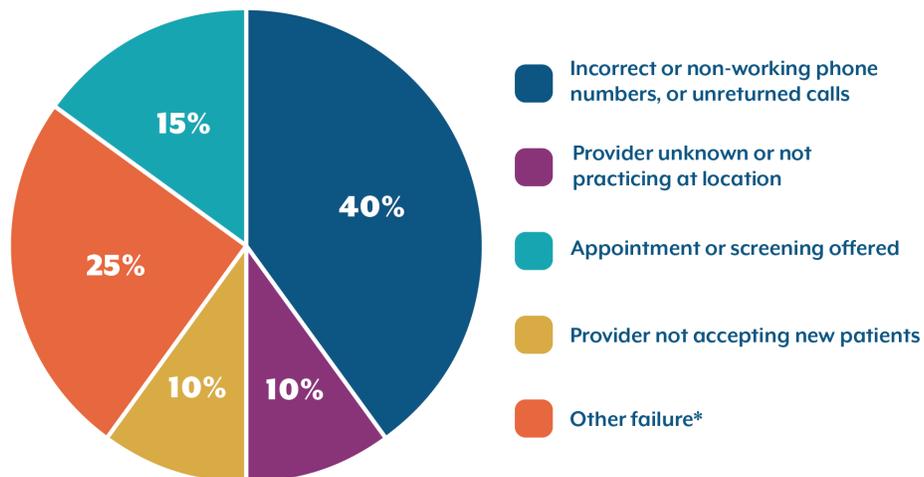
Table 5. Empire BlueCross BlueShield call results

Plan: Empire BlueCross BlueShield | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	5	3	2	23%	67%
Scenario B (child)	7	4	0	0	0%	100%
All provider totals	20	9	3	2	15%	85%

Empire BlueCross BlueShield has approximately 1.5 million members in its health plans in New York.⁸⁴ We called psychiatrists, psychologists, masters-level therapists, and social workers in New York City listed in Empire BlueCross BlueShield’s provider directory. We were unable to obtain an appointment with any of the providers we called under the child scenario. The office of one social worker explained that the provider is not taking any more Empire BlueCross BlueShield members. One provider listing led to a real estate company; another to a dental clinic.

Figure 5. Empire BlueCross BlueShield call outcomes



*Providers were incorrectly listed as treating children.

84. 2018-2021 DOH EPO and PPO Plan Profiles, *supra* note 78; 2021 DOH Statewide Plan Profiles, *supra* note 79.

6. Excellus

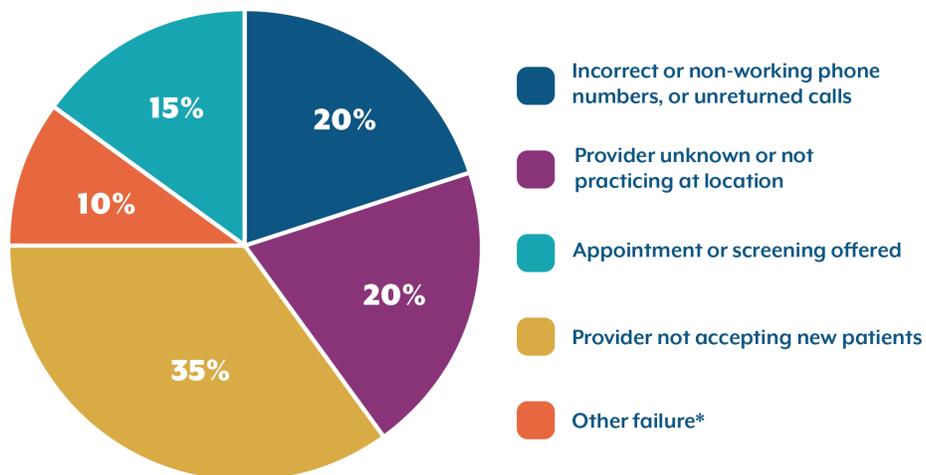
Table 6. Excellus call results

Plan: Excellus | Location: Rochester

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	5	3	2	23%	67%
Scenario B (child)	7	4	0	0	0%	100%
Excellus totals	20	9	3	2	15%	85%

Excellus has approximately 1.2 million members in its HMO and Medicaid plans, primarily in the Rochester area.⁸⁵ We called psychiatrists, doctoral-level psychologists, and social workers in Rochester listed in Excellus's provider directory. The three Excellus providers who were accepting patients required an initial screening, with a wait time of several days to several weeks. We counted these calls as successful because an appointment for the screening could be scheduled and actual treatment seemed likely. In contrast, the office of one psychiatrist required that prospective patients visit their clinic only between 8am and 10am on Mondays or Wednesdays to be evaluated before an appointment could be offered, and could not guarantee an appointment with any particular psychiatrist in the practice. Given the very narrow intake hours and uncertainty about follow-up, we did not count this as a successful appointment. Another psychiatrist said that she had told Excellus several times that she is not accepting new patients, but the plan still had not removed her from its directory. The Excellus provider directory does not specify whether providers are accepting new patients, as required by New York law.

Figure 6. Excellus call outcomes



*Providers did not treat outpatients or only accepted patients who came in for evaluation during very limited walk-in hours.

85. 2021 DOH Statewide Plan Profiles, *supra* note 79.

7. Fidelis

Table 7. Fidelis call results

Plan: Fidelis | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	8	3	1	23%	77%
Scenario B (child)	7	2	0	0	0%	100%
New York City totals	20	10	3	1	16%	84%

Plan: Fidelis | Location: Albany

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	0	0	0	0%	100%
Scenario B (child)	7	2	1	0	14%	86%
Albany totals	20	2	1	0	5%	95%

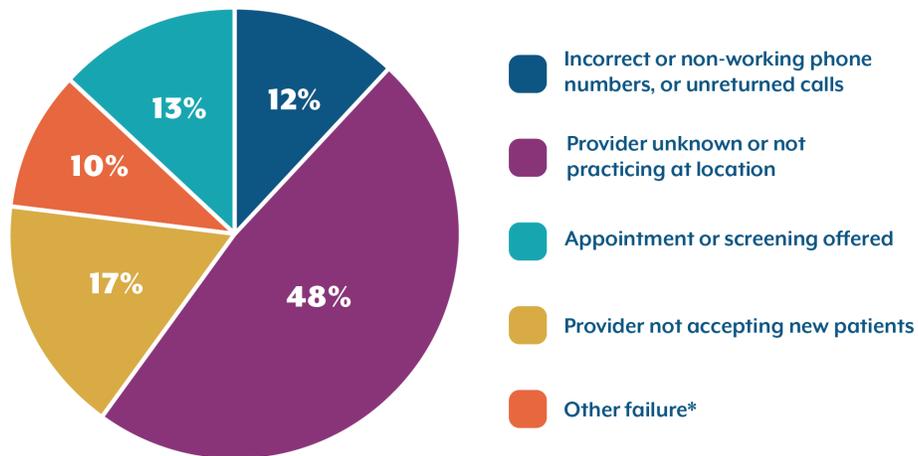
Plan: Fidelis | Location: Buffalo

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	3	3	2	23%	77%
Scenario B (child)	7	2	1	1	14%	86%
Buffalo totals	20	5	4	3	20%	80%

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Fidelis totals	60	17	8	4	13%	87%

Fidelis has approximately 1.9 million members in its HMO and Medicaid plans in New York.⁸⁶ We called psychiatrists in New York City, Albany, and Buffalo listed in Fidelis’s provider directory. For calls in Buffalo to child providers, we also included two licensed mental health counselors and one psychologist. The person who answered one incorrect phone number stated that she had received several calls based on the incorrect Fidelis listing and had tried, unsuccessfully, to get the plan to correct the error. In Albany, three calls were answered by staff at inpatient hospital units that do not treat outpatients; no calls for an appointment for an adult resulted in an offer of an appointment. The only successful call to an Albany provider for a child was for a virtual session in several weeks or an in-person session in New Windsor, which is 92 miles from Albany. All calls to providers treating children in New York City were unsuccessful, either because the contact information contained in the directory was incorrect or they were not accepting new patients. For the few providers who offered appointments, the wait time ranged from one day to six months.

Figure 7. Fidelis call outcomes



*Providers did not treat outpatients, required a referral from within their practice, or were on leave.

86. *Id.*; 2018-2021 DOH EPO and PPO Plan Profiles, *supra* note 78.

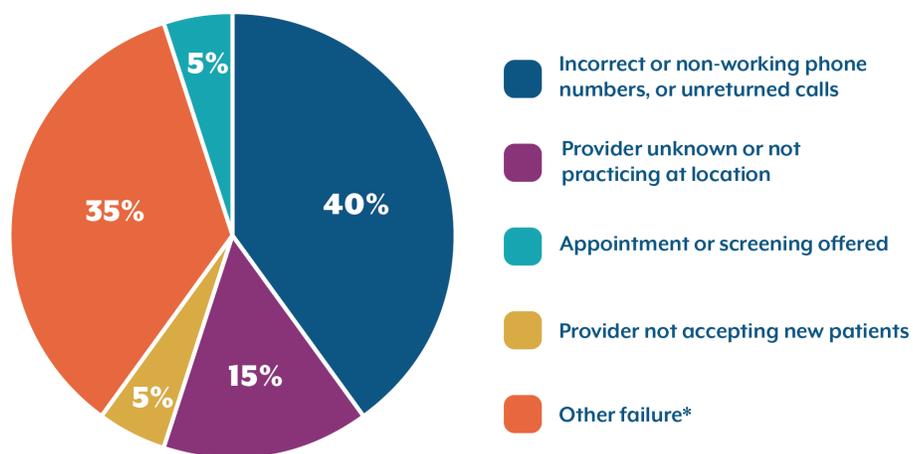
8. HealthFirst

Table 8. HealthFirst call results
Plan: HealthFirst | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	3	1	0	8%	92%
Scenario B (child)	7	4	0	0	0%	100%
HealthFirst totals	20	7	1	0	5%	95%

HealthFirst has approximately 1.7 million members in its commercial and Medicaid plans in New York.⁸⁷ We called psychiatrists, doctoral-level psychologists, and social workers in New York City listed in HealthFirst’s provider directory. Only one call resulted in an appointment offer — for a virtual visit the next day. Four providers listed in the directory as treating children in fact only accepted adult patients.

Figure 8. HealthFirst call outcomes



*Providers were incorrectly listed as treating children, required a referral from within their practice, or were not in-network.

87. DOH Medicaid Managed Care Enrollment Data; DOH Child Health Plus Enrollment Data; DOH QHP and EP Enrollment Data; DFS Prior Approval Rate Application Data, all *supra* note 83.

9. Independent Health

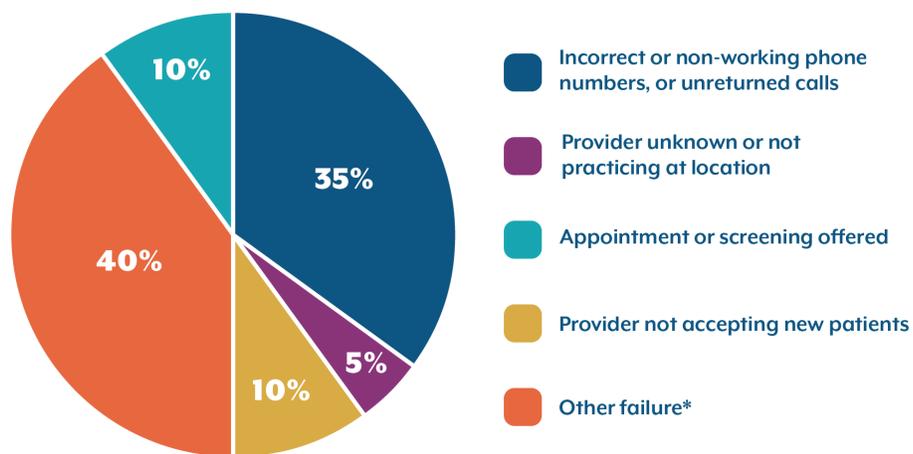
Table 9. Independent Health call results

Plan: Independent Health | Location: Buffalo

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	8	0	0	0	0%	100%
Scenario B (child)	12	4	2	1	17%	83%
Independent Health totals	20	4	2	1	10%	90%

Independent Health has approximately 160,000 members in its HMO and Medicaid plans in New York.⁸⁸ We called psychiatrists, doctoral-level psychologists, and social workers in Buffalo listed in Independent Health's provider directory. Six providers (including four from whom we sought an appointment for a child) did not accept patients. These included two psychiatrists who did not see outpatients at all, a behavioral health supervisor who did not see patients, and a psychologist whose practice was limited to neuropsychological testing. Additionally, despite being listed as treating children, two providers did not accept patients under the age of 18. For the few providers who offered appointments, the wait time ranged from two days to two weeks. The Independent Health provider directory does not specify whether providers are accepting new patients, as required by New York law.

Figure 9. Independent Health call outcomes



*Providers did not treat outpatients, were not in-network, or were incorrectly listed as treating children.

88. 2021 DOH Statewide Plan Profiles, *supra* note 79

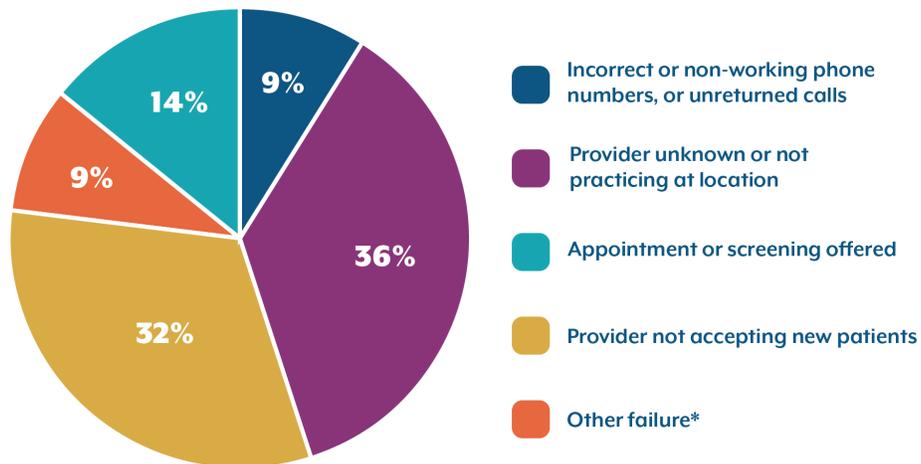
10. MetroPlus

Table 10. MetroPlus call results
Plan: MetroPlus | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	14	5	2	1	14%	86%
Scenario B (child)	8	3	1	0	13%	87%
MetroPlus totals	22	8	3	1	14%	86%

MetroPlus has approximately 700,000 members in its commercial insurance and Medicaid plans in New York.⁸⁹ We called psychiatrists, doctoral-level psychologists, and social workers in New York City listed in MetroPlus’s provider directory. Of the seven psychiatrists we called, just one offered an appointment, but for medication management only. Two social workers offered appointments in the next week, but only for virtual psychotherapy. We counted these as successful appointments, even though many patients prefer or need in-person appointments and both psychotherapy and medication management. For the few providers who offered appointments, the wait time was one day to more than two months.

Figure 10. MetroPlus call outcomes



*Providers were not in-network or required referrals from within their practice.

89. *Id.*

11. Molina

Table 11. Molina call results

Plan: Molina | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	4	1	0	8%	92%
Scenario B (child)	7	4	1	1	14%	86%
New York City totals	20	8	2	1	10%	90%

Plan: Molina | Location: Buffalo

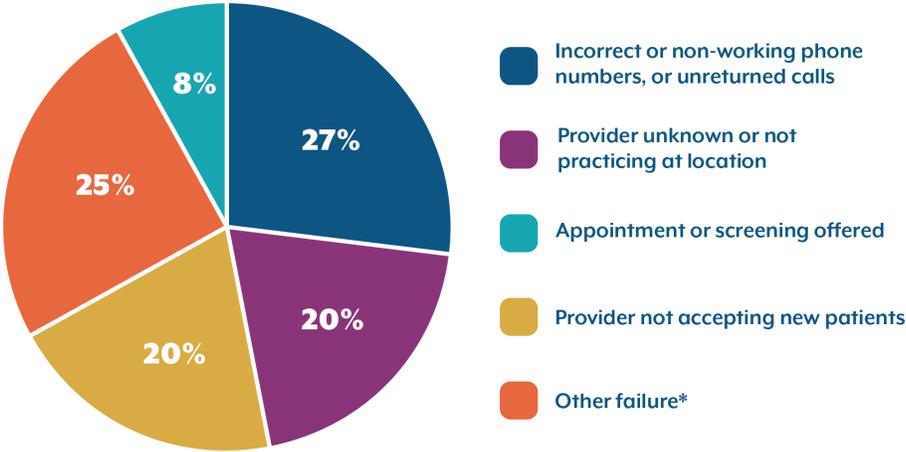
Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	1	1	1	8%	92%
Scenario B (child)	7	1	0	0	0%	100%
Buffalo totals	20	2	1	1	5%	95%

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Molina totals	40	10	3	2	8%	92%

Molina has approximately 390,000 members in its commercial insurance and Medicaid plans in New York.⁹⁰ We called psychiatrists, doctoral-level psychologists, masters-level counselors, and social workers in New York City and Buffalo who were listed in Molina’s provider directory. Only one provider offered an intake appointment for children, although they were at a location in the Bronx despite a listing in Manhattan; nonetheless, we counted this as a success. Four providers only accepted patients with referrals, including one that only accepted patients referred from within the clinic. Several providers had narrow practices that were not disclosed in their listings. The voicemail for a social worker listed as accepting adult patients stated that the office was a school-based program. Another provider listed as treating children was actually a school-based clinic. A psychiatrist we called worked at a cancer center and only treated oncology patients. For the few providers who offered appointments, the wait time ranged from a few days to two weeks at the earliest.

90. DOH Medicaid Managed Care Enrollment Data; DOH Child Health Plus Enrollment Data; DOH QHP and EP Enrollment Data; DFS Prior Approval Rate Application Data, all *supra* note 83.

Figure 11. Molina call outcomes



**Providers did not treat outpatients, required referrals, or were not in-network.*

12. MVP

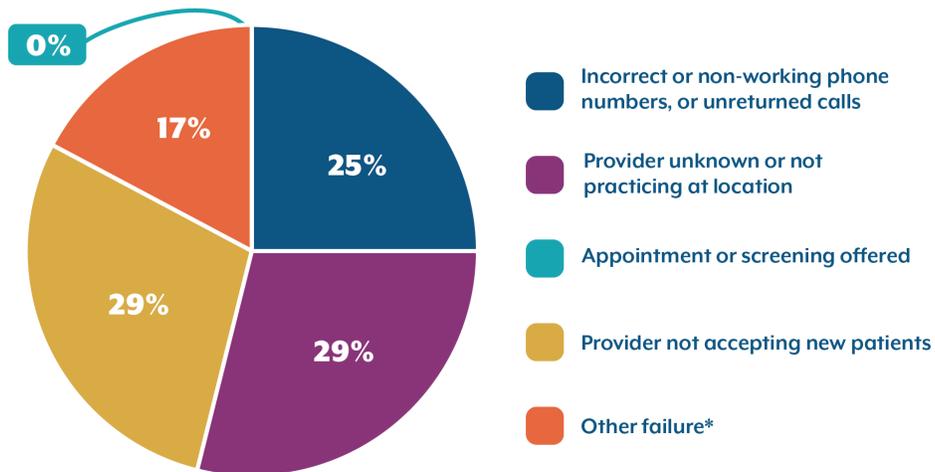
Table 12. MVP call results

Plan: MVP | Location: Albany

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	14	4	0	0	0%	100%
Scenario B (child)	10	5	0	0	0%	100%
MVP totals	24	9	0	0	0%	100%

MVP has approximately 440,000 members in its commercial insurance and Medicaid plans in New York.⁹¹ We called psychiatrists, doctoral-level psychologists, master’s-level mental health counselors, and social workers in Albany listed in MVP’s provider directory. None of these providers offered appointments. Seven did not work at the location reached by the listed phone number and seven were not accepting new patients. Two providers we called for a child appointment only accepted patients with developmental disabilities, but this limitation was not indicated in their listings.

Figure 12. MVP call outcomes



*Providers only treated patients with developmental disorders, only offered group therapy, or belonged to a virtual practice that did not permit the patient to choose a provider.

91. 2018-2021 DOH EPO and PPO Plan Profiles, *supra* note 78; 2021 DOH Statewide Plan Profiles, *supra* note 79.

12. UnitedHealthcare

Table 13. UnitedHealthcare call results

Plan: UnitedHealthcare | Location: New York City

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	6	2	1	15%	85%
Scenario B (child)	7	5	0	0	0%	100%
New York City totals	20	11	2	1	10%	90%

Plan: UnitedHealthcare | Location: Albany

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	6	5	3	38%	62%
Scenario B (child)	7	5	4	0	57%	43%
Albany totals	20	11	9	3	45%	65%

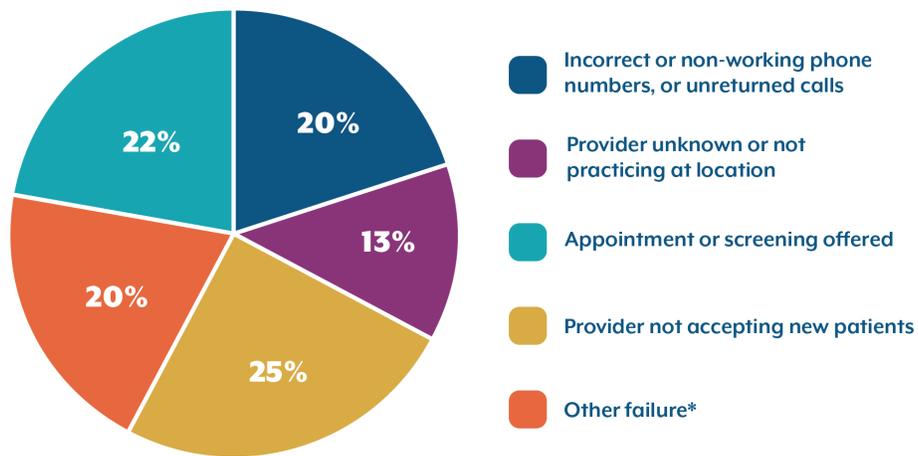
Plan: UnitedHealthcare | Location: Buffalo

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult)	13	7	2	2	15%	85%
Scenario B (child)	7	1	0	0	0%	100%
Buffalo totals	20	8	2	2	10%	90%

Location, scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
UnitedHealthcare totals	60	30	13	6	22%	78%

UnitedHealthcare⁹² has approximately 1.7 million members in its commercial insurance and Medicaid plans in New York.⁹³ Staff called psychiatrists, as well as social workers for child treatment, in New York City, Albany, and Buffalo listed in UnitedHealthcare’s provider directory. Three New York City psychiatrists practiced under a fully virtual psychotherapy service called Talkiatry, which could not guarantee an appointment with the doctor listed in the directory. Because we could not confirm that the listed doctor was in-network and accepting patients, we did not count these calls as successful appointments. Another provider practiced through a virtual-only service that was not yet licensed in New York and could not offer an appointment. One psychiatrist offered an appointment for medication management but not psychotherapy. We counted these offers as successful appointments even though many patients prefer and need both modes of treatment. For the few providers who offered appointments, the wait time ranged from one day to at least one month.

Figure 13. UnitedHealthcare call outcomes



**Providers belonged to a virtual practice that did not permit the patient to choose a provider, were not in-network, were incorrectly listed as treating children, only treated a very narrow category of patients, did not treat outpatients, or were not operating in New York.*

92. UnitedHealthcare includes UnitedHealthcare Insurance Company of New York, Inc., Oxford Health Insurance of New York, and UnitedHealthcare Community Plan.

93. 2021 DOH Statewide Plan Profiles, *supra* note 79.

Table 14. Total results for all plans

	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
All plans totals	396	143	56	33	14%	86%

By scenario	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
Scenario A (adult) totals	240	79	35	22	15%	85%
Scenario B (child) totals	156	64	21	11	13%	87%

By location	Total calls	In-network	Any appointment offered	In-person appointment offered	Success percentage	Ghost listing percentage
All New York City plans totals	206	88	32	18	16%	84%
All Albany plans totals	90	28	12	5	13%	87%
All Buffalo plans totals	80	19	9	7	11%	89%
Rochester totals (Excellus only)	20	8	3	3	15%	85%

Figure 14. Total plan outcomes

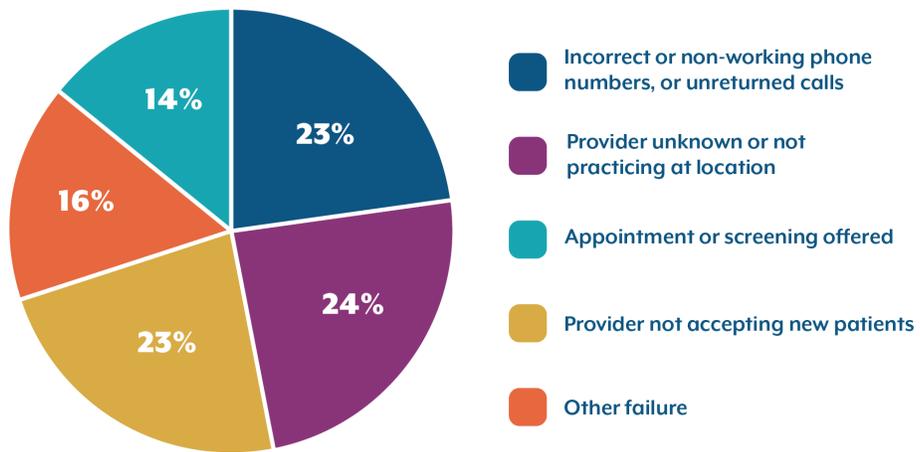
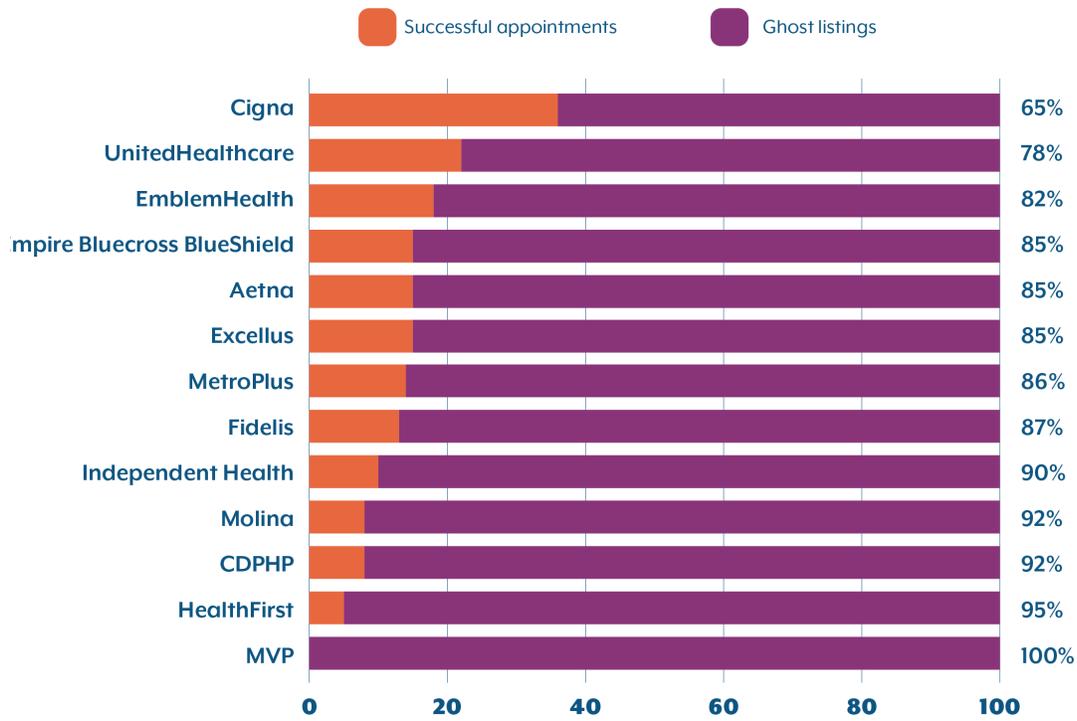


Figure 15. Plan results comparison



D. Discussion

Mental health services are inaccessible to many New Yorkers who rely on health insurance to cover the cost of care. The health plans included in this report misrepresent the availability of their coverage for mental health services across the state, papering over the reality that they have insufficient in-network providers for the 12 million New Yorkers they serve. The survey confirmed that 13 health plans' provider directories are "ghost networks," as only 14 percent of calls resulted in an appointment being offered, despite the fact that the vast majority of the providers we called were listed as accepting new patients. Only eight percent of calls resulted in an in-person appointment being offered. The success rate for the 13 plans ranged from zero to 35 percent.

These results are consistent with previous studies of provider directory accuracy for mental health providers: 18 percent in the Senate Finance Committee study,⁹⁴ 26 percent in Malowney et al.,⁹⁵ 17 percent in Cama et al.,⁹⁶ 14 percent in Blech, et al.,⁹⁷ and three percent in Tenner, et al.⁹⁸

The study confirms widespread violations of directory accuracy laws⁹⁹ and suggests an alarming absence of in-network providers of mental health services. This gap in care will lead to adverse health incomes and higher financial costs to patients, especially those in marginalized groups. Inaccurate directories also distort health insurance markets and undermine health insurance regulation.

1. Ghost networks lead to adverse health outcomes

Inaccurate directories cause consumers seeking care to expend time and resources combing through website listings and calling providers' offices to secure an appointment with an in-network provider.¹⁰⁰ This is a particularly daunting challenge when 86 percent of the listed providers are inaccurately listed or unavailable. Ghost networks can exacerbate mental health conditions, creating additional anxiety and feelings of hopelessness for patients, who may delay or forego care altogether due to the difficulty of accessing services, the

94. Senate Comm. on Fin., Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks 4 (May 3, 2023), <https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf>.

95. Malowney et al., *supra* note 15, at 95.

96. Cama et al., *supra* note 15, at 621.

97. Blech et al., *supra* note 76, at 964.

98. Tenner et al., *supra* note 73, at 291.

99. See N.Y. Ins. L. §§ 3217-a(a)(17), 4324(a)(17); N.Y. Pub. Health L. § 4408(1)(r); 42 U.S.C. § 300gg-115(a) (No Surprises Act).

100. Kristin N. Ray et al., *Opportunity Costs of Ambulatory Medical Care in the United States*, 21 Am. J. Managed Care 567 (2015), <https://www.ajmc.com/view/opportunity-costs-of-ambulatory-medical-care-in-the-united-states>.

cost, or both.¹⁰¹ The pernicious impact of ghost networks is illustrated by the mother who called the OAG Health Care Bureau Helpline, as described on page 9, *supra*, because she could not locate a culturally competent in-network psychiatrist to treat her clinically depressed Black son, resulting in his increased problems in school and the community.

Academic research suggests that insurers' failure to ensure that their mental health provider directories are accurate — and to maintain adequate mental health networks — has exacerbated the mental health crisis. Many Americans struggle to access mental health care because of an insufficient pool of behavioral health care providers in insurance networks.¹⁰² In a 2021 study of adults with private insurance receiving both specialty mental health and medical care, participants were twice as likely to rate their mental health network as inadequate compared with their medical network.¹⁰³

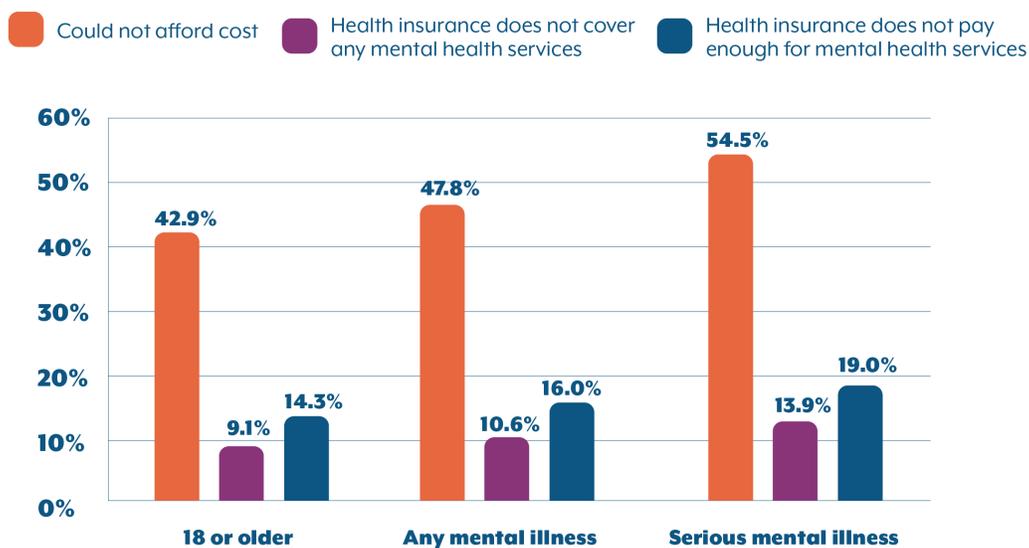
101. Dicken, *supra* note 13, at 17; *Barriers to Mental Health Care: Improving Provider Director Accuracy to Reduce the Prevalence of Ghost Networks*, U.S. Senate Committee on Finance 2-3 (May 3, 2023) (written testimony of Mary Giliberti, Chief Public Policy Officer, Mental Health America), <https://www.finance.senate.gov/imo/media/doc/Mary%20Giliberti-written%20testimony%205-1.pdf>; *id.* at 2 (testimony of Robert L. Trestman, PhD, MD On Behalf of the American Psychiatric Association), [hereinafter Trestman Testimony], <https://www.finance.senate.gov/imo/media/doc/Robert%20Trestman%20APA%20testimony%20050123%20FINAL.pdf>. See also Simon F. Haeder et al., *A Knotty Problem: Consumer Access and the Regulation of Provider Networks*, 44 J. Health Pol. Pol'y L. 937, 938-39 (2019) [hereinafter Haeder et al., *A Knotty Problem*], <https://read.dukeupress.edu/jhpl/article-abstract/44/6/937/139734/A-Knotty-Problem-Consumer-Access-and-the?redirectedFrom=fulltext>; Simon F. Haeder et al., *Going the Extra Mile? How Provider Network Design Increases Consumer Travel Distance, Particularly for Rural Consumers*, J. Health Pol. Pol'y L. 1107, 1127 (2020) [hereinafter Haeder et al., *Going the Extra Mile?*], <https://pubmed.ncbi.nlm.nih.gov/32464649/>; Jinkyung Kim et al., *Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care*, 44 Health Serv. Rsch. 145, 156-57 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669622>.

102. See, e.g., Hemangi Modi, *Exploring Barriers to Mental Health Care in the U.S.* (Am. Assoc. of Med. Colls. Rsch. and Action Institute, Oct 10, 2022), <https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care>.

103. Susan H. Busch et al., *Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults with Private Insurance*, 4 JAMA Network Open 1, 6 (Oct. 22, 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2785383>. Similarly, a 2022 survey of private and non-Federal public employers found that while 82% of employers believed that there was a sufficient number of primary care providers in their networks, only 44% believed there was a sufficient number of behavioral health providers in the networks. Kaiser Family Found., *2022 Employer Health Benefits Survey* (Oct. 27, 2022), <https://www.kff.org/report-section/ehbs-2022-summary-of-findings>.

Surveys consistently show that lack of adequate insurance coverage is a major reason why consumers with mental health conditions go without treatment. According to a 2022 survey conducted by The Harris Poll, 43 percent of Americans who needed mental health or substance use-related care in the past year did not receive it, compared to only 21 percent of those who needed primary care.¹⁰⁴ Notably, 43 percent of those who did not receive necessary mental health care in the past year cited insurance-related issues as the barrier and 37 percent reported that cost-related issues prevented them from accessing care.¹⁰⁵ Similarly, a 2021 survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that among the 57.8 million adults aged 18 or older in 2021 with any mental illness in the past year, only 47 percent (or 26 million people) received mental health services,¹⁰⁶ and 28 percent (or 15.5 million people) perceived an unmet need for mental health services.¹⁰⁷ The most common reason for not receiving treatment, reported by 43 percent, was because they could not afford it.¹⁰⁸ 14 percent said their health insurance did not pay enough for mental health services, and nine percent said they health insurance did not cover any mental health services.¹⁰⁹

Figure 16. Reasons for not receiving mental health services in the past year, 2021



Source: Substance Abuse and Mental Health Services Administration

104. Nat'l Council for Mental Wellbeing, 2022 Access to Care Survey Results 4 (May 11, 2022), <https://www.thenationalcouncil.org/resources/2022-access-to-care-survey-results>.

105. *Id.* at 9, 20.

106. Ctr. for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Servs. Admin., Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health 58 (2022), <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRRev010323.pdf>.

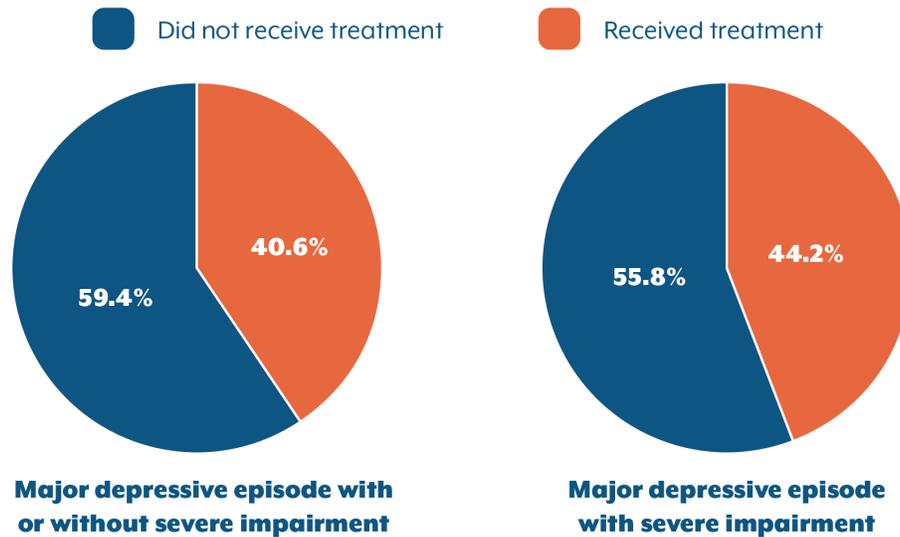
107. *Id.* at 60.

108. *Id.* at A-33.

109. *Id.*

The SAMHSA national survey also shows that most of the five million adolescents aged 12 to 17 in 2021 who had a past year major depressive episode (MDE) did not receive treatment for depression in the past year:¹¹⁰

Figure 17. Received treatment in the past year for depression: Youth aged 12-17, 2021



Source: Substance Abuse and Mental Health Services Administration

Several witnesses in the OAG’s mental health hearings described a vicious cycle in which consumers — in particular, children — are unable to access outpatient services, leading to an escalation in their symptoms until they reach a crisis point and require hospitalization or a similarly high level of care.¹¹¹ As a result, children often spend weeks and months in emergency rooms or overly restrictive settings before they can be appropriately discharged because of a lack of community-based services, as exemplified by these parents’ stories:

“My child was discharged suddenly from a [residential treatment facility (RTF)] because of safety issues and violent harm to others. We spent three months waiting in an emergency department before a safe appropriate placement was arranged. My child is ready to be discharged from the RTF but I am wracked with anxiety because there aren’t any community services available and we’re being told we may have to wait four months before . . . my son can be admitted to a clinic or home-based care. Without the supports in place, I’m forced to choose between working and caring for my child.”¹¹²

110. *Id.* at 55.

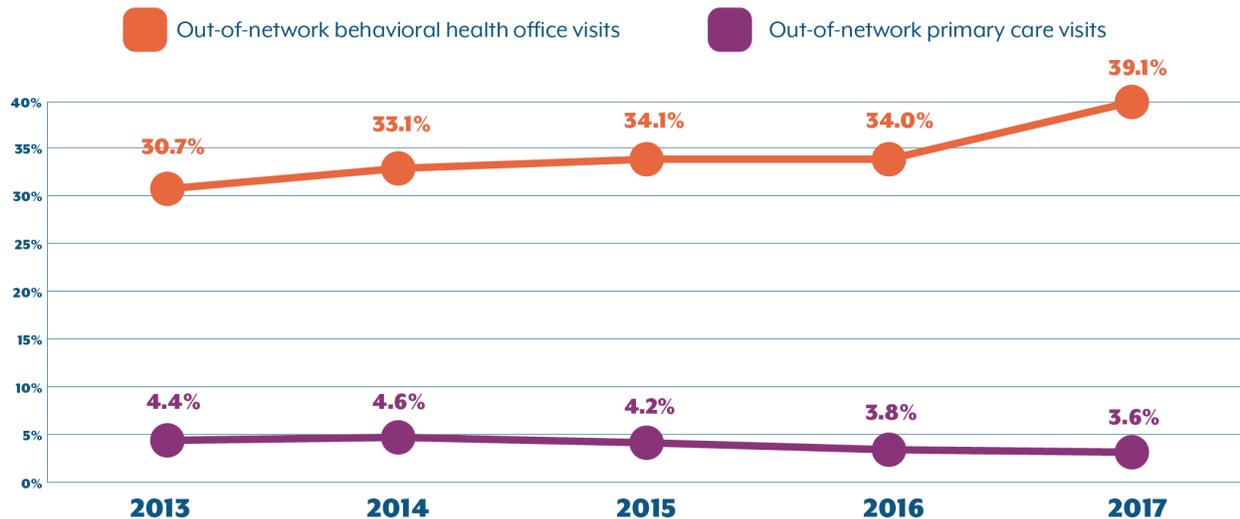
111. See, e.g., June 2022 OAG Mental Health Hearing Tr., *supra* note 9, at 65-69.

112. *Id.* at 75 (testimony of Andrea Smyth, President of the New York State Coalition for Children’s Behavioral Health) (providing stories from the perspective of multiple parents).

2. Ghost networks impose higher financial costs on consumers

Inaccurate directories — and the resultant inability to find in-network providers — lead many consumers to seek out-of-network care.¹¹³ A study analyzing health insurance claims data showed large disparities in out-of-network provider use between behavioral health and physical health services.¹¹⁴ In New York in 2017, behavioral health outpatient office visits were 10 times more likely than medical/surgical primary care visits to be out-of-network.¹¹⁵

Figure 18. New York disparity analysis, PPO plans, 2017



Source: Milliman

These results — which show that almost half of behavioral health office visits are out-of-network — suggest that provider networks for such services are inadequate.¹¹⁶

Many consumers who use out-of-network providers are confronted with surprise bills.¹¹⁷ In other words, they did not initially know that a provider was out-of-network. In a national survey conducted in 2018, the majority of respondents who had used a mental health provider directory encountered inaccuracies, and as a result of those inaccuracies, were twice as likely to be treated by an out-of-network provider and four times more likely

113. Dicken, *supra* note 13, at 17.

114. Stoddard Davenport et al., Milliman Research Report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement 6* (2019), <https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p>.

115. *Id.* at 65.

116. *Id.*

117. Simon F. Haeder et al., *Surprise Billing: No Surprise In View Of Network Complexity*, Health Affs. Blog (June 5, 2019) [hereinafter Haeder et al., *Surprise Billing*], <https://www.healthaffairs.org/content/forefront/surprise-billing-no-surprise-view-network-complexity>.

to receive a surprise outpatient out-of-network bill.¹¹⁸ The most common directory error — seen by 36 percent of respondents who used a directory — was that the provider was incorrectly listed as taking new patients.¹¹⁹ 26 percent of respondents reported that a provider listed in the directory did not accept their insurance.¹²⁰

Higher out-of-network utilization means higher costs for consumers.¹²¹ A study of psychotherapy costs between 2007 and 2017 found that out-of-network prices dramatically increased for both adults (from \$123.30 to \$148.64) and children (from \$119.83 to \$139.18), even as in-network prices and cost sharing declined.¹²² Consumers who lack out-of-network benefits must pay the entire cost of treatment, which is a strong deterrent to seeking care. Notably, HMOs and exclusive provider organizations (EPOs), which comprise more than three-quarters of QHPs, have closed networks, meaning that nonemergency care from out-of-network providers generally is not covered.¹²³

In June 2022, Annemarie Uliasz submitted written testimony describing her inability to obtain in-network treatment for her elementary school-age child, who suffers from Attention Deficit Hyperactivity Disorder. She was forced to use an out-of-network provider, which cost her a total of \$7,400 in a six month period.¹²⁴

118. Susan H. Busch & Kelly A. Kyanko, *Incorrect Provider Directories Associated With Out-Of-Network Mental Health Care And Outpatient Surprise Bills*, 39 Health Affs. 975, 978-80 (2020), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01501>.

119. *Id.* at 978.

120. *Id.*

121. *Id.*; Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 Yale L. Pol'y Rev. 78 (2021), https://yalelawandpolicy.org/sites/default/files/YLPR/2_burman_pe.12.2_78-148.pdf; Haeder et al., *Surprise Billing*, *supra* note 117, <https://www.healthaffairs.org/doi/10.1377/hblog20190603.704918/full/>; Timothy Callaghan et al., *Past experiences with surprise medical bills drive issue knowledge, concern and attitudes toward federal policy intervention*, 17 Health Econ. Pol'y L. 298 (2022), <https://pubmed.ncbi.nlm.nih.gov/34670641/>.

122. Nicole M. Benson & Zirui Song, *Prices and Cost Sharing for Psychotherapy In Network Versus Out Of Network In The United States*, 39 Health Affs. 1210, 1212-1213 (July 2020), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.01468>. The prices are adjusted to 2016 US dollars.

123. Press Release, Avalere, 2020 Exchange Plan Networks Are the Most Restrictive Since 2014 (Dec. 11, 2019), <https://avalere.com/press-releases/2020-exchange-plan-networks-are-the-most-restrictive-since-2014>.

124. June 2022 OAG Mental Health Hearing Written Testimony, *supra* note 10, at 4; Telephone interviews with Annemarie Uliasz (July 6, 2023 and Nov. 29, 2023).

3. Ghost networks disproportionately harm marginalized populations

Studies suggest that the impacts of navigating directory errors fall disproportionately on populations that are already marginalized in the health care system.¹²⁵ Ghost networks are particularly harmful to low-income people, people of color, individuals with disabilities (especially those with mental health conditions), and women, who are over-represented in the Medicaid program and are least able to afford the cost of out-of-network care.¹²⁶ People with mental health needs already experience discrimination within the health care system and society more broadly.¹²⁷

4. Ghost networks distort the health insurance market and undermine insurance regulation

Inaccurate directories also hinder the ability of consumers to choose their health care and health plan, as some consumers choose a plan based on the inclusion of a desired provider in a network directory.¹²⁸ Finally, ghost networks undermine network adequacy laws because regulators rely on directory data for assessments of the adequacy of networks.¹²⁹ In particular, assessment of compliance with appointment wait-time standards generally rely on directory data.¹³⁰ Consequently, inaccurate provider directories render these standards illusory.¹³¹

125. Abigail Burman & Simon F. Haeder, *Without a Dedicated Enforcement Mechanism, New Federal Protections Are Unlikely to Improve Provider Directory Accuracy*, Health Affs. Forefront, Nov. 5, 2021, <https://www.healthaffairs.org/content/forefront/without-dedicated-enforcement-mechanism-new-federal-protections-unlikely-improve>; Elizabeth J. Brown et al., *Racial Disparities in Geographic Access to Primary Care in Philadelphia*, 35 Health Affs. (Millwood) 1374 (2016); Blumenberg E, Agrawal AW. *Getting Around When You're Just Getting By: Transportation Survival Strategies of the Poor*, 18 J. Poverty 355 (2014).

126. Burman, *supra* note 121, at 98-100.

127. National Alliance on Mental Illness, *Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity 6* (2016), 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; Burman & Haeder, *supra* note 125.

128. Davenport et al., *supra* note 114; Burman, *supra* note 121, at 128.

129. Simon F. Haeder et al., *A Consumer-Centric Approach to Network Adequacy: Access to Four Specialties in California's Marketplace*, 38 Health Affs. (Millwood) 1918 (2016) [hereinafter Haeder et al., *A Consumer-Centric Approach to Network Adequacy*].

130. See Off. of Inspector Gen., Dep't of Health & Hum. Servs., *Access to Care: Provider Availability in Medicaid Managed Care 8* (2014), <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

131. Simon F. Haeder et al., *Mixed Signals: The Inadequacy of Provider-Per-Enrollee Ratios for Assessing Network Adequacy in California (and Elsewhere)*, 15 World Med. & Health Pol'y 258, 258 (2021) [hereinafter Haeder et al., *Mixed Signals*], <https://doi.org/10.1002/wmh3.466>.

V. Recommendations

Substantial action is needed to remedy the interrelated problems of inaccurate directories and network inadequacy. Policymakers should follow an approach that has been termed “police patrols and fire alarms.”¹³² **First**, regulators should require health plans to actively and frequently monitor health insurance networks through secret shopper surveys and other techniques. The goal should be to collect and analyze information about actual provision of services by network providers. Where deficiencies are found, regulators should bring enforcement actions against violators, mandating penalties, corrective actions, and restitution to consumers. **Second**, information regarding health plans’ mental health directory accuracy and network adequacy compliance should be made available to consumers on easily accessible websites that allow comparison of health plans, and consumer complaint mechanisms should be enhanced, so that consumers can assert their own rights. **Third**, health plans must be proactive in taking steps to increase compliance. These three principles are embodied in the below recommendations for regulatory reforms, increased enforcement, and health plan actions.

A. Regulatory reforms

As confirmed by academic research¹³³ and recognized by the New York State legislature,¹³⁴ current network adequacy regulations for commercial insurance plans are lacking. As noted above, both DFS and DOH must propose regulations for network adequacy for mental health and substance use disorder treatment services by December 31, 2023.¹³⁵ Only robust requirements that incorporate specific and explicit compliance benchmarks and focus on outcomes, i.e., actual access to mental health services, can address the tremendous unmet need for mental health services.

Regulators should incorporate these standards into New York directory accuracy and network adequacy regulations for all New York health plans, including commercial, QHPs, Medicaid, and Child Health Plus. In the past, baseless cost concerns have led to resistance to laws and regulations that would increase health insurance coverage of mental health treatment. But increasing access to mental health services would likely **reduce**

132. *Id.*

133. See Chima D. Ndumele et al., *Association of State Access Standards With Accessibility to Specialists for Medicaid Managed Care Enrollees*, 177 *JAMA Intern. Med.* 1445 (2017), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2648744>.

134. L.2023, c. 57, pt. II, subpt. F, § 2, eff. May 3, 2023.

135. N.Y. Pub. Health L. § 4403(5)(b).

overall health care costs. According to a 2022 report issued by the Satcher Health Leadership Institute, reducing mental health care inequities in the period from 2016 through 2020 could have saved nearly 117,000 lives and approximately \$278 billion nationwide.¹³⁶

1. Employ secret shopper surveys or full network audits

New York should adopt regulations that require health plans to conduct audits of compliance with directory accuracy, network adequacy, and mental health parity requirements using a standardized methodology, and to report the results to regulators, who would make them available on a public website. The “gold standard” to ensure compliance with directory accuracy and network adequacy laws is either a secret shopper study or a comprehensive audit of a provider network. Both directly verify actual provider in-network status in real time, as reflected in this report.

California provides a well-developed model of a comprehensive mental health network audit with reporting to the state and public disclosure, which New York should adopt. California requires health plans to issue accurate provider directories indicating whether providers are accepting new patients, update online directories at least weekly, and to contact all listed providers at least once a year to confirm that their listings are accurate.¹³⁷ Using a standardized methodology created by the California Department of Managed Health Care (DMHC),¹³⁸ health plans must annually survey all network providers to identify each provider’s next available urgent and non-urgent appointments, and demonstrate compliance with appointment wait time standards (discussed below) by obtaining a 70 percent rate of compliance.¹³⁹ If a health plan does not meet the standards, it must conduct an internal inquiry, submit a corrective action plan, and may be subject to disciplinary action.¹⁴⁰ The DMHC reviews the information submitted by health plans annually, makes recommendations for changes to protect enrollees, and posts final findings on an easy-to-use online dashboard,¹⁴¹ which includes annual Timely Access to Care Reports that rank health plans by compliance rate.¹⁴²

136. Satcher Health Leadership Institute, Satcher Health Leadership Institute at Morehouse School of Medicine Releases First-Ever Report Demonstrating the Devastating Cost of Mental Health Inequities (Sept. 7, 2022), <https://satcherinstitute.org/satcher-health-leadership-institute-at-morehouse-school-of-medicine-releases-first-ever-report-demonstrating-the-devastating-cost-of-mental-health-inequities>.

137. Cal. Health & Safety Code § 1367.27.

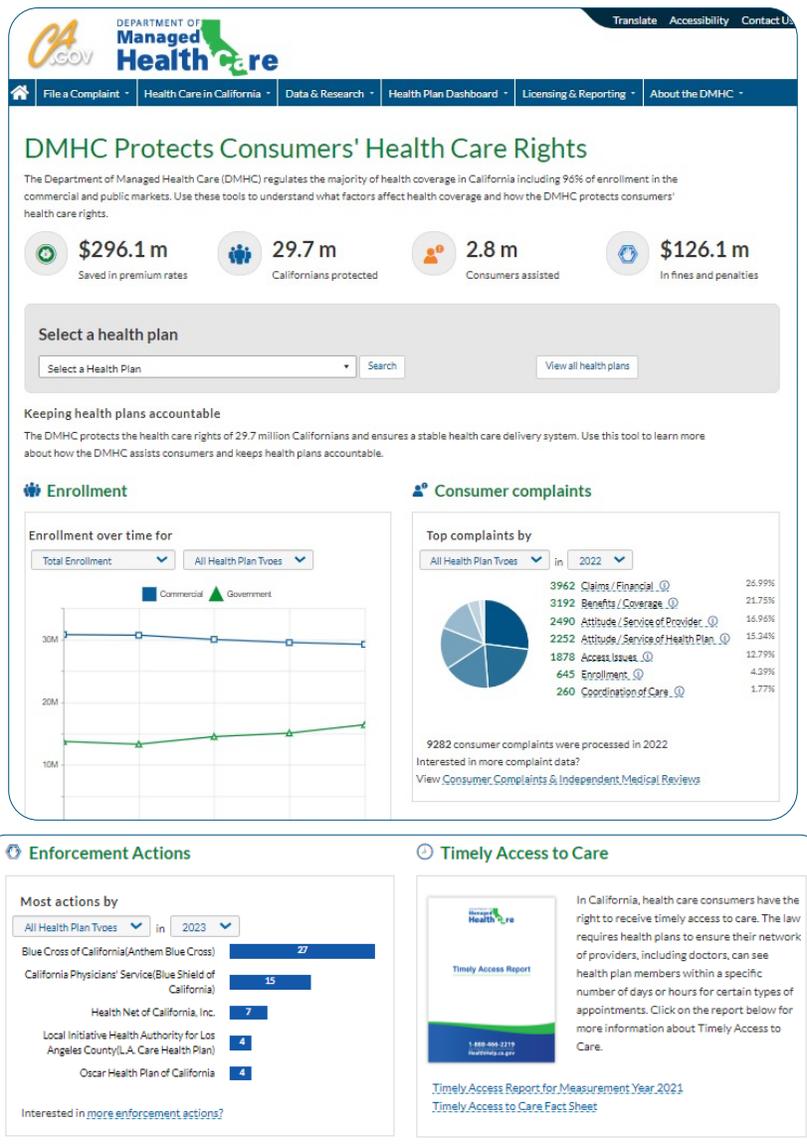
138. See California Department of Managed Health Care, Reporting Year 2024/Measurement Year 2023 Provider Appointment Availability Survey Manual (2022), <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Ry%202024%20MY%202023%20PAAS%20Manual.pdf?ver=WlrOdFMZajlDjDhDW9wTGg%3d%3d>.

139. Cal. Code of Regs. tit. 28 §§ 1300.67.2.2(b)(12)(A), (f) (2023).

140. *Id.* §§ 1300.67.2.2(d), (f)(1)(l), (h)(6)(C), (j).

141. Cal. Dep’t of Managed Health Care, DMHC Protects Consumers’ Health Care Rights, <https://wps0.dmhc.ca.gov/dashboard/MarketPlace.aspx> (last visited Nov. 10, 2023).

142. Cal. Health & Safety Code § 1367.03(i). DMHC’s Timely Access Reports are posted at <https://www.dmhc.ca.gov/AbouttheDMHC/DMHCReports/PublicReports.aspx#TAR> (last visited Nov. 10, 2023).



Source: California Department of Managed Health Care

California is not alone in conducting audits, including secret shopper surveys. In New York, DOH uses secret shopper calls to monitor the network adequacy of Medicaid MCOs.¹⁴³ And in 2023, CMS issued a proposed Medicaid access regulation that would require states to contract with an independent entity to conduct annual secret shopper surveys.¹⁴⁴ The surveys would determine each managed care plan's compliance with both the provider directory and appointment wait time standards accuracy (which are discussed below), with a minimum rate of compliance with appointment wait time standards of 90 percent.¹⁴⁵

143. Elizabeth Hinton & Jada Raphael, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*, Kaiser Family Found., Appendix Table 1 (June 15, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes>.

144. Amendment to Medicaid and Children's Health Insurance Program (CHIP) Managed Care, 88 Fed. Reg. 28243 (proposed May 3, 2023) (to be codified at 42 C.F.R. pt. 438.68(f)).

145. *Id.* The 90 percent compliance rate is the same as the standards for QHPs on the FFE, which is effective for plan years beginning on or after January 1, 2025. This requirement would become effective at least four years after the effective date of the final version of the proposed rule. *Id.*

2. Analyze network adequacy metrics

Network adequacy must be measured through metrics that demonstrate actual access to treatment. A list of names on a page is not sufficient. Time and distance standards, which specify the maximum time it should take for a consumer to travel to an appointment with a provider, and provider-to-enrollee ratios have limited usefulness, in particular if provider directories are filled with errors.¹⁴⁶ In contrast, by codifying in regulations the metrics set forth below, New York can measure access and thus ensure that health plans have adequate mental health provider networks.

a) Strengthen appointment wait time standards

New York should adopt regulations that require all health plans to meet robust appointment wait time standards for all product lines, and to show compliance through self-audits. DFS has not issued appointment wait time standards for commercial health plans. As noted above, DOH has established wait time standards that apply only to Medicaid and Child Health Plus plans,¹⁴⁷ including that for urgent care, appointments must be available within 24 hours of a request.¹⁴⁸ These standards must be strengthened and clarified. First, they should apply to all health plans. Second, DOH must clarify that they apply to individual outpatient providers who are not clinics or programs. Third, robust enforcement is needed. Appointment wait time standards in isolation — i.e., without audits or secret shopper surveys — are likely to be ineffective in ensuring access to services.¹⁴⁹

California's comprehensive approach — which should be employed in New York — requires health plans to show through audits that consumers can schedule urgent care appointments for psychiatrists and nonphysician mental health providers within 96 hours, and non-urgent appointments within 10 business days for nonphysician mental health providers and within 15 business days for psychiatrists.¹⁵⁰ As noted, plans must demonstrate a 70 percent compliance rate.¹⁵¹

146. Haeder et al., *Mixed Signals*, *supra* note 131, at 264-67; Haeder et al., *A consumer-centric approach to network adequacy: Access to four specialties in California's Marketplace*, 38 Health Aff. 1918, 1918 (2019), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2019.00116>; Haeder et al., *A Knotty Problem*, *supra* note 105, at 937-954; Haeder et al., *Going the extra mile?*, *supra* note 101 at 1107-1136; Simon F. Haeder et al., *Integrating Travel Distance Into Assessments of Provider Networks Using a Dyadic Approach: The Case of California's Affordable Care Marketplace*, SAGE Rsch. Methods Cases: Med. Health, Jan. 2020, <https://methods.sagepub.com/case/travel-distance-provider-networks-dyadic-californias-affordable-care>.

147. DOH Model Contract, *supra* note 57. Notably, 2023 amendments to the New York Public Health Law require DOH to consider, in determining network adequacy, the number of grievances filed by enrollees relating to waiting times for appointments. N.Y. Pub. Health L. § 4403(5)(b).

148. DOH Model Contract, *supra* note 57, at 15-1.

149. Haeder et al., *Secret Shoppers Find Access to Providers and Network Accuracy Lacking*, *supra* note 71; Off. of Inspector Gen., Dep't of Health & Hum. Servs., *Access to Care: Provider Availability in Medicaid Managed Care 8* (2014), <https://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>.

150. Cal. Code of Regs. tit. 28 § 1300.672.2(c)(5); Cal. Health and Safety Code § 1367.03(a)(5).

151. Cal. Code of Regs. tit. 28 § 1300.672.2(b)(12)(A) and (f).

Federal agencies have adopted these types of standards. Starting in 2025, CMS will require ACA plans issued on a Federally Facilitated Exchange (FFE) to meet strict appointment wait time standards — including that behavioral health appointments be available within 10 business days — at least 90 percent of the time.¹⁵² To count towards meeting the appointment wait time standards, providers must be licensed in their state and have in-person services available.¹⁵³ Although telehealth is an important vehicle for delivering behavioral health services, requiring availability of in-person services to satisfy adequacy requirements is also important, as many consumers lack broadband access or have a strong preference or need for in-person services.¹⁵⁴ Similarly, in 2023 CMS proposed Medicaid access regulations that would establish a maximum appointment wait time of 10 days for outpatient mental health and substance use disorder providers (both children and adults),¹⁵⁵ coupled with secret shopper surveys to measure compliance, the results of which would be made public. Appointments offered via telehealth would count toward compliance only if the provider also offers in-person appointments.¹⁵⁶

b) Analyze and report to regulators indicators of network adequacy

New York should adopt regulations that require health plans to analyze and submit to regulators data regarding key network adequacy indicators, including:

(1) Claims data showing treatment of members by in-network providers

It is vitally important that new regulations require that health plans analyze, and report to regulators, data showing whether each of its in-network mental health providers are actually treating plan members. This is the most direct measure of access to treatment and relies on information already in the possession of health plans. Such an approach has been used for several years in New Jersey, which requires health insurers to confirm the participation of any in-network provider who has not submitted a claim for a period of 12 months or otherwise communicated their intention to continue to participate in the insurer's network.¹⁵⁷

152. 45 C.F.R. § 156.230(a)(2)(i)(B); Ctrs. for Medicare and Medicaid Servs., 2023 *Final Letter to Issuers in the Federally-facilitated Exchanges* 12, 13, 15 (Apr. 28, 2022)

<https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf> [hereinafter 2023 Final Letter] (noting that CMS delayed applicability of the appointment wait time standards until the 2025 plan year and that it will release guidelines for compliance in later guidance).

153. *Id.* at 12, 15 (noting that CMS delayed applicability of the appointment wait time standards until the 2025 plan year and that it will release guidelines for compliance in later guidance).

154. Trestman Testimony, *supra* note 101, at 3.

155. Amendment to Medicaid and Children's Health Insurance Program (CHIP) Managed Care, 88 Fed. Reg. 28092, 28243 (proposed May 3, 2023) (to be codified at 42 C.F.R. pt. 438.68(e)(2)). This requirement would become effective at least three years after the effective date of the final version of the proposed rule. *Id.* at 28243.

156. *Id.*

157. N.J.A.C. 11:24C-4.6(d).

Researchers have analyzed health plans' claims data to identify ghost networks. A study published in 2022 applied a claims analysis methodology to examine realized access to treatment, showing that most in-network mental health providers do not actually treat health plan members. The researchers analyzed Medicaid claims data to determine whether providers listed in directories in Oregon in 2018 were actually seeing patients. "In-network" providers were defined as those with any medical claims filed for at least five unique Medicaid beneficiaries enrolled in a given health plan during a one-year period, and included primary care providers, mental health prescribers, and non-prescribing mental health clinicians. The researchers found that 58 percent of network directory listings were "phantom" providers who did not see Medicaid patients, including 67 percent of mental health prescribers, 59 percent of mental health non-prescribers, and 54 percent of primary care providers.¹⁵⁸

(2) Out-of-network utilization

Health plans should also be required to analyze and report to regulators the percentage of plan members submitting claims for mental health treatment with out-of-network providers. High out-of-network utilization can signal an inadequate provider network.¹⁵⁹ Numerous studies have shown that out-of-network utilization is higher for mental health conditions than for physical health conditions.¹⁶⁰ Indeed, New York law recognizes that out-of-network utilization is an important metric. Pursuant to 2023 amendments to the New York Public Health Law,¹⁶¹ DOH must consider during its network adequacy reviews the availability of appropriate and timely care, including "an analysis of the rate of out-of-network utilization for covered mental health and substance use disorder services as compared to the rate of out-of-network utilization for the respective category of medical services."¹⁶²

Additionally, in August 2023, the Biden Administration proposed MHPAEA regulations that address network adequacy by requiring health insurers to collect and evaluate outcomes data to assess the impact of NQTLs on access to mental health and substance use disorder benefits as compared to medical/surgical benefits,¹⁶³

158. Zhu et al., *supra* note 15.

159. Busch & Kyanko, *supra* note 118, at 981.

160. *Id.* at 975-983; Wendy Y. Xu et al., *Cost-Sharing Disparities for Out-of-Network Care for Adults With Behavioral Health Conditions*, JAMA Network Open, Nov. 6, 2019, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2753980>; Davenport et al., *supra* note 114, at 6; Kelly A. Kyanko et al., *Out-of-Network Provider Use More Likely in Mental Health than General Health Care Among Privately Insured*, 51 Med. Care 699 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4707657/pdf/nihms735108.pdf>.

161. L.2023, c. 57, pt. II, subpt. F, § 2, eff. May 3, 2023.

162. N.Y. Pub. Health L. § 4403(5)(b).

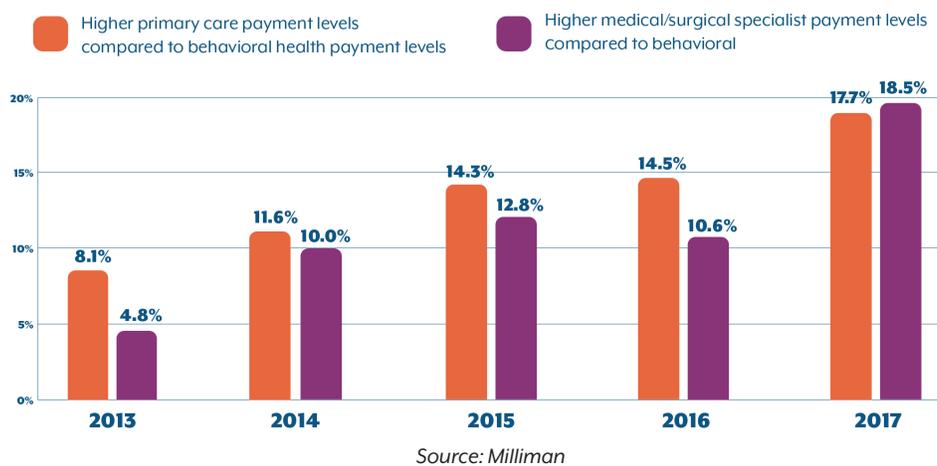
163. Requirements Related to the Mental Health Parity and Addiction Equity Act, Amending Requirements for the Group Health Insurance Market, 88 Fed. Reg. 51659 (proposed Aug. 3, 2023) (to be codified at 45 C.F.R. pt. 146.136(c)(4)(iv)(A)).

including out-of-network utilization rates.¹⁶⁴ The OAG submitted a comment letter on behalf of 18 attorneys general strongly supporting the proposed regulation.¹⁶⁵

(3) Provider reimbursement rates

Health plans should analyze and report to regulators data comparing reimbursement rates for mental health providers against rates for medical/surgical providers. Studies have shown that health plans pay lower rates for mental health than for physical health providers, which may discourage mental health providers from joining health plan networks, resulting in a lack of access to in-network treatment.¹⁶⁶ A 2019 report by the actuarial firm Milliman showed significant reimbursement disparities between providers of behavioral health and physical health services. Strikingly, in New York in 2017, average in-network reimbursement rates were 18 percent higher for primary care and 19 percent higher for physical health specialist office visits than for behavioral health office visits, with the disparities greater than in prior years.¹⁶⁷

Figure 19. In-network reimbursement levels relative to Medicare-allowed office visits, New York



164. *Id.* Under the proposed MHPAEA regulations, if the data show material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits, the differences would be considered a strong indicator that the health insurer violates MHPAEA, and the health insurer would need to take reasonable action to address the material differences to ensure compliance. *Id.* [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(B)]. For NQTLs related to network composition, a violation of MHPAEA would be presumed if the relevant data show material differences in access to in-network MH/SUD benefits as compared to medical/surgical benefits. *Id.* [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(C)]. Such NQTLs include “standards for provider and facility admission to participate in a network or for continued network participation, including methods for determining reimbursement rates, credentialing standards, and procedures for ensuring the network includes an adequate number of each category of provider and facility to provide services under the plan or coverage.” *Id.* [Proposed 45 C.F.R. § 146.136(c)(4)(iii)(D)].

165. Press Release, Office of the N.Y. State Att’y Gen., Attorney General James Leads Coalition of 18 Attorneys General in Calling for Mental Health and Substance Use Disorder Coverage Parity (Oct. 18, 2023), <https://ag.ny.gov/press-release/2023/attorney-general-james-leads-coalition-18-attorneys-general-calling-mental>.

166. Tami L. Mark et al., *Comparison of Medicaid Reimbursements for Psychiatrists and Primary Care Physicians*, 71 *Psychiatr. Serv.* 947 (2020), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.202000062>; Tami L. Mark et al., *Differential Reimbursement of Psychiatric Services by Psychiatrists and Other Medical Providers*, 69 *Psychiatr. Serv.* 281 (2018), <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700271>.

167. Davenport et al., *supra* note 114, at 65.

Low reimbursement rates offered by health plans for mental health services are a major reason why providers decide not to join insurance networks,¹⁶⁸ and contribute to disparities in network adequacy.¹⁶⁹ With a high demand for services and low in-network reimbursement rates, providers can earn more by deciding not to accept insurance and instead adopt a cash or self-pay model.¹⁷⁰ According to the FAIR Health database, a typical plan pays an in-network mental health provider \$128 for a 45-minute therapy session, whereas an out-of-network provider charges \$300 for a 45-minute session.¹⁷¹

During the Senate Finance Committee's hearing on ghost networks in May 2023, which accompanied the Committee's release of a report detailing errors in Medicare Advantage health plan directories,¹⁷² the American Psychiatric Association submitted testimony regarding health insurers' disparate treatment of mental health providers:

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.¹⁷³

The above testimony demonstrates that network inadequacy is the direct consequence of health insurers' low reimbursement rates for mental health providers.

Requiring analysis of provider reimbursement rates is consistent with existing laws. Under MHPAEA, which has been incorporated into New York law,¹⁷⁴ provider reimbursement rates are an NQTL that must be comparable between mental health and physical health treatment.¹⁷⁵ Additionally, proposed MHPAEA regulations issued in August 2023, described above, would require health insurers to collect and evaluate outcomes data regarding provider reimbursement rates and remedy disparities.¹⁷⁶ And proposed Medicaid regulations would require

168. Modi, *supra* note 102, <https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care>; Dicken, *supra* note 13, at 10.

169. Modi, *supra* note 102; Dicken, *supra* note 13, at 10.

170. See Dicken, *supra* note 13, at 10-11.

171. See *Estimate Cost*, Fair Health Consumer (Jul. 21, 2023, 1:00 PM), <https://www.fairhealthconsumer.org/medical>.

172. Senate Comm. on Fin., *supra* note 94.

173. Trestman Testimony, *supra* note 101, at 6.

174. N.Y. Ins. L. §§ 3216(i)(31), (i)(35); 3221(l)(5), (7); 4303(g), (l).

175. 45 C.F.R. § 146.136(c)(4)(ii)(D).

176. 88 Fed. Reg. at 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(A)], <https://www.govinfo.gov/content/pkg/FR-2023-08-03/pdf/2023-15945.pdf>.

states to submit an annual payment analysis comparing managed care plans' payment rates for mental health services (both adult and pediatric) as a proportion of Medicare's payment rate,¹⁷⁷ along with a plan to address any deficiencies.¹⁷⁸

(4) Network breadth

Finally, health plans should analyze and report to regulators data analyzing "network breadth," which is the percentage of all providers in a health plan's service area that participate in its network.¹⁷⁹ Narrow provider networks limit consumers' access to treatment. A 2017 study of ACA marketplace plans concluded that 45.6 percent of primary care providers participated in at least one ACA plan network, compared with only 21.4 percent of mental health providers.¹⁸⁰ Similarly, a 2023 study found that nearly two-thirds of psychiatrist networks in Medicare Advantage were narrow (with fewer than 25 percent of providers in a network's service area), but did not observe such narrow networks for primary care physicians or other physician specialists.¹⁸¹ The researchers concluded that narrow psychiatrist networks may disadvantage enrollees who seek mental health services.¹⁸² Accordingly, CMS requires that QHPs issued on the FFE analyze network breadth.¹⁸³ CMS compares the breadth of each QHP's network with the network breadth of other QHPs available in the same county.¹⁸⁴ To enable consumers to compare the breadth of health plan networks, CMS will post its results on its <https://www.healthcare.gov/> website.¹⁸⁵ CMS will classify each QHP's network as "Basic" if it has fewer than 30 percent of available providers, "Standard" if it contains between 30 and 69 percent of available providers, and "Broad" if it contains 70 percent or more of available providers.¹⁸⁶

177. *Id.* at 28245 [Proposed 42 C.F.R. §438.207(b)(3)]. This requirement would become effective at least four years after the effective date of the final version of the proposed rule. *Id.* [Proposed 42 C.F.R. §438.207(g)].

178. *Id.* [Proposed 42 C.F.R. §438.207(f)].

179. 2023 Final Letter, *supra* note 152, at 16-17; Ctrs. for Medicare and Medicaid Servs., 2024 Final Letter to Issuers in the Federally-facilitated Exchanges 13 (May 1, 2023), <https://www.cms.gov/files/document/2024-final-letter-issuers-508.pdf> [hereinafter 2024 Final Letter] (noting that the approach for network transparency remains unchanged from 2023).

180. Jane M. Zhu, *Networks In ACA Marketplaces Are Narrower For Mental Health Care Than For Primary Care*. 36 Health Affs. 1624, 1627 (2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0325>.

181. Jane M. Zhu et al., *Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets*. Health Affs. 909, 914 (2023), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1037734/>.

182. *Id.*

183. 2023 Final Letter, *supra* note 152, at 16-17; 2024 Final Letter, *supra* note 179, at 13 (noting that the approach for network transparency remains unchanged from 2023).

184. *Id.*

185. 2023 Final Letter, *supra* note 152, at 16-17.

186. *Id.* at 17; 2024 Final Letter, *supra* note 179, at 13 (noting that the approach for network transparency remains unchanged from 2023).

3. Require insurers to remedy network inadequacy

New regulations should require health plans to take steps to remedy disparities or gaps in network adequacy as indicated by the metrics described above. Requirements proposed by federal agencies are useful models. Under proposed regulations for Medicaid managed care, if a state identifies an area in which an MCO's access to care can be improved, the state must submit to CMS for approval a remedy plan that identifies specific remedial actions.¹⁸⁷ These plans may include increasing payment rates to providers, improving outreach and problem resolution to providers, reducing barriers to provider credentialing and contracting, providing for improved or expanded use of telehealth, and improving the timeliness and accuracy of processes such as claim payment and prior authorization.¹⁸⁸ Under proposed regulations for MHPAEA, if a health plan's data show material differences in access to mental health and substance use disorder benefits as compared to medical/surgical benefits, the differences would be considered a strong indicator that the health insurer violates MHPAEA, and the health insurer would need to take reasonable action to address the material differences to ensure compliance.¹⁸⁹ New York network adequacy regulations should incorporate such provisions for all health plans.

4. Require health plans to meet cultural competence and language access standards

New regulations should also require health plans to meet cultural competence and language access standards. At the OAG's January 2023 mental health hearing, several consumers and advocates testified about the need for culturally competent mental health care.¹⁹⁰ As described by Sara Taylor, a Black parent from Rochester:

Having a system where there's no professional clinical staff of color that looks like us, programs that lack training, and culturally responsible care is heart-wrenching . . . [For example,] admitting my child to a children's psychiatric hospital 60 miles away with her matted hair, I asked the staff is there anyone that can do ethnic hair. They say what do you mean. Always asking is there a therapist of color, told we don't have any trained. Calling for 911 emergencies, they manhandle her.¹⁹¹

187. 88 Fed. Reg. at 28245 [Proposed 42 C.F.R. §438.207(f)]. This requirement would become effective at least four years after the effective date of the final version of the proposed rule. *Id.* [Proposed 42 C.F.R. §438.207(g)].

188. *Id.*

189. 88 Fed. Reg. at 51659 [Proposed 45 C.F.R. § 146.136(c)(4)(iv)(B)].

190. Jan. 2023 OAG Mental Health Hearing Tr., *supra* note 9, at 135-41, 167-72 (testimony of Sara Taylor and Chacku Mathai); see also June 2022 OAG Mental Health Hearing Tr., *supra* note 9, at 69 (testimony of Alice Bufkin) (calling for "strategies to increase the number of multilingual providers and providers of color," including "reducing educational debt of new practitioners, establishing loan forgiveness programs and scholarships, and providing college credit for on-the-job experience and learning.").

191. Jan. 2023 OAG Mental Health Hearing Tr., *supra* note 9, at 137-139.

Such standards already exist for certain health plans. Federal Medicaid regulations require that state network adequacy standards consider the ability of MCO network providers to communicate with limited English proficient enrollees in their preferred language, and to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with physical or mental disabilities.¹⁹² DOH has incorporated this requirement into its model contract for MCOs, which specifies that MCOs must ensure the cultural competence of their provider networks by requiring participating providers to complete State-approved cultural competence training annually, including training on the use of interpreters, for all staff who have regular and substantial contact with enrollees.¹⁹³ Additionally, the 2023 amendments to the New York Public Health Law¹⁹⁴ require DOH to consider during its network adequacy reviews a network's ability to provide culturally and linguistically competent care to meet the needs of the enrollee population.¹⁹⁵ These provisions should be codified into a regulatory requirement that all New York health plans provide access to culturally and linguistically competent mental health care.

5. Enhance consumer complaint mechanisms

New regulations should make it easier for consumers to file complaints regarding directory inaccuracy and network adequacy with regulators and health plans, using prominent and simple web portals. Ideally, complaint mechanisms help consumers resolve access barriers and give regulators visibility to potentially systemic problems with health plans' networks.¹⁹⁶ A 2020 study, however, found that among consumers who encountered inaccuracies in mental health directories, only three percent reported that they had filed a complaint with a government agency.¹⁹⁷ Only nine percent said that they had submitted a grievance or complaint form to their insurer, and 16 percent said they had complained to their insurer by phone.¹⁹⁸ These findings suggest that consumers should be made more aware of their right to file complaints, in particular regarding directory inaccuracy and network inadequacy, and that complaint mechanisms should be made easier to use. A “one stop shop” for complaints about health plan practices, which would transmit complaints to both health plans and regulators, would be a vast improvement.

192. 42 C.F.R. §§ 438.68(c)(1)(vii), (viii).

193. DOH Model Contract, *supra* note 57, at 15-8.

194. L.2023, c. 57, pt. II, subpt. F, § 2, eff. May 3, 2023.

195. N.Y. Pub. Health L. § 4403(5)(b).

196. Alex Gillespie & Tom W. Reader, *Patient-Centered Insights: Using Health Care Complaints to Reveal Hot Spots and Blind Spots in Quality and Safety*, 96 *Milbank Q.* 530, 530-67 (2018).

197. Busch & Kyanko, *supra* note 118, at 979-80.

198. *Id.* at 980.

6. Explore the possibility of a centralized provider directory

Finally, New York should explore the possibility of a centralized provider directory for all health plans, which may improve compliance with regulations and access to treatment. Updating provider directories, each of which typically has different format and data entry protocols, imposes significant burdens on providers and health plans. The estimated cost to U.S. health care providers of sending directory updates to insurers via disparate technologies, schedules, and formats is \$2.76 billion annually.¹⁹⁹

Some have proposed a centralized directory as a solution.²⁰⁰ A promising model already exists in New York. For New York State of Health plans, DOH maintains the NYS Provider & Health Plan Look-Up, which allows consumers shopping for a health plan to search for particular providers to determine if they are in various health plan networks.²⁰¹ The tool is updated with information submitted by health plans; it therefore does not reduce burdens on providers who must still update their listings with each health plan in which they participate. It does not include all of the information specified in New York's directory accuracy requirements, in particular whether providers are accepting new patients, and is not designed to allow consumers to search for particular types of providers, such as mental health specialists. But with technical enhancements it could be transformed into a comprehensive directory that could supplant the myriad of unreliable directories maintained by health plans, thus reducing burdens on providers and plans, while offering an even more valuable resource to consumers. It is estimated that a single platform could save approximately \$1.1 billion nationally each year.²⁰²

199. Council for Affordable Quality Healthcare, *The Hidden Causes of Inaccurate Provider Directories* at 2 (2019), <https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf>.

200. Ctrs. for Medicare and Medicaid Servs., *Request for Information*, 87 Fed. Reg. 61018 (Oct. 7, 2022).

201. N.Y. State Provider & Health Plan Lookup, <https://pndslookup.health.ny.gov/> (last visited Nov. 10, 2023).

202. Council for Affordable Quality Healthcare. *The Hidden Causes of Inaccurate Provider Directories* (2019), at 3.

B. Enforcement

It is essential to address the network and access issues that directory inaccuracies may mask. This can be done only by enforcing accuracy requirements and quantitative network adequacy standards in tandem, in particular appointment wait-time requirements. The three key elements are audits, consequences, and transparency.

1. Audits

As discussed above in Section V(A)(1), new regulations should require health plans to conduct robust audits of both accuracy and adequacy requirements and submit the results to regulators for review and public disclosure. Academic research shows that audits provide benchmarks allowing compliance to be measured over time. A study of health plans' compliance with California's rigorous directory accuracy requirements showed significant improvement with respect to non-physician mental health providers, for whom the rate of correct listings increased from 70 percent in 2018 to 81 percent in 2019.²⁰³ Plans' compliance with appointment wait time standards improved slightly with respect to urgent care with psychiatrists, from 47 percent to 49 percent during the same period.²⁰⁴

2. Consequences

Regulators must impose consequences for violations, including monetary penalties, to incentivize health plans to maintain accurate directories and adequate networks. In the past, states rarely carried out enforcement actions or imposed meaningful sanctions against health plans, despite having various enforcement mechanisms at their disposal.²⁰⁵ For example, for Medicaid managed care plans, states may impose corrective action plans, monetary penalties, or terminate contracts with MCOs that do not meet their obligations.²⁰⁶ Yet a 2022 survey of state Medicaid programs showed that only nine of 38 states reported issuing monetary or non-monetary penalties for non-compliance with MCO contractual network adequacy standards within the past three years.²⁰⁷ Despite this history, several prominent examples evidence a trend towards greater enforcement. As described above, the OAG has entered into settlements regarding directory inaccuracy and network adequacy

203. Abigail Burman & Simon F. Haeder, *Provider Directory Inaccuracy and Timely Access for Mental Health Care*, 29 Am. J. Managed Care 96, 98 (2023), <https://www.ajmc.com/view/provider-directory-inaccuracy-and-timely-access-for-mental-health-care>.

204. *Id.* at 96-102.

205. Abigail Burman & Simon F. Haeder, *Potemkin Protections: Assessing Provider Directory Accuracy and Timely Access for Four Specialties in California*, 47 J. Health Politics, Pol'y and L. 319, 343 (2022).

206. 42 C.F.R. § 438.702.

207. Elizabeth Hinton & Jada Raphael, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*, Kaiser Family Found. (Jun. 15, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes>.

with UnitedHealthcare²⁰⁸ and Carelon.²⁰⁹ Critically, these settlements made consumers whole by providing reimbursement to those who were financially impacted by directory inaccuracies. Additionally, regulators in New York,²¹⁰ California,²¹¹ Washington,²¹² and Massachusetts²¹³ have recently announced significant enforcement actions related to access to mental health care.

3. Transparency

New regulations should require regulators to collect and publish data online regarding health plans' compliance with directory accuracy and network adequacy laws, so that consumers can easily see and compare the quality of plans' mental health coverage and make informed choices about their health care. This model already exists for health care facilities across the country. For example, CMS's Compare tool allows consumers to compare ratings for hospitals and nursing homes.²¹⁴ Similar information regarding provider directory accuracy rates and network adequacy should be available to all consumers on easily accessible websites. As noted above, California

208. Press Release, Jan. 19, 2012, *supra* note 17; Press Release, Dec. 19, 2006, *supra* note 17.

209. Press Release, Mar. 5, 2015, *supra* note 19, at ¶¶ 60.

210. In November 2023, OMH announced \$2.6 million in total fines to five Medicaid managed care plans for repeatedly and inappropriately denying claims and failing to pay required rates for behavioral health treatment. Press Release, Gov. Kathy Hochul, Governor Hochul Announces \$2.6 Million in Fines Against Insurance Companies for Failing to Adequately Cover Behavioral Health Services (Nov. 9, 2023), <https://www.governor.ny.gov/news/governor-hochul-announces-26-million-fines-against-insurance-companies-failing-adequately>.

211. In October 2023, the California Department of Managed Health Care ("DMHC") fined health insurer Kaiser Permanente \$200 million for deficiencies in its mental health coverage, including failure to ensure network adequacy and timely access to treatment. Press Release, California Dep't of Managed Health Care, DMHC, Kaiser Permanente Reach Settlement Agreement to Transform Plan's Behavioral Health Care Delivery System and Improve Behavioral Health Statewide (Oct. 12, 2023), [https://www.dmhc.ca.gov/AbouttheDMHC/Newsroom/October12,2023.aspx#:~:text=\(Kaiser%20Permanente\)%20to%20make%20significant,behavioral%20health%20care%20to%20enrollees](https://www.dmhc.ca.gov/AbouttheDMHC/Newsroom/October12,2023.aspx#:~:text=(Kaiser%20Permanente)%20to%20make%20significant,behavioral%20health%20care%20to%20enrollees). Kaiser agreed to remedy deficiencies in its delivery and oversight of behavioral health care, including providing timely access to care, network adequacy, conformity to mental health parity, and improving grievances and appeals processes.

212. In October 2023, the Washington State Insurance Commissioner fined UnitedHealthcare \$500,000 for not demonstrating compliance with mental health parity laws, in particular failing to address a disparity between the insurer's reimbursement rates for certain types of mental health/substance use disorder providers as compared to medical and surgical providers. Press Release, Office of the Ins. Comm'r of Washington State, Kreidler Fines UnitedHealthcare \$500,000 for Not Demonstrating Compliance with Mental Health Parity Laws (Oct. 18, 2023), <https://www.insurance.wa.gov/news/kreidler-fines-unitedhealthcare-500000-not-demonstrating-compliance-mental-health-parity-laws>. UnitedHealthcare must report various metrics to the state every six months and propose a resolution for any disparity of more than ten percent between behavioral health and medical services with respect to office visit reimbursement rates and out-of-network provider usage.

213. In 2020, Massachusetts fined six health plans for provider directory inaccuracies. Press Release, Office of the Att'y Gen. Maura Healey, AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents (Feb. 27, 2020), <https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents>.

214. *Find & Compare Providers Near You*, Medicare.gov, <https://www.medicare.gov/care-compare> (last visited Nov. 13, 2023).

provides the best example of transparency, with an annual Timely Access Report posted on its website that ranks insurers by rate of compliance with appointment wait time standards.²¹⁵

C. Plan reforms

Health plans must take steps to be proactive about compliance with specific accuracy and adequacy requirements, and should be encouraged to voluntarily undertake reforms that will improve access to mental health care, as outlined below.

1. Recruit additional mental health providers into networks

Health plans should expand their networks by conducting outreach to attract new providers, using all available recruiting mechanisms.²¹⁶ In particular, conducting outreach in communities of color can expand the volume as well as the diversity of provider networks.

Health plans sometimes contend that the network adequacy problems they face are caused by a purported workforce shortage of qualified mental health providers to join their networks. Although shortages may exist in certain areas, a blanket excuse falls flat for several reasons. First, that a significant number of consumers receive out-of-network behavioral health care demonstrates that many qualified providers could participate in health plan networks but do not.²¹⁷ For example, in New York in 2017, 39 percent of behavioral health office visits were to an out-of-network provider.²¹⁸ The American Psychiatric Association called such findings “evidence of a pattern of behavior by insurance companies that is forcing patients to use costly out-of-network care.”²¹⁹ Active health plan recruitment of mental health providers would help bring health plans closer to compliance with both directory accuracy and network adequacy requirements, because these new providers would be available to accept new patients. As of late October 2023, according to DOH and New York Department of Education websites,²²⁰ there were 96,137 New York-licensed mental health providers with New York addresses:

215. Cal. Health & Safety Code § 1367.03(i) (West 2023). DMHC’s Timely Access Reports are posted at <https://www.dmhc.ca.gov/AbouttheDMHC/DMHCReports/PublicReports.aspx#TAR>.

216. Karen L. Brodsky, *Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions*, *The Commonwealth Fund*, Aug. 2005, https://www.commonwealthfund.org/sites/default/files/documents/__media_files_publications_fund_report_2005_aug_best_practices_in_specialty_provider_recruitment_and_retention__challenges_and_solutions_852_brodsky_best_practices_specialty_provider_recr_pdf.pdf.

217. Busch & Kyanko, *supra* note 118.

218. Davenport et al., *supra* note 114, at 65.

219. Mark Moran, *Survey Finds Dramatic Disparities in Reimbursement, Out-of-Network Use*, *Am. Psychiatric Ass’n: Psychiatric News* (Dec. 26, 2017), <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.1a8>.

220. *New York State Licensed Professions*, N.Y. State Educ. Dep’t, Office of the Pros., <https://www.op.nysed.gov/professions-index> (last visited Nov. 13, 2023); *New York State Physician Profile*, N.Y. State, <https://www.nydoctorprofile.com> (last visited Nov. 13, 2023).

Table 15. Licensed mental health providers in New York

Licensure	Total in New York
Psychiatrists	9,770
Psychiatric Nurse Practitioners	3,291
Master Social Workers	30,182
Clinical Social Workers	28,112
Psychologists	11,365
Mental Health Counselors	9,755
Creative Arts Therapists	1,742
Marriage and Family Therapists	1,269
Psychoanalysts	651
TOTAL	96,137

Source: New York State Education Department and DOH

New York health plans should actively recruit each of these providers types to join their networks and to the extent possible allow them to bill for services.²²¹

2. Increase provider reimbursement rates

Health plans should also increase reimbursement rates for mental health providers to incentivize more providers to join their networks.²²² The increased demand for mental health services in recent years has exacerbated longstanding network inadequacy, but health plans bear responsibility due to their low reimbursement rates for mental health services compared with physical health care.²²³

221. Heather Saunders et al., *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs*, Kaiser Family Found. (Jan. 10, 2023), <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>.

222. *Id.*; Brodsky, *supra* note 216.

223. Heather Saunders et al., *supra* note 221; Brodsky, *supra* note 216.

3. Decrease administrative burdens on providers

Health plans can incentivize greater mental health provider participation in networks by reducing administrative burdens that deter many providers from joining networks. For example, health plans sometimes require that providers obtain prior authorization before a patient can receive treatment.²²⁴ The prior authorization process can be time-consuming and resource-intensive for providers.²²⁵ It can also harm patients. In a 2022 American Medical Association survey, 94 percent of physicians reported that prior authorization caused patients to suffer delays in access to necessary care, and 33 percent had seen a patient suffer a serious adverse event because of prior authorization burdens or delays.²²⁶

In addition, after a patient begins treatment, health plans sometimes require providers to continually provide documentation to demonstrate that treatment remains medically necessary, sometimes ceasing to cover treatment even though the provider has determined that additional treatment is needed.²²⁷ Even after paying claims, health plans may “claw back” payments. Written testimony submitted during the OAG’s June 2022 mental health hearing addressed the negative impact of these practices:

The New York State Psychiatric Association (NYSPA) stated that since January 2021, psychiatrists have experienced “a significant increase in utilization review efforts and activities undertaken by health plans,” resulting in widespread and improper denials or down-coding of claims.²²⁸ NYSPA warned that these actions “have a chilling effect” on providers and ultimately hurt patients who are unfairly denied reimbursement for needed services.

A Rochester-area psychologist stated that some health plans have a reputation for “pulling back reimbursement after-the-fact.”²²⁹ After paying claims, the health plan says that the treatment is not medically necessary and requests that the provider refund the monies paid. This creates frustration and financial distress in mental health providers as their expert judgement is second-guessed and they face delays in reimbursement.²³⁰

224. See Ani Turner et al., *Impacts of Prior Authorization on Health Care Costs and Quality* (Nat’l Inst. for Health Care Reform, Nov. 2019), <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf>.

225. Moran, *supra* note 219.

226. Am. Medical Ass’n, *2022 AMA Prior Authorization (PA) Physician Survey* (2023), <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>.

227. Dicken, *supra* note 13, at 17-18.

228. Rachel Fernbach, *Submitted Written Testimony in June 2022 OAG Mental Health Hearing Written Testimony*, *supra* note 10.

229. *Submitted Written Testimony from Dr. Claire McLauchlin*, *supra* note 21.

230. *Id.*

By reducing administrative burdens such as time-consuming and unnecessary prior authorization and documentation requirements, and paying claims promptly, health plans can attract and retain more mental health providers.²³¹

VI. Conclusion

This survey conducted by the OAG found that 13 major health plans in New York have ghost mental health networks, with only 14 percent of network providers accepting new patients, contrary to their directory listings. As we navigate a mental health crisis that continues to harm millions of New Yorkers, this is unacceptable. But there are solutions, including more focused regulations, increased enforcement, and voluntary actions by health plans, all of which can increase access to needed mental health care.

231. Heather Saunders et al., *supra* note 221. For example, in a 2021 settlement with the OAG, UnitedHealthcare agreed to stop using a program that applied arbitrary visit thresholds to trigger utilization review of psychotherapy, which included intensive documentation demands imposed on mental health providers. Press Release, Office of the N.Y. State Att’y Gen., Attorney General James and U.S. Department of Labor Deliver \$14 Million to Consumers Who Were Denied Mental Health Care Coverage (Aug. 12, 2021), <https://ag.ny.gov/press-release/2021/attorney-general-james-and-us-department-labor-deliver-14-million-consumers-who>.



***Office of the New York State
Attorney General Letitia James***

Inaccurate and inadequate:

*Health plans' mental health provider
network directories*

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