American College of Physicians
Leading Internal Medicine, Improving Lives

December 5, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Request for Information; National Directory of Healthcare Providers & Services [RIN 0938–ZB72]

Dear Administrator Brooks-LaSure:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) regarding the establishment of a National Directory of Healthcare Providers and Services (NDH). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 160,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

The current state of health care professional (HCP) directories leaves much to be desired. ACP agrees with CMS on many of the problems with current methods of HCP information exchange that the Agency describes throughout the RFI. The information in current directories is often fragmented and inaccurate, and the technical systems of most directories do not support interoperability or other functionality that would be useful for physicians and other health care stakeholders.

Additionally, ACP members have described the current systems related to maintaining, updating, or correcting physician information for payers as "mind-numbingly long and complicated," and have found it very difficult to manage and update their information amongst the multitude of HCP directories that currently exist. The processes for updating directory information are a significant burden for physicians, who must manage their information among the various existing repositories for HCP information, which can be very time-consuming and costly for HCPs, as CMS acknowledges.

It is perhaps even more problematic that because of the current systems in place, patients are met with incomplete, inaccessible, and inaccurate information when seeking care that meets their specific needs and preferences. These deficiencies come at a cost to them and other health care consumers, who must devote excessive time and effort to find accurate, reliable HCP information when seeking care that suits their needs. The downstream effects of these problems can be broad and have negative consequences for patient health.

Given the abundance of problems associated with existing HCP directories and the significant value of the benefits to be gained from centralization, ACP strongly supports the development of a centralized national directory of HCP information. ACP agrees with the 2020 Office of the National Coordinator for Health Information Technology (ONC) Fast Healthcare Interoperability Resources (FHIR) At Scale Taskforce's

(FAST) findings that "one authoritative national source of truth" is needed with urgency, and that the National Plan and Provider Enumeration System (NPPES) is not the best mechanism to maintain HCP identifying data. While we agree that the NDH concept described by CMS in this RFI is the right approach, the College insists that the government be the owner of this directory and that its use allow for "plug and play" functionality without additional financial burden to individual physicians or heath care systems for upkeep and maintenance. We also agree with FAST's findings that CMS would be an appropriate potential owner of such a national directory.

"National Directory of Healthcare Providers and Services" Concept and Perceived Benefits

Health care industry stakeholders, including physicians, patients, and payers, have much to gain from a single, standardized repository of reliably accurate HCP information that allows patients to make informed choices based on their personal health care conditions and circumstances. A key expectation of the College is a national HCP directory that is centralized, fully interoperable, and able to be updated seamlessly while maintaining privacy and security protocols. As CMS acknowledges, there are many deficiencies associated with the current systems in place for sharing HCP information. Nearly all health care stakeholders—HCPs, patients, and payers—would benefit from improvements made to the status quo of HCP directories.

ACP agrees with the expected benefits of a national HCP directory that CMS identified throughout the RFI. Physician burden reduction continues to be a foremost priority of the College, and the creation of a national HCP directory would inevitably reduce a variety of burdens for physicians. From ACP's perspective, the most valuable benefits include burden reduction and reduced cost for physicians and other HCPs, as well as the gains in health equity expected to result from improving patient access to broader and more accurate, reliable HCP information.

ACP previously supported the development of a single standard for HCP directories to facilitate interoperability and improve care coordination. In January 2021 comments to CMS, ACP supported the expansion of requirements to Medicaid and CHIP programs for payers to implement and maintain a "Provider" Directory API that makes clinician directory information publicly available to third-party applications. ACP stated that "ensuring digital health contact information is updated and published is important for achieving interoperability and improving care coordination," and advocated that physician engagement in the NPPES should not be overly burdensome or complex. We echo those same principles and recommendations in the case of a national HCP directory.

Maintenance of Accuracy: Existing System Concerns and Incentivization

To support the "centralized data hub" concept and improve directory function, CMS has asked for feedback on establishing an NDH that would overlay existing CMS systems that have directory-like functions, consolidate the data within them, and provide a single point of entry for clinicians to streamline workflows. While the College agrees with these goals, we are concerned about how corrections will be made and how accuracy will be maintained. Considering the current solutions (state, payer, and health systems' human resources [HR] systems) are often terribly inaccurate in their current state, accuracy will remain a challenge in a centralized directory that pulls information from existing systems unless robust mechanisms are put in place to assure accuracy and maintenance moving forward.

We agree with CMS that incorporating a requirement to have up-to-date digital contact information in a national HCP directory in the Promoting Interoperability category of the Merit-based Incentive Payment System (MIPS) program could serve as a good incentive for updating information in a national HCP directory.

Data Elements and Functionality

General/Basic Data Elements

In December 2014, ACP submitted comments in response to a CMS proposed rule regarding Benefit Payment Parameters for 2016. With regard to qualified health plans (QHPs) and network adequacy, the College supported the proposed requirement that provider directories be up-to-date, accurate, complete, and, at a minimum, include: (1) information on which providers are accepting new patients, (2) the provider's location, (3) contact information, (4) specialty, (5) medical group, and (6) any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and OPM. The College continued:

> Online provider directories should be updated at least monthly. The College reiterates its support for the development of an online search tool to allow federally-facilitated marketplace users to search for QHPs by clinician and hospital name and filter out health plans that do not include the consumer's chosen clinician or hospital in network. Requiring QHP issuers to provide network data in machine-readable format may facilitate the development of such tools by third-party entities; however, this should not substitute the agency's work to develop tools to improve the consumer shopping experience.

ACP recommends that CMS consider the inclusion of the same data elements and features in a national HCP directory, to the extent possible.

Health Equity and SDOH Data Elements

When patients and other health care consumers are met with incomplete, inaccessible, and inaccurate information in directories when seeking HCPs that meet their specific needs and preferences, it comes at a cost to them. They must devote excessive time and effort to find accurate, reliable HCP information. For patients, in addition to the inconvenience, time intensiveness, and exclusionary effects of inaccurate and fragmented directories, being denied a free and accurate source of HCP information can have further negative consequences on their physical health. Patients of physicians who share certain experiences and characteristics with themselves ("concordance") have historically been shown to have higher medication adherence,[1] patient satisfaction,[2] and better health outcomes.[3] A single accurate directory maintained by a trustworthy source would be a powerful, invaluable tool for patients to use to seek out and identify HCPs with criteria they require or prefer.

Regarding the accessibility of a national directory, it is important that the information disseminated by a national HCP directory be easy to read and understand for diverse populations of users, including those with a disability or limited English proficiency. In previous comments to CMS regarding its Basic Health Program proposed rule, ACP advocated that "provider" directories be available for use by people with disabilities and those with limited English proficiency. Similarly, ACP urges CMS to consider various usability and accessibility features that could be included in a national HCP directory. ACP recommends that directories be easily accessible and understandable to diverse audiences of varying abilities and English language proficiency.

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[1] Traylor AH, Schmittdiel JA, Uratsu CS, Mangione CM, Subramanian U. Adherence to cardiovascular disease medications: does patient-provider race/ethnicity and language concordance matter? J Gen Intern Med. 2010 Nov;25(11):1172-7. https://pubmed.ncbi.nlm.nih.gov/20571929/.

[2] LaVeist TA & Nuru-Jeter A. (2002). Is Doctor-Patient Race Concordance Associated with Greater Satisfaction with Care? *Journal of Health and Social Behavior*, *43*(3), 296–306. https://www.jstor.org/stable/3090205.

[3] Alsan M, Garrick O, and Graziani G. 2019. "Does Diversity Matter for Health? Experimental Evidence from Oakland." *American Economic Review*, 109 (12): 4071-4111. https://www.aeaweb.org/articles?id=10.1257/aer.20181446.

ACP agrees with CMS that a national HCP directory can have far-reaching implications for health equity. Listing HCP characteristics such as race, ethnicity, or language (REL) data could be beneficial in terms of patient-HCP concordance. However, if such a directory were to list REL data of HCPs, ACP is concerned about the potential sources of this data and their accuracy. Much of the information from potential sources for such data, including state owned systems, payer systems, and health systems' HR systems, are often incorrect. The College warns that the data source(s) for a national HCP directory are likely to contain inaccurate information, and we reiterate that inaccurate and unreliable REL or SDOH-related HCP information can have potentially significant negative implications for the health care trajectories of patient directory users.

Other Useful Data Elements: State Licensure, Plan Participation, Allied HCP Information, and Price and Quality Information

Other data elements that would be helpful to include are state licensure information and plan participation for HCPs, data elements reflecting the same spectrum of information for allied health professionals, and eventually, price and quality information.

Given variations in state licensure listings and requirements, state licensure information for HCPs and information about HCP participation in plans such as the Prescription Drug Monitoring Program and Medicare/Medicaid would be useful. Additionally, ACP supports the inclusion of allied HCPs in a national HCP directory.

ACP previously advocated for improved health care through increased transparency of various types of health care related information, including HCP directory information related to price and quality. In a 2017 position paper, *Improving Health Care Efficacy and Efficiency Through Increased Transparency*, the College advocated for the development of health care comparison and decision-making tools with features akin to those described by this CMS RFI and made some recommendations for the features and functionality that should be incorporated into such tools. Below are some of ACP's recommendations from the position paper that are also applicable to the development of a centralized national HCP directory as proposed by CMS.

1. ACP supports taking steps to ensure the availability of reliable and valid information that allows consumers, physicians, payers, and other stakeholders to compare and assess medical services and products in a meaningful way. ACP reaffirms the position that "price should never be used as the sole criterion for choosing a physician, other health care professional, or health care service" […]
2. Health plans and health care facilities should clearly communicate to a consumer whether a provider or clinician is in-network or out-of-network and the estimated out-of-pocket payment responsibilities of the consumer.
3. ACP recommends that payers, plans, and other health care organizations develop patient-targeted health care value decision-making tools that are written for patients at all levels of health literacy that make price, estimated out-of-pocket cost, and quality data available to consumers. This information should be communicated in an easy-to-understand way. Tools should aggregate price, cost, and quality information on health care services and treatments, including prescription drugs.

ACP agrees with CMS' goal of bolstering its existing efforts to streamline data processes to improve the value and usability of its data and is pleased that CMS sees value in linking clinician contact information and quality data into one streamlined resource to help consumers identify, compare, and locate HCPs who meet their specific needs and preferences. However, the College cautions that the eventual inclusion of price and quality information will be dependent upon how relevant data is collected and disseminated,

which will need to be thoughtfully and systematically managed. ACP acknowledges that the inclusion of some of these data elements and features is not a priority for most stakeholders (virtually all except for patients), and that price and quality comparison features will not be among the foremost utilities and features of a national HCP directory.

Technical Framework for an NDH

In terms of technical specifications for a national HCP directory, ACP insists that the use and integration of the directory be straightforward and convenient without any additional financial burden for upkeep and maintenance for individual physicians or health care systems. For example, access to and use of the directory should not require additional build, or it should come free as a requirement of EHR vendor certification.

Additionally, several years before the release of ACP's 2017 policy paper on improving transparency and efficiency in health care, ACP advocated for many of the same principles and features described in the current CMS RFI. In April 2014, ACP submitted comments to ONC regarding the Voluntary 2015 Edition EHR Certification Criteria NPRM, in which the College supported the idea of a single standard for HCP directories and for EHR technology that can query HCP directories for individual HCPs, "organizational providers," and relationships between individual HCPs and "organizational providers." We noted, however, that what is needed first is more study of what a useful and usable model should contain and cautioned that premature specification could result in a directory structure that does not allow accurate identification of HCPs (e.g., Dr. John Smith, cardiology, NYC). We note the same considerations here, in planning for the development of a national HCP directory.

Conclusion

The College is encouraged by the concerns and questions posed by the RFI and appreciates the opportunity to share our feedback. In particular, ACP appreciates the raising of important issues such as the mitigation of administrative burden; evaluation of cost and resources; and the assurance of accurate, credible, equitable, and interoperable sources of information within the establishment of a national HCP directory. The College remains committed to working with CMS and other key stakeholders and emphasizes the importance of weighing these considerations early on. The College would welcome the opportunity to engage with the Agency further and provide input on potential future data elements. ACP also appreciates that CMS is asking many important questions at this stage. Thank you for considering our comments as the Agency continues to evaluate the implications of this proposal. Please contact Nadia Daneshvar, Associate, Health IT Policy, at ndaneshvar@acponline.org if you have questions or need additional information.

Sincerely,

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