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Submitted via www.regulations.gov

December 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-0058-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information: National Directory of Healthcare Providers & Services [RIN 0938-ZB72]

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information entitled "National Directory of Healthcare Providers & Services," 87 *Fed. Reg* 61018 (October 7, 2022) seeking input to inform the potential future establishment of a nationwide "centralized data hub" for healthcare provider, facility, and entity directory information.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. medical schools; 14 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and nearly 80 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC agrees with CMS that there is a great need to improve healthcare provider information within health plan directories to ensure they contain accurate information for patients while reducing the burden on providers to submit and update the information included. Health plan directories are often the first source used by patients to identify healthcare providers and check whether a clinician is within their health plan's network and taking on new patients. But too often, health plan directories contain outdated or even erroneous information frustrating

patients and providers alike. For providers, as CMS notes, there is often great cost for physician practices to maintain directory information, coupled with frustration due to "varying frequencies and levels of detail at which different directories require information."[1]

The AAMC strongly supports efforts to build stakeholder consensus to inform the future development of a centralized solution to improving health plan directories to improve patient experience and reduce burden for providers. Specific feedback in response to questions posed by CMS follows.

CMS Should Carefully Weigh Both the Benefits and Challenges of a Centralized National Directory of Healthcare Providers & Services (NDH) if the Agency Undertakes Designing and Implementing an NDH

The AAMC agrees with the general premise that a national, centralized NDH has great potential to improve the accuracy and actionability of information contained in health plan directories while also significantly reducing burden on providers to maintain information. The challenge, however, is ensuring that all providers and all payers meaningfully use the NDH. Use of the NDH will largely depend on how easy it is to update, validate, and verify information for providers and the ability to populate directories for health plans. Ultimately the success of the NDH will depend on whether it is able to replace the current system in which each health plan dictates separate and distinct requirements for directory information.

As CMS notes, "widespread adoption of, and trust in, an NDH would be necessary to fulfill this role as a 'centralized data hub' for directory information."[2] The AAMC agrees. Ensuring success of the NDH will require careful consideration and stakeholder consensus on the following design elements: a core agreement of what types of "listed entities" (i.e., individuals and groups of providers) should be included in the NDH, a core set of standardized data elements (including definitions for those elements), and core functionality for updating information, including the ability for providers to delegate directory maintenance.

Listed Entity Types

If the intent of the NDH is to best capture for patients the information of *all* health care providers within their health plan's network, the AAMC believes it is critical for CMS to consider a broad range of listed entity types, including those not enrolled in Medicare. The AAMC is concerned that if the NDH is limited to those providers enrolled in Medicare for payment, by requiring validation of information through matches to the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), there is a real risk of missing a critical group of healthcare providers and services in the NDH. For example, analysis suggests that nearly 43 percent of the 28,000 providers who opt out of Medicare reimbursement provide mental and behavioral health services.[3] Instead, CMS should consider design elements that help patients to understand

[1] 87 *Fed. Reg.* 61018
[2] *Id.* at 61024.
[3] Chris Larson, 43% of Medicare Opt-Outs are Behavioral Health Providers, Behavioral Health Business (April 2022).

whether a provider accepts Medicare reimbursement and alternatives for validation outside of PECOS for such providers.

Core Data Elements

A data hub is only as good as the data it contains. The standardized data elements and their definitions need to be appropriate from the outset. This will require a lot of careful thought, collaboration, and agreement among all stakeholders. The following offers a sample of the questions that will need to be asked and answered collectively for the NDH to succeed in improving patient experience with directories and reducing provider burden.

- Who controls the information? If the focus of the NDH is to primarily capture information held by providers, should the core data elements be those for which providers are solely responsible? A recent paper from the American Medical Association (AMA) and the Council for Affordable Quality Healthcare, Inc. (CAQH) notes that "no single party is the exclusive keeper of this information" and that some information is controlled by the clinician, the practice or the facility, and other data can be owned by the health plan, or indeed shared by both the provider (health system, practice, or clinician) and the plan.[4] Understanding these dynamics for each data element will be critical to designing a successful NDH.
- Should there be different required data elements depending on provider type (facility, individual, group practice)? For example, should the definitions for data elements capturing language options available for a patient be differentiated by language supports available within a facility versus those spoken by an individual clinician?
- What is the best way for the NDH to capture provider locations, especially for individual clinicians? Should it be any location that clinician might practice, or only where they regularly practice (potentially defined as a percentage of their time)? How can that best be captured to ensure that health plans can take the information and accurately note which locations are in network for the plan? Additionally, there has been debate on whether a provider's home must be included as a location if they provide telehealth services from their home. Many providers are likely to be uncomfortable having their home addresses included as practice location data in a publicly available directory, for privacy reasons and especially given the growing concern of violence against health care providers.
- What level of detail of services should be included? Should services be defined as best understood by patients, such as in-office services only or telehealth services, or as more complex service codes better understood by providers and plans? If the latter, how should additional information or support be available for patients and their families?

Core Functionality – Delegation and Support for Bulk Updates

CMS notes that it is critical that the NDH allow and support listed entities to delegate and authorize other individuals (either in their organization or through intermediary organizations) to

[4] CAQH and AMA, Improving Health Plan Provider Directories (January 2022) at 6.

submit data directory information. CMS notes analysis finding low rates of provider updates in the National Plan and Provider Enumeration System (NPPES) to include digital contact information as required under new CMS rules, and that very few of the digital endpoints submitted were valid Fast Healthcare Interoperability Resources (FHIR®) endpoints.[5]

The AAMC believes part of the challenge for providers in meeting CMS requirements to include digital contact information was due to the lack of technical support for bulk updates. Member institutions reported frustration with being unable to reach a support team at NPPES or CMS to assist and troubleshoot bulk update submissions and concerns. One aspect of this challenge was the inability to encrypt the bulk update through the NPPES portal, though the file requires the inclusion of sensitive individual data, such as social security number, place of birth, and date of birth to match with information currently in NPPES. Some AAMC member institutions ultimately decided against a bulk upload to protect the security of such sensitive data, though it pushed the burden to individual clinicians to manually update their records. Additionally, some member institutions struggled to complete information gathering necessary for a bulk upload due to the requirement to match sensitive individual information with current records in NPPES as the way to validate and complete the bulk update process. CMS should engage stakeholders to better understand the current challenges with delegation and bulk data submission with NPPES to not only improve data submission for that system but also for the design of a future NDH.

CMS Should Evaluate Potential Positive Incentives for Providers and Health Plans to Use the NDH

CMS asks whether there should be positive or negative incentives to encourage use of a future NDH. Negative incentives will only frustrate the intent of improving systems for stakeholders. The best positive incentive to encourage use of the NDH is that if it delivers on the aim to improve accuracy of information, reduce burden on providers and improve the ability of patients to access meaningful information.

CMS Should Consider and Evaluate NDH Design Options to Support Health Equity Goals

The AAMC strongly supports the agency's health equity goals, including defining health equity as the "fair and just opportunity to attain optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors."[6] We recognize that it is meaningful for patients to find providers from similar backgrounds or who offer specific services. To this end, we support the inclusion of core data elements that capture a provider's spoken languages, telehealth services, and accessibility supports available for providing patient-centered and accessible services. At this time, we believe it may be premature to require the collection and public reporting of information regarding a provider's race, ethnicity, age, gender identity, and whether a provider offers LGBTQ+ friendly services. Ideally, all providers would feel safe including such information, though we fear that with the increased politicization of some aspects of the physician-patient relationship and

[5] *Supra* at 61022.
[6] CMS Framework for Health Equity 2022-2032

increasing violence against health care personnel that not all providers will be comfortable including such information in a nationwide publicly accessible database. CMS should work with stakeholders to determine the value of such information to patients and balance this against the concerns raised. In general, we also encourage CMS to engage patients and providers on what information should be considered for inclusion in an NDH and to better understand the benefits and challenges of including and accessing such information to support health equity.

CMS Should Commit to a Phased Approach to Implementing an NDH

The AAMC appreciates CMS's enthusiasm for the potential of an NDH to assist patients and relieve burden on providers. However, we urge CMS to commit to a phased implementation approach to an NDH. CMS notes the potential for the NDH to integrate provider performance on quality metrics such as those maintained by CMS on its *Care Compare* website.[7] The AAMC believes that may be a possibility for a future application for the NDH but cautions against overly complicating the initial focus to improve the timeliness and accuracy of directory information for patients, providers, and plans. We encourage CMS to begin any design and implementation of a centralized NDH with a clear goal of solving the immediate issues of the accuracy and burden of maintaining information in health plan directories before considering integration of additional data. As part of this process, CMS should regularly engage stakeholders to understand NDH usage and trends (patients, providers, and health plans alike) to then consider how to use this information in the design and implementation of future state applications. The AAMC believes that this will help to not only better ensure success towards the initial aim, but also support the creation of an enduring tool that can improve over time to meet the needs of all stakeholders.

Conclusion

The AAMC thanks CMS for the opportunity to provide input on this request for information. We strongly support efforts to improve directory information for patients and reduce maintenance burden on providers. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medicine community. Please contact my colleague Phoebe Ramsey (pramsey@aamc.org) with any questions about these comments.

Sincerely,

Rosha C. McCoy MD

Rosha Champion McCoy, M.D., FAAP
Acting Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and CEO

[7] *Supra.* at 61025.