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# Preparing for the era of provider network transparency

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Transparency is one of the top buzzwords in healthcare today. In the last few years, we have seen the rollout of significant healthcare transparency initiatives focused on portable health records, hospital costs, drug costs, quality data, and many other things (e.g., Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First).[1] And yet, with a good deal less fanfare, healthcare policymakers have also put in place the changes necessary to usher in a new era in health plan provider networks—the era of provider network transparency. In the following paragraphs, we discuss the coming of provider network transparency, what it means for health plans, and the steps their compliance teams need to make to prepare.

## Provider directory difficulties

Health plans maintain provider directories to give members and prospective members a listing of available in-network providers. Directories vary somewhat in format and data elements. Still, all directories include common core data elements: provider name and address, specialty, contact information, and whether the provider is accepting new patients. While rules vary, state Medicaid agencies, Medicare Advantage, and most state insurance departments require health plans to post provider directories on their websites, update them regularly, and make a paper version available on request.

Directories have taken on added importance in recent years. Provider shortages have constricted access to some professions in some geographic areas.[2] Also, several health plans have embraced narrow network strategies to drive members to lower-cost or higher-quality providers. Cari Lee, vice president of government affairs for Quest Analytics and former state insurance administrator, notes, "We are seeing a patchwork of new regulatory proposals at all levels of government to address provider directory transparency. For example, the private payers under all three federal surprise billing drafts would need to create and document a formal provider verification process, which includes removing providers who have not updated their information in the last six months. At the same time, many states are enacting laws with varying directory provisions."

This activity is in response to heightened awareness about provider directory inaccuracies. For three consecutive years, directory audits from the Centers for Medicare & Medicaid Services (CMS) demonstrated that roughly half of the Medicare Advantage provider directory entries were errant in some way.[3] Audits of California Medicaid directories in 2015 revealed a similar error rate.[4] And CMS compliance reviews from 2018 revealed that provider directory accuracy was a concern for 17 of 22 audited health insurance exchange qualified health plans.[5] Research published in the *American Journal of Managed Care* in 2019 confirms all of this and documents that

Google is a slightly more accurate source of provider addresses than health plan provider directories.[6]

At the same time, consumers are taking matters into their own hands. For instance, consumers who thought they were seeing an in-network provider based on the directory but got billed for out-of-network care have filed lawsuits against the insurers.[7] Based on non-exhaustive research, it appears multiple lawsuits have been filed against health plans over the last three years because an inaccurate directory misinformed—or allegedly misinformed—consumers as they sought to select a provider. Documentation is difficult to compile, but there is a good chance these cases were settled outside of court.

## COVID-19 places new strains on provider networks

With the COVID-19 straining health systems and access, accurate provider network information is especially important. The pandemic has prompted some regulators to charge health plans with reexamining their provider networks to ensure they remain appropriate during the pandemic. One common mitigation is using telehealth as a proxy for traditional providers in meeting the needs of health plan members. For example, the Minnesota Department of Health, the regulator of provider networks in its state, along with the Minnesota Department of Commerce issued provider network guidance calling for health plans to "continue to consistently verify that their provider networks are up to date and are adequate to handle an increase in utilization, taking steps to adjust networks should delivery system capacity become an issue."[8]