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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]

## Today: Preparing for compliance

As health plans begin to evaluate their provider directory processes and prepare for a multitude of regulations, where should they start? A strategy focused on measuring, managing, and monitoring provider directories will ultimately ensure the best results.

First, health plans should ensure they have processes in place to manage their provider networks, which includes auditing and verifying their providers regularly. Given that each regulating body has a different definition of "regular" updates, health plans should err on the side of more frequent updates to meet a broader swath of requirements. Verification might include increasing provider outreach or automating internal systems to update information—ideally in real time—as providers submit changes.

Second, health plans should manage their provider networks by performing additional verification checks on the accuracy of their provider data. Ensuring provider rosters do not contain deceased, retired, or unlicensed providers is critical. Regulators increasingly have the tools to analyze provider data at a more granular level and are likely to notice data errors that lead to network adequacy inflation.

Third, health plans want to monitor the ongoing health of their networks as they prepare for an increasingly consumer-focused healthcare experience. With the rise of healthcare cost estimators, drug finders, and coming hospital price comparison tools, healthcare consumer tools are entering the healthcare market and might transform it. Consumers will have access to information in ways they have never had in the past, including more details about their choice of providers. The Interoperability and Patient Access final rule will create new consumer portable electronic health records and provider directory application programming interfaces exposing data errors in a whole new light for both payers and providers.[9] The pressure to get it right will not only come from the regulatory side but also the competitive market.

### Establishing public-facing directories and 'sources of truth'

On March 9, CMS finalized its interoperability regulation in combination with a sister regulation of the

Department of Health & Human Services Office of the National Coordinator for Health Information Technology. While most of the attention on these regulations is focused on the portability of electronic health records enabled by the regulation, the regulation contains a provision that will require Medicare Advantage and Medicaid provider directories to be posted electronically on a common application programming interface. Meanwhile, this past January, CMS recommended that Medicare Advantage plans use CMS's National Plan and Provider Enumeration System database as a source of truth for their directories.[10]

While addressing provider directory accuracy is a priority, health plans cannot solve access issues by looking at accuracy alone. They must also consider the impact provider data accuracy has on network adequacy. CMS stated in its 2020 call letter that the "accuracy of MAO [Medicare Advantage Organization] provider directories continues to be a concern for the agency. Inaccurate provider directories may impede access to care and bring into question the adequacy and validity of the MAO's provider network."[11] According to Lee, "It is both inadequate and inaccurate networks that disrupt access to care for consumers. Payers need to understand the inextricable link between the two to avoid inflating their network adequacy, such as listing a provider in their network at 25 addresses when they only see patients at two."

## What comes next

With the knowledge of existing problems and seeing the greater accountability that health plans will soon face from inaccurate provider information, several initiatives are underway to help health plans correct for erroneous provider data. "What I would say is you cannot measure what you don't manage and vice versa," says Lee. "Health plans need automated solutions that provide a real-time lens into their provider data, allowing them to identify gaps, remediate them across their business lines, and track their progress over time."

As a result of the changes that are underway, provider networks and directories, in particular, will be, for the first time, democratized. Any entity that wants to download and compare provider networks will be able to do so. Network comparisons could be based on regulatory network adequacy standards, the network breadth of peer plans, network accuracy based on outlier tests for providers listed in multiple directories, or, as the American Medical Association proposes, year-over-year network stability measures.[12] This democratization of network information will let researchers, provider groups, or consumer groups report on general network trends (Are networks narrowing year over year? Are Medicaid networks really more narrow than other networks?) and aberrant health plans. More importantly, regulators will be able to conduct more effective and continuous provider network oversight at a far lower level of effort and without health plans, even knowing that their networks are being surveilled.

## Takeaways

- Across healthcare, there is a push to measure, manage, and monitor provider directories.
- The key tool for provider network transparency is the provider directory, but directories are widely inaccurate.
- Empowered by new tools, regulators and others have new opportunities to monitor and detect network accuracy errors.
- Health plans that do not take steps to address directory inaccuracies face considerable long-term compliance risks.
- Directory information will power new consumer tools and measures of provider networks, further raising the stakes for directory accuracy.

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**2** "Shortage Areas," Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services, June 16, 2020, https://bit.ly/2N7hxVV.
**3** Susannah Luthi, "Medicare Advantage provider directories still riddled with errors," *Modern Healthcare*, December 4, 2018, https://bit.ly/3efVbh8.
**4** Soumya Karlamangla, "Medi-Cal patients may not have adequate access to doctors, audit finds," *Los Angeles Times* , June 16, 2015, https://lat.ms/2YKMKDR.
**5** U.S. Centers for Medicare & Medicaid Services, *2018 Plan Year Federally-Facilitated Exchange Issuer Compliance Summary Report*, February 7, 2020, https://go.cms.gov/2Cu0RG1.
**6** Michael Adelberg et al., "Do Machine-Readable Directories Improve Provider Directory Accuracy?" *Managed Care Cast* (podcast), *American Journal of Managed Care*, May 16, 2019, https://bit.ly/3fs5MWm.
**7** Katie Keith, "Consumers Sue Centene Over Network Adequacy, Transparency," *Health Affairs Blog*, January 15, 2018, https://bit.ly/3fM7ceD.
**8** Commissioner Steve Kelley and Commissioner Jan Malcolm, *Memorandum to Health Insurance Carriers Related to Coronavirus (COVID-19)*, Minnesota Department of Commerce, Minnesota Department of Health, March 13, 2020, https://bit.ly/3fuS7xy.
**9** U.S. Centers for Medicare & Medicaid Services, "Interoperability and Patient Access Fact Sheet," March 9, 2020, https://go.cms.gov/2TGX7r3.
**10** Kathryn A. Coleman, "National Plan and Provider Enumeration System as a Resource to Improve Provider Directory Accuracy," U.S. Centers for Medicare & Medicaid Services, January 3, 2020, https://bit.ly/2ALAj2D.
**11** U.S. Centers for Medicare & Medicaid Services, *Announcement ofCalendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2019, https://go.cms.gov/2N4w1WC.
**12** Andis Robeznieks, "6 ways to improve Medicare Advantage physician networks," American Medical Association, December 11, 2019, https://bit.ly/2YMcwaF.