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December 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted electronically: <http://www.regulations.gov>

RE: Request for Information; National Directory of Healthcare Providers & Services — AHIP Comments

Dear Administrator Brooks-LaSure:

Every American should be able to easily find a clinician or facility skilled in the type of care they seek, that is convenient to access, and with whom they are comfortable. That is why AHIP¹ and its health insurance provider members are committed to making accurate provider directory information available to all Americans. Health care and health insurance providers, including the federal government, must work together to ensure that directories include the most accurate and up-to-date information available. This information is essential to help people shop for health care coverage and make their care more affordable. Guided by this commitment, we offer our vision for a National Directory of Healthcare Providers & Services (NDH).

AHIP appreciates that CMS has created this forum for dialogue on this priority. Maintaining accurate directories is a shared responsibility between clinicians, facilities, and health insurance providers. Despite the best efforts of health insurance providers, including direct outreach to providers, electronic solutions, advanced analytics and artificial intelligence methods, and ongoing validation and audits, the directories remain imperfect.

Health insurance providers work continuously to improve provider directories and are subject to several different and varying federal requirements across various types of coverage (e.g., Medicare, Medicaid and the commercial health insurance markets). In addition, at least 39 states also impose their own state-specific provider directory requirements.

¹ AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

That experience shows there are two formidable barriers to ensuring accurate provider directory information:

- Providers often do not consistently provide updates to their contact information, and they may provide inaccurate information.
- There is no single source-of-truth for provider information that can be leveraged to verify what is contained in directories.

Americans need a public-private partnership between the federal government, providers, payers and vendors to streamline collection of this information and improve its accuracy. A cohesive, national approach to building a technology-enabled infrastructure will help ensure accuracy, reduce burden, and improve efficiency. This approach also could serve as a source of truth that health insurance providers could leverage to build more accurate directories.

We agree that CMS should explore the creation of an NDH. However, its success will depend on the NDH meeting the needs of both the private sector as well as the federal government. Meaningfully reducing the burden for everyone of collecting and maintaining the necessary data will require a solution that addresses the needs of all stakeholders.

We agree it is essential to reduce the burden of collecting and maintaining directory information to ensure it is comprehensive and up-to-date. However, in our experience, burden reduction alone is not a significant enough incentive to ensure providers consistently update their information in a timely and accurate way. As such, we urge CMS to explore appropriate measures to ensure accountability of providers for updating the NDH to ensure success.

The success of the NDH will also depend on its use. We recommend the NDH become the source of truth for basic provider information (e.g., provider contact information such as name and address, information on services offered and qualifications, and demographic information such as gender required under current regulations and guidance). To ensure acceptance and use of the NDH, CMS and other federal agencies should hold health insurance providers harmless if they use data from the NDH in their provider directories. Otherwise, payers will need to continue to verify these data independently to comply with various federal and state requirements, adding administrative work with little value for patients and consumers.

We agree with CMS that health insurance providers should continue to spearhead the collection of certain information like network status, as they are the source of truth based on their contracts with providers. However, for this to work, CMS will need to collect more information in the NDH than it would to support Medicare. For example, CMS should collect all addresses at which a provider practices, not just where they accept Medicare. This will permit private plans to leverage the NDH, without having to ask providers the same questions separately, and cross walk it to their needs. This also means that only private plans will have all of the data elements patients and consumers need. Thus, consumer-facing directory tools for enrollees or consumers shopping for a plan should also remain in the purview of the private plans. If CMS tries to recreate this information in the NDH for consumer use, it will add administrative burden,

complexity, and cost for insurance providers, and the information will inherently be lagged compared to the plan tools.

CMS also should continue to examine other ways to minimize the administrative burden on providers and plans that will encourage efficient and correct information while also leveraging resources like vendors and data science, such as an interoperable infrastructure. There are also multiple opportunities to reduce variation between federal policies governing provider directories, as well as variation between federal and state policies. As part of this work, CMS should work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines. Together, we can ensure the NDH meets all relevant requirements or has the capability to allow organizations to collect additional data points that may be required to meet state requirements or business needs.

AHIP and its members look forward to working with CMS to develop an NDH through a public-private partnership that will help reduce administrative burden and costs for everyone, which in turn will help make coverage and care more affordable, while also permitting providers to spend more of their time caring for patients. We thank CMS for considering the potential of an NDH and stand ready to partner with you to make this vision a reality. If you have any questions, please contact me at (202) 778-3246 or at dlloyd@ahip.org.

Sincerely,

A handwritten signature in cursive script that reads "Danielle A. Lloyd".

Danielle A. Lloyd, MPH
Senior Vice President, Private Market Innovations & Quality Initiatives

Attachment

ATTACHMENT AHIP DETAILED COMMENTS

I. Establishment of an NDH

CMS issued a request for information (RFI) soliciting public comments on establishing a National Directory of Healthcare Providers & Services (NDH) that could serve as a “centralized data hub” for healthcare provider, facility, and entity directory information nationwide. CMS believes the establishment of an NDH could reduce the burden of collecting and maintaining directory information and improve the accuracy of such information by reducing the number of locations providers need to update their data. CMS believes the agency could potentially alleviate some of these burdens and improve the state of provider directories through a CMS-developed and maintained, Application Programming Interface (API)-enabled, national directory.

Every patient and consumer should easily find a clinician or facility skilled in the type of care they seek, is convenient to consult, and is comfortable to work with. To achieve this goal, health care and health insurance providers, including the federal government, must work together to ensure that directories include the most accurate and up-to-date information available about in-network providers. This information is critical to inform shopping for health care coverage and maximizing the value of health coverage. Guided by this commitment, we offer our vision for a National Directory of Healthcare Providers & Services (or NDH).

Maintaining accurate directories is a shared responsibility between clinicians, facilities, and payers. Despite the best efforts of plans, including direct outreach to providers, advanced analytics and artificial intelligence methods, and electronic solutions, the directories remain far from 100 percent accurate. **We believe a public-private partnership between the federal government, providers, payers and solutions vendors is needed to streamline collection of this information and improve its accuracy.** A cohesive, national approach to building a technology-enabled infrastructure will help ensure accuracy, reduce burden, and improve efficiency.

Health insurance providers work continuously to improve provider directories and are subject to several federal requirements across various insurance lines of business (e.g., Medicare, Medicaid and the commercial health insurance markets) to keep provider directories up to date. In addition, today at least thirty-nine states also impose state-specific provider directory requirements. **Health insurance providers have found two formidable barriers to ensuring accurate provider directory information (1) health care providers often do not consistently provide updates and they may provide inaccurate information, and (2) there is no single source-of-truth for provider information that can be leveraged to verify provider information**

AHIP agrees that CMS could play an important role in improving the accuracy of provider directories and reduce the burden of collecting and maintaining the information needed to support them. CMS could reduce burden and improve accuracy through standardization, technology, provider education, and support. **CMS should explore the establishment of a national directory; however, we urge CMS to consider the needs of the private sector in**

such a database and ways to leverage existing initiatives and enhance standardization.

Stakeholders across the healthcare industry both contribute to and require the information the NDH could contain. The federal government should consider the potential burden for providers associated with populating and maintaining the NDH if the private payer system remains as is because their needs are not met by the solution. Minimizing the burden of gathering and maintaining the necessary data to support an NDH will require a solution that addresses the needs of all stakeholders.

To ensure it meets the needs of the private sector, CMS should develop the NDH using a federated model supported by a public-private partnership rather than centralized control by CMS. An NDH that uses a federated model could serve as a national data repository with access by providers, payers, states, and approved vendors. To maximize the efficiency and burden reduction, some entities like states and vendors could be given the ability to add information to the NDH. Moreover, such a model would allow connections with other data management systems such as electronic health records (EHRs) as well as scheduling and practice management systems that providers may already be using. These systems contain important information that could support provider directories without requiring providers to enter information in multiple locations. Without the ability to engage all stakeholders, a federal, centralized solution that does not incorporate the needs of the private sector will reinforce fragmentation, not alleviate burden.

CMS should work with stakeholders including private plans, providers, and vendors to develop and implement a meaningful framework for the NDH. AHIP supports the creation of an NDH and believes the framework will work most effectively through a public-private partnership that meets the needs of both public and private payers to maximize value to all stakeholders. To accomplish this, **CMS should establish a Technical Expert Panel (TEP) to develop technological approaches and identify necessary policy changes to support this work.** To promote a diverse set of input, this TEP should include a representative sample of health insurance providers as well as other relevant stakeholders such as providers, states, vendors, and consumer groups.

Stakeholders across the industry are working to address the current challenges of provider directories. Health insurance providers have invested in the use of advanced analytics and vendors continue to develop innovative products that can enhance current provider directories. CMS should explore ways to leverage existing efforts and support additional efforts to standardize data elements so the NDH can build on what is currently working. To explore how advanced in technology and interoperability could mediate the current challenges to directories, CMS should invest additional funds to increase the efficiency and adoption of scalable technological solutions for provider directories, such as the Health Level 7 (HL7) FHIR at Scale Taskforce (FAST) accelerator.

Summary Recommendations:

- Take further steps to move towards the NDH's creation in consultation with stakeholders.
- Employ a federated model for the NDH and create a public-private partnership between the federal government, providers, payers and solutions vendors.

II. Potential Use Cases for an NDH

CMS solicits comments on potential use cases for an NDH, what data elements could be collected through the NDH, and what entities could participate in an NDH. As noted above, AHIP believes there is value in establishing an NDH. If properly built an NDH could benefit stakeholders across the healthcare sector.

Contact Information and Services Offered

As a first phase for the NDH, AHIP supports developing a system to update and share provider contact information (e.g., name, address), information on services offered and qualifications (e.g., specialty, education) and other demographic information (e.g., gender, race, ethnicity) required under current regulations and guidance.¹ This initial use case would improve the availability and accuracy of such information to reduce the burden of maintaining provider directories.

More accurate provider contact and demographic information would support the creation of better provider directories for consumer use. Consumers depend on the directories created by their payers (both public and private) to support their choice of a healthcare provider. However, AHIP members have noted that data such as provider contact information can change frequently, and it can be challenging for payers to ensure its reliability and validity. This is compounded by the challenge of providers not updating data and no single source-of-truth for provider information. The lack of consistent updates and inability to easily verify provider information means that information that changes frequently is more likely to be inaccurate. AHIP members note that a provider's contact information and service location may change often. For example, information such as practice addresses, affiliated providers within a group practice, phone numbers, and office hours are often not current and are not updated in a consistent and timely manner. Furthermore, many large multi-specialty group practices do not maintain accurate service locations and hours of operation for providers who work out of more than one location. However, we recognize that this is essential information for consumers to find a healthcare provider who offers services that are accessible for them. **The creation of an NDH could allow healthcare providers to update essential information such as their contact and demographic information in one location that could then be updated throughout other systems through interoperable networks as opposed to the provider need to update with each payer they contract with, minimizing the burden of such updates and ideally encouraging providers to make necessary updates consistently.**

CMS should also consider state regulations and individual needs when developing the required data elements for the NDH. We also note there is variability across state Medicaid provider files regarding the availability, file format, content, and accuracy of provider demographic and contact information. While we encourage alignment with federal directory requirements as a starting point, we recommend CMS to work with State Medicaid agencies to align provider data files with data in the NDH. Otherwise, Medicaid managed care organizations and other

¹ For example, Section 116 of the Consolidated Appropriations Act, 2021 requires the name, address, specialty, telephone number, and digital contact information for each provider.

stakeholders working with the Medicaid program will continue to need to ask providers for additional information.

Digital Endpoints

The NDH should also be a system to collect and share information on digital endpoints from providers and payers to support implementation of the CMS Interoperability rules and potentially the advanced explanations of benefits (AEOBs). Better and more accessible information on digital endpoints will facilitate the exchange of health information and support a transition to technological solutions such as electronic prior authorization (ePA). We note that CMS should work with providers and other stakeholders to educate and improve understanding on digital endpoints and how they work.

The CMS Interoperability and Patient Access Final rule and the ONC 21st Century Cures Act Final rule represented important steps towards improved information sharing. However, sharing data over the pathways created by these rules depends on payers and providers being able to find each other's digital endpoints. Digital endpoints are essential to the implementation of requirements such as the payer-to-payer data exchange and AEOBs.

An endpoint describes the technical details of a location that can be connected to for the delivery/retrieval of information. Sufficient information is required to ensure that a connection can be made securely, and appropriate data transmitted as defined by the endpoint owner.² Improved interoperability across the system offers the opportunity for all parties involved in a patient's care to have better information to coordinate services. Easier access to digital endpoints would allow more timely data exchange across the system. A directory of payer and provider FHIR endpoints, for example, is critical to being able to "find" the organizations required for sharing data.

As interoperability progresses and an NDH evolves in future iterations, additional organizations could share contact information to facilitate better relationships with community-based organizations and other services that are crucial to addressing social drivers of health but may be outside of the traditional scope of the healthcare system. Better digital contact information could also facilitate the use of technology to streamline healthcare payment and administrative functions. For example, easier access to digital endpoints could support the transition to electronic prior-authorization.

Building a system to allow easy access to digital endpoints will be essential to the success of the Trusted Exchange Framework and Common Agreement (TEFCA). For stakeholders to successfully share data through the Qualified Health Information Networks (QHINs) it will be necessary to have access to digital endpoints to complete the transaction. The NDH could be an opportunity to allow a more efficient means of exchange of digital endpoint information and could be leveraged to support the implementation of TEFCA.

² <https://www.hl7.org/fhir/endpoint.html>

Future Uses Cases

AHIP also sees potential future use cases for the NDH. Information on licensing, credentialing, and accreditation would require information and input from additional stakeholders and would go beyond what may be feasible in the first iteration of an NDH. However, CMS could explore building the NDH in a way that would allow organizations such as state medical boards, accrediting bodies, and educational institutions to add or verify information. CMS could explore building authentication capabilities into the NDH and allowing for the collection of additional data points to support the collection of information on licensing, credentials, and accreditation. Building the NDH in a way to support this type of information could streamline and enable many other use cases and further reduce the burden on providers and payers. We agree with CMS that information in the NDH should be verified against a primary data source, but this could be done by approved vendors to which providers could delegate their updates. If data could not be verified by a primary data source, then there should be a field indicating as such. However, verification process could also benefit from a federated model. Approved or certified vendors would also have the ability to verify and validate data that could be shared across the system.

Summary Recommendations:

- Develop a system to update and share provider contact information, information on services offered and qualifications, and demographic information required under current regulations and guidance as a first phase.
- Expand the NDH after this initial phase to collect and share information on digital endpoints and work with stakeholders to provide education and enhance understanding of digital endpoints.

Entities to Include

Overall, AHIP supports allowing a broad range of healthcare organizations to provide information into the NDH. From the health insurance provider perspective, the NDH should at minimum include information from all entities that payers are required to include in various directory requirements. In addition, over time all individuals and entities who have national provider identifiers should be included. In later stages, we agree there would be value in allowing other types of organizations who are not currently included in provider directories or specifically contract with health plans to also participate. For example, this could include Community Based Organizations. CMS should work with stakeholders to determine how best to phase in additional types of organizations who are not covered by current directory requirements and may have less experience reporting into current systems such as NPPES.

We support a broad definition of healthcare providers for whom participation would be available, but not required, for organizations not traditionally included in directories such as community-based organizations. We agree information on these organizations could be useful; however, we are concerned about placing new burdens on these groups, especially as the NDH is in an early stage. One approach for determining which providers to include in the NDH would be any provider that has a billing/contractual relationship with a payer. CMS could work with stakeholders to determine how to best incentivize participation in the NDH. For example,

penalties may be necessary for providers for whom payers are required to include information in directories, while incentives could be used to draw new organizations into the NDH.

After a phased in approach, CMS should ultimately include all provider types participating in the Medicare, Medicaid, and Marketplace (i.e., QHP) programs at minimum.

Summary Recommendations:

- Include at a minimum information from all entities that payers are required to include in various directory requirements. Ultimately expand the NDH to include all provider types participating in the Medicare, Medicaid, and Marketplace programs.
- Consider expanding the NDH to allow other provider types on a voluntary basis in initial phases as they build the capacity to report.

Data Elements Needed

Success of an NDH will require the ability to allow for flexibility. Stakeholders may need different pieces of information to meet local requirements or to support individual business needs. As such the NDH should include functionality to allow extensibility of the data elements required. That is, organizations should be able to establish a relationship and have the ability to ask for additional data elements beyond a core set of data elements all entities would be required to report. Without the ability to allow extensions to meet individual needs, stakeholders will still need to find ways to share these extra pieces of information, thereby limiting the value proposition of a single place for providers to maintain the data. Designing the NDH to support a core set of data elements with the ability to customize would avoid organizations asking for additional information outside of the NDH and maintain a streamlined system.

CMS should also consider how frequently each piece of information is likely to change and how often updates may be needed. Some pieces of information are unlikely to change very often. While provider location and contact information may change more frequently, certain facilities, such as hospitals and ambulatory surgery centers, are unlikely to relocate multiple times over the course of a year. For these types of data elements that will not change often or at all, CMS should work with stakeholders to define such facilities and use enforcement discretion to allow flexibility to provide updates to the NDH on an annual basis unless necessary due to a change (e.g., a change in name or ownership of the facility). In addition, CMS should exempt telehealth, virtual providers, or other home health and mobile providers who do not provide services in a bricks and mortar location from such requirements as they do not provide services at a physical location. However, providers with a bricks and mortar location who also offer telehealth services should share information about the availability of such services in the NDH. CMS should work with stakeholders to identify which pieces of information are more dynamic and likely to change frequently and develop strategies to promote more consistent updates to the NDH.

We also caveat that CMS should work with stakeholders to develop the core set of data elements supported by the NDH. Below we share the health insurance provider perspective and feedback on potential data elements. As noted above, CMS should create a public-private

partnership to oversee the NDH. Such a partnership could support work to develop the core set of data elements as well as potential extension elements that may be required.

Contact Information

First CMS should include data elements that capture a provider's location, including all addresses at which a provider practices as well as whether the provider offers telehealth services, including which modalities are available. Currently, payers are required to collect information on address, city, state, and ZIP code. However, location is a frequently changing field and current data collection efforts do not capture the associated nuances with location information. **To improve the usefulness and accuracy of information, addresses must be tied to purpose in the NDH.** For example, beyond collecting just an address, the NDH should collect follow-up information to help users understand how best to use that information. For example, addresses should be tied to questions such as:

- Do you receive mail at this address?
- Do you see patients or take appointments in this location?
- Does this location offer accommodations for people with disabilities?

More granular location information tied to purpose would allow payers to create more accurate provider directories with the information pulled from the NDH.

Today most provider demographic databases have one entry per provider, which means that usually one address is included. We know that many providers work out of multiple clinic sites and may have a business address that is different from any of these care sites. Along with the ability to have multiple addresses and address types associated with a provider, we would discourage CMS from using a postal address as the location index in the NDH. How addresses are entered creates a plethora of opportunities for errors that will require active management and data cleaning—and would likely be prohibitive given the potential size of this resource. Suitable identifiers should be included in the NDH to ensure it is clear whether or not two records are for the same location, taking into consideration that there are often many ways to indicate the same street address through abbreviations, vanity spellings, etc. Standard identifiers could also help clearly indicate which provider-to-organization affiliations are valid at which locations. Ideally, the location should be a unique code of some sort that corresponds to the postal address but is not the address itself. There will also need to be a location designation for telehealth services.

Beyond information on location, the NDH should collect other contact information including telephone number, including which number should be used to schedule appointments, website URL (if applicable), and fax number. CMS could also ask providers to verify if they would like payers to publish their information in the payers' directories and provide a time stamp that indicates when information was last updated. CMS should also consider publishing a schedule of update and verification frequency so stakeholders have consistent expectations for when updates may occur.

Digital Endpoints

Information on digital endpoints is becoming increasingly essential as we move towards an interoperable health care system. A key challenge to implementation of the current interoperability and data sharing requirements is the lack of a way to easily look up another

organization's digital endpoints. The NDH could play a key role in promoting interoperability and information sharing by ensuring digital endpoints are easily accessible. Additionally, all stakeholders would need these provider endpoints to be verified and validated as to their association to the represented provider on an ongoing basis. Addressing the verification and validation process through the NDH could streamline this process and make it more efficient.

Information on Individual Providers

The NDH could also be leveraged to collect information on provider demographics and the services offered. Again, the NDH should collect all information payers currently need to meet federal regulations on provider directories. For example, the NDH could collect information on a provider's specialty and what services they offer (e.g., if telehealth is offered or if an obstetrician is currently only offering gynecological services). The NDH should also collect information to support consumer's choice in a provider such as information on cultural and linguistic capabilities and office/location accessibility under the Americans with Disabilities Act (ADA). The NDH could also collect basic demographic information such as gender from providers as required by current directory regulations. CMS could explore building enhanced demographic data fields to support the collection of information on additional data elements such as race and ethnicity. However, these data elements that could be considered sensitive to the provider or not required for compliance with federal provider directory regulations should allow for a choice not to respond at this time given the controversial nature and risk of discouraging use of the NDH.

A future phase of the NDH could also collect information required for accreditation and credentialing purposes. We recommend CMS build the NDH so that data entry could expand but focus on core data elements in phase one. Information collected from facilities in the initial phase could focus on the facilitate type, accessibility, and services offered.

Relationships

Understanding clinician relationships is a significant challenge in producing accurate provider directories. A clinician may practice independently as well as part of a group. Moreover, clinicians may have privileges at one or more hospitals. **The NDH should collect information to allow payers to easily discern clinician relationships to provide better information to consumers. Collecting information on group name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN) will allow payers to determine relationships between clinicians and groups.** CMS could also explore collection information on where a clinician has hospital privileges.

There are instances where a provider in a location is affiliated with multiple provider organizations. Their participation in a plan's network and their willingness to take on new patients will vary by what organization with which they are affiliating their care—even though it is the same provider at the same address. For this reason, we also believe the NDH must capture all organizational affiliations of a provider, such as, all the tax IDs under which the provider can bill, but CMS should gather additional stakeholder feedback to ensure this captures the necessary detail for all NDH users.

CMS should also develop ways for healthcare providers to share data that enables other stakeholders to understand the relationships among individual providers who may practice

different specialties but are part of a group. For example, an anesthesiologist that does not see patients directly or a radiologist that would never see the patient but would read the reports and images.

CMS should also explore ways the NDH could provide information on when a clinician leaves a group or practice. Currently it can be challenging for payers to determine if a clinician has left a group to join a new practice or if a clinician is no longer practicing due to retirement, death or a career change. Better information on terminations and the reason why could help payers offer better information to consumers. Information on whether a provider participates in Medicare (has Medicare ID) and/or Medicaid (has a Medicaid ID) would also be useful. In addition, it would be useful to collect information on any state provider identification numbers.

Modalities Available

The COVID-19 pandemic accelerated the use of telehealth and has brought telehealth access to the forefront. More clinicians are offering telehealth services and some providers have moved their practices entirely online. Consumers have also become more accepting of telehealth and some may prefer to receive services via telehealth in certain circumstances. For example, many consumers prefer the flexibility and privacy of receiving behavioral health services via telehealth. As such, payers need better information from providers about whether they offer telehealth services and if they are accepting new patients via telehealth. **We recommend that the NDH consider a data element for providers to share information on the modalities of service available.** We note this would also be valuable as a way to promote health equity.

Accepting New Patients

Another frequently changing and challenging to collect data element is whether a provider is accepting new patients. We recognize this information is essential to consumers, however, whether a provider is accepting new patients can change quickly and depends on several factors. For example, a clinician may have limited ability to take on complex cases, is only accepting new patients via telehealth or is on short term disability or parental leave. Even within a health plan, a provider may be accepting new patients under one product (e.g., employer PPO coverage), while not accepting new patients under another (e.g., an ACA HMO plan). For each provider, this may result in hundreds of combinations that may change frequently.

There is value in the NDH collecting information from providers on whether they are collecting new patients but in the initial phase of work should only focus on broad information on provider availability. While we recognize this information would be very general, it could be useful for payers to understand which healthcare providers are not accepting new patients at all (e.g., the provider may be preparing to retire, or the practice is full). The NDH should include whether the provider is accepting new patients, but for any initial version should be a binary (yes/no) or trinary (accepting patients for all products, not accepting patients for any products, accepting patients depending on the product) as selected by the provider. Payers or third-party application developers could build upon that information and build tools that direct consumers a digital endpoint where they could determine if that provider is accepting their specific insurance.

Information Not to Collect through the NDH

CMS should not mandate the collection information on payers' networks or insurance acceptance through the NDH. While we see the potential value in allowing organizations to note relationships through the NDH (e.g., to request updated information or to receive notification when information is updated), this information should not be used as a proxy for information on networks from payers. We define networks as what insurance networks a particular provider participates in. Instead, CMS should build the NDH so that payers can pull information and supplement it with their information on network status to ensure accurate and consistent information is provided to members of a health plan. However, CMS could build the NDH with extensionality in mind so that payers could collect additional information from providers using the same user interface that is unique to the plan and would assist with connecting the information to network specific information at the same time. These data added via extensions would only be stored with the payer requesting it, not with the NDH.

Summary Recommendations:

- Build the NDH in a phased approach. The initial phase should focus on collecting digital endpoints then expanding to collect the contact and demographic information from providers currently required by federal regulations. Subsequent phases could expand to include additional provider types and data elements.
- We recommend the NDH not mandate the collection information on payers' networks or insurance acceptance.

III. Policy Dependencies

CMS seeks comment on the policy dependencies to building an NDH.

Health insurance providers have demonstrated their commitment to provide meaningful information to consumers to support their choice of a provider. Payers invest significant resources to verify and correct inaccurate data from providers and to outreach to providers who do not update current directories. Payers have also been working diligently to implement the requirements of the CMS Interoperability Rule, the No Surprises Act, and the Transparency in Coverage final rule. Payers are also expecting potential additional requirements in the Interoperability and Prior Authorization proposed rule. While certain provisions of the NSA and these rules are intended to achieve similar objectives, together these policies create a complex web of overlapping requirements that heighten burden. We encourage CMS and other government agencies to consider the need for new, thoughtful solutions as payers and health care providers navigate new requirements. Working together, we can provide consumers better information to support their health care decisions without creating significant administrative burden and increases in health spending. Above all, regulatory action must:

- Prioritize empowering consumers.
- Improve their ability to make informed decisions about where to seek healthcare.
- Drive affordability.
- Ensure that the consumer experience is meaningful and as seamless as possible.
- Strengthen consumer trust by ensuring the accessibility of comprehensive and accurate information.

We appreciate CMS's considerations of the policy dependencies and potential changes necessary to ensure adoption of the NDH. During the prior administration and Congress, new legislative provisions were enacted, and multiple regulatory requirements were finalized—all aiming to promote data sharing and price transparency. However, the result was a series of fragmented and, in some cases, conflicting provisions. Certain requirements in the Transparency in Coverage final rule and the Interoperability and Patient Access final rule will not provide consumers with information that is meaningful or actionable and would likely increase health care costs and jeopardize patient privacy. Further, the No Surprises Act creates statutory requirements that overlap with requirements in the Transparency in Coverage rule. While certain components of the interoperability and transparency final rules offer a good start, other requirements are ill-conceived and should be reconsidered to improve accuracy, reduce operational inefficiencies and discordant rules across markets, and increase the health care system's readiness for successful implementation.

As noted in our May 2021 letter to Secretary Becerra, payers believe, consumers and patients deserve easy access to the actionable information they need to make informed decisions about their health and health care for themselves and their families. Sharing clinical data across hospitals, physicians, payers, and consumers while making accurate information on costs more accessible should empower Americans and their families as they make choices about their health and finances. However, complex and overlapping polices can strain resources and prevent successful implementation of these tools. We recommend CMS implement the NDH in the context of other regulations payers and health care providers are currently implementing, while exploring ways to streamline the regulatory environment to facilitate implementation.

Roadmap for Implementing Transparency and Interoperability Requirements

AHIP recommends a phased-in approach to the NDH that puts the consumer first, while also minimizing administrative burden and additional costs to the health care system. In partnership with the private sector, the Departments should develop a roadmap for building the necessary infrastructure that is put into the context of the other NSA and Interoperability Rules to create a cohesive, staged approach to achieve success. AHIP believes this approach will best position the industry to strengthen consumer trust, reduce burden and duplication for stakeholders, and improve health care quality and efficiency.

Streamline and Harmonize Directory Requirements

First, for the NDH to successfully reduce burden and achieve wide scale use, it must include all the information necessary for payers to meet compliance with federal provider directory requirements across product lines. Health plans are subject to multiple federal and state requirements to keep provider directories up to date in the commercial, Medicare, and Medicaid markets. In addition, since 2016, for over three-quarters of states in the federally-facilitated Exchanges, qualified health plans (QHPs) are required to maintain machine-readable provider directories. Moreover, CMS has implemented requirements for Medicare, Medicaid, and CHIP plans to make directory information available over a FHIR-enabled API. However, each of these regulations requires the collection of different data elements. The NDH must be able to collect all the required elements for federal regulations as well as for accreditation bodies.

Reconciling and streamlining these varying requirements could prevent situations where the NDH does not allow a payer to meet a requirement, necessitating additional data collection from providers. **To facilitate this, CMS should work with the tri-agencies (Department of Labor and Treasury) and Medicaid state agencies as well as accreditation bodies to reconcile and align requirements across federal, state, and accreditation programs.**

Summary Recommendations:

- Work with other federal and state agencies as well as accreditation bodies to reconcile and harmonize regulations regarding provider directories to ensure payers can use information in the NDH to fulfill these requirements without additional asks of providers.

Ensure Equal Payers and Provider Accountability

Another challenge are the unequal incentives on payers and providers to maintain directory information. While payers are subject to enforcement action if provider directories are found to be inaccurate, compliance is also dependent on provider responses as acknowledged in the RFI. We do not believe burden reduction alone will be sufficient to motivate providers to maintain accurate information in the NDH. Numerous previous efforts have aimed to improve accuracy of provider directory data, including an AHIP pilot with a dozen health plans conducted in 2016. Covering three states and over 400,000 providers, the pilot program faced significant challenges with provider response rates, managing multiple data formats and regulatory requirements, resolving data conflicts, and conducting outreach through multiple channels. Of the three states included in the pilot project, one state (California) included strong accountability measures that incentivized providers to respond to requests to update their information. This demonstrated that when regulatory requirements or contractual requirements such as payment delays are used, providers are more likely to respond.³

Provider directory accuracy depends on plans receiving timely responses to update requests. While we appreciate the FAQs⁴ related to implementation of the No Surprises Act that emphasized the importance of providers responding to plan requests, we believe additional actions will be necessary to promote compliance and participation in the NDH. Thus, we encourage CMS to align incentives to ensure this information is entered and maintained on a regular basis. We believe that both “carrots” and “sticks” are needed to ensure timely, accurate updates. CMS should establish a mechanism that holds providers accountable for updating data and this should apply to both facilities and non-facility providers.

CMS should also work with stakeholders to ensure understanding of the potential limitations of the NDH. For example, CMS could remind providers in any rulemaking related to the database that they must still reply to payer requests for information to ensure the NDH does not inadvertently increase the non-response rate.

Summary Recommendations:

- Work with states to align federal and state requirements on the frequency of updates to avoid payers needing to ask providers for additional updates to meet state regulations.

³ <https://www.ahip.org/resources/provider-directory-initiative-key-findings>

⁴ [FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 \(dol.gov\)](#)

- Require providers to verify the information in the NDH at intervals that will meet all state and federal requirements on private plans.

Hold Payers Harmless if Data from the NDH is Used

Such a broad rethinking of how provider data is captured, managed, and updated will have significant downstream implications. Health insurance providers and other entities will depend on the accuracy of this information and share information directly to beneficiaries and enrollees. The NDH must be reliable source of truth if broad adoption is to be achieved. We urge CMS to use its existing regulatory authority across the programs it manages to ensure that health insurance providers are not held accountable for incorrect information pulled from the NDH.

To garner use and trust, CMS and states must offer a “safe harbor” to any health plan or intermediary that relies on the NDH. For example, the Section 116 of Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act (CAA), 2021 requires validation of provider directory information every 90 days and updates to payer databases within two business days of receiving new or revised information from a provider that affects the directory, along with new patient protections for consumers who were provided inaccurate information. The two-day timeframe is difficult to payers to meet and the requirements to proactively confirm information every 90 days overwhelms providers with outreach from payers and can lead to low response rates in some cases. We appreciate CMS exploring the NDH as a potential solution to the burden of provider directories, including the particular challenges imposed by the CAA. As CMS develops and builds the NDH, we ask that CMS exercise enforcement discretion or continue to apply good faith compliance until the NDH is operational, so that stakeholders are not building in the wrong direction in the meantime.

Summary Recommendations:

- Hold harmless plans that rely on the NDH to populate their provider directories and later find the information to be inaccurate upon audited.
- Consider plans in compliance with the CAA if they rely on the NDH and exercise enforcement discretion until the NDH is built.

Use the CEHRT Program to Incentivize Connections to the NDH

As noted above, solutions vendors could facilitate the implementation of an NDH and provide alternative ways for organizations to upload and receive information to and from the NDH. CMS should work with ONC to update the requirements of the ONC Health IT Certification Program to support use of the NDH and ensure the NDH can interact with tools providers currently use such as EHRs and practice management systems. **ONC should leverage the Certification Program to ensure Certified Electronic Health Record (CEHRT) vendors build the necessary connections to the NDH to allow data entry to be as easy as possible for providers to facilitate updates.**

Summary Recommendations:

- Establish accountability measures to ensure broad provider participation in the NDH.

- Work with ONC to update the Certification Program to require HIT vendors to build necessary connections to the NDH.

IV. Impact on Health Equity

CMS seeks comments on how the NDH could be used to advance health equity and health equity considerations that could impact the design of the NDH.

AHIP applauds CMS's consideration of health equity in the design of the NDH and considers health equity a priority of its own. For far too long, discrimination and systemic racism have served as barriers to health equity for minority and underserved communities. Payers agree that mitigating these barriers to care is key to an equitable health care system and are actively promoting health equity by taking concrete steps to reduce disparities. Improving access to care and ensuring consumers have information to support their healthcare decisions are critical to addressing disparities in care. **However, CMS should work with stakeholders to carefully consider how best to operationalize the NDH to promote health equity.**

On one hand, it is important to collect and publish the information consumers need to support their choice of a healthcare provider. The NDH could play an important role in sharing better information about a provider's identity, cultural and linguistic capabilities, skills and training providing care for diverse populations, and commitment and experience to serving different populations. This information could help consumers either find providers who share their identity or find providers who have the experience, training, and commitment to delivering culturally competent and respectful care. AHIP notes that underscoring current health disparities is the cultural competency and humility of our health care institutions. Cultural competency is a reflection of how clinicians, payers, and other organizations are delivering health care services to meet the social, cultural, and linguistic needs of their patients. Research shows that racial and ethnic minorities are often disproportionately burdened by chronic illness and disease. Payers understand that every patient has different needs, and our member companies continue to invest in strategies to improve health outcomes for all the people they serve. The ability to provide more detailed information on a provider's capabilities could allow payers to work with members to help them find care that best meets their needs.

However, it may be difficult to verify information such as cultural and linguistic capabilities. We realize that some of this information will be self-attested by the provider themselves and cannot be readily verified. Additionally, there are few or no accredited trainings for providing respectful care to various diverse populations and intersectional identities, so it will also be difficult to verify the quality of trainings listed. For these reasons, **we believe the NDH should include a parameter for each data source that indicates whether the information is externally verified or obtained from a provider self-attestation.** This will ensure that users can appropriately assess the possible limitations of the data while also having access to information they may not otherwise be able to obtain.

There is also increasing interest in collecting and reporting information on provider race and ethnicity to support consumer choice in finding a provider who shares a similar identity. To improve the collection of this important information, CMS should add data elements on provider

race, ethnicity, and language. However, there should be a response option that allows providers to select “I choose not to respond” to ensure they have agency whether to disclose personal information on their identity or not given concerns voiced by providers. Some providers are not comfortable providing this information due to concerns about racism and discrimination. Other providers have expressed concerns that they would be expected to serve certain populations based on their identity. To ensure as frictionless of an experience as possible to encourage broad adoption, CMS, other agencies, and accreditation bodies should not place any type of requirement for provider race or ethnicity information to be included in payer directories until the data has been collected at scale and is verified to be accurate.

Finally, CMS should consider how to include organizations and clinicians who may be less resourced. Not all providers have adopted EHRs or other health information technology (HIT). While providers are now required to maintain FHIR-based APIs, it would still require substantial infrastructure investments to build out the technology for this purpose, especially for safety-net, small, and rural providers. Similarly, some providers may not have staff to manage data reporting or financial resources to contract with vendors who can provide these services. CMS should ensure there are easy to access, no-cost ways for organizations to participate in the NDH. For example, CMS could maintain a simple, user-friendly web-interface to allow updates. CMS should also consider ways to include less technologically savvy providers when determining which data elements to include. While many across the system would like to move away from the use of legacy technologies like fax machines, many smaller or less resourced providers are still dependent on them and may not have the ability to adopt new solutions.

An NDH will not solve the challenges of provider directories if only a subset of providers can use it. Moreover, imposing technological barriers to use of the NDH risks perpetuating disparities. CMS could also consider incentives to support providers with IT upgrades and infrastructure or alternative mechanisms for updating their data.

Summary Recommendations:

- Work with stakeholders to carefully consider how best to operationalize the NDH to promote health equity.
- Collect data on fields such as a provider’s race, ethnicity, and language well as cultural and linguistic capabilities.
- Consider how to best include organizations and clinicians who may be less resourced.

V. Data Submission and Maintenance

CMS seeks feedback on considerations for data submission. CMS asks for input on how data can be collected, updated, verified, and maintained without creating or increasing burden on providers and others who could contribute data to an NDH, especially for under-resourced or understaffed facilities.

For the NDH to successfully reduce burden, it must have accurate information and reduce effort required to update information. A national, standardized, interoperable data infrastructure could play an important role in improving the accuracy of provider directory information while reducing the effort required to maintain this information. Improving accuracy and completeness

of provider directories requires solutions where health plans, providers, vendors, and other stakeholders work together to coordinate updates in a timely manner. CMS should develop a public-private partnership to provide oversight and input to the content and technical standards as well as the data submission and maintenance processes for the NDH.

CMS should leverage existing resources and initiatives to improve the current data and submission and maintenance process. Building on and coordinating existing industry initiatives to reduce provider burden could standardize and streamline the processes to submit, verify, and share data. Continuing to allow authorized representatives such as approved vendors to submit data on behalf of providers will minimize the burden of transitioning to the NDH. However, we caution any solutions must be vendor agnostic.

To ensure consistent data collection, government agencies, including CMS, should harmonize current regulations on provider directories across multiple programs. CMS should resolve the discrepancies in required data and timeline updates for different product lines, so payers are able to utilize the common information in the NDH and avoid asking providers for additional updates and data elements. Consistent requirements would increase use of the NDH and its value to all stakeholders. For example, implementing turnaround times consistent with Medicare Advantage for all product lines could strike a balance between ensuring timely updates and allowing the necessary time for verification.

As CMS builds a data submission and maintenance process, CMS should consider how frequently a piece of information is likely to change and will need to be updated. Some information is more static and less likely to change such as a clinician's specialty or the location of a hospital; other information such as a clinician's location or ability to accept new patients is dynamic and will change frequently.

How data is structured and how questions on the data entry form are worded will be essential to improving accuracy. **CMS should consider how to ask for information and how questions will be interpreted.** For example, asking if a clinician is accepting new patients at a given location will give different information than asking if that clinician practices at a given location. Again, a public-private partnership could provide guidance and standards on how to structure and ask for data. **Moreover, CMS could ensure that NDH design processes includes cognitive testing of the NDH data collection form and questions.**

CMS should also consider ways to allow for the collection of additional data that payers may need to meet state regulations or their specific business needs. Allowing for flexibility and extensionality could avoid payers asking providers for additional information or updates outside of the NDH.

We agree there is value in verification of the data in the NDH but caution there is currently no "gold standard" to verify data against. The information currently shared to populate provider directories can be incomplete, incorrect, inconsistent, provided by different staff members of an organization, or require updates to provider contracts, practice areas, or specialties. For example, even simple data points like the name of the practice or phone number can be difficult to verify. Practices may have multiple names due to location, legal name, licensing requirements, or

particular providers. Phone numbers can refer to the main office line, specific offices or divisions, or individual providers. In addition, the person providing the information can range from office staff to financial managers to the providers themselves.

Payers have found that data from NPES can also have errors when building the machine-readable files required for QHP issuers. **To ensure acceptance and use of the NDH, CMS and other federal agencies should hold payers harmless if they use data from the NDH in their provider directories.** Otherwise, payers will continue to verify data independently and ask providers for additional updates.

Finally, when developing a process for data submission and maintenance, CMS should consider provider capabilities and technology savviness. Updates need to be easy to make and the NDH should allow solutions that enable provider buy-in. We suggest CMS explore a role for vendors to continue to make directory updates on provider's behalf while also creating a way that providers can update independently without vendors such as an easy to access web portal, and building connections to systems providers are already using. CMS could also explore solutions based on AI to flag potential errors for providers and ways for other parties to flag potentially incorrect data. For example, a payer could flag that they have been receiving feedback from members that a provider's address is out of date.

Summary Recommendations:

- Work across government agencies to harmonize current regulations on provider directories across multiple programs to ensure consistent data collection.
- Work with the public-private partnership overseeing the NDH to develop data submission and maintenance processes. Key considerations include how frequently a data element is likely to change and how data entry questions are likely to be interpreted by users.
- Consider ways to allow for the collection of additional data that payers may need to meet state regulations or their specific business needs.
- Hold payers harmless if they use data from the NDH in their provider directories, together with the Departments of Treasury and Labor.
- Consider provider capabilities when developing a data submission and maintenance process.

VI. Delegation of Authority to Submit Data on a Provider's Behalf

CMS notes it would be critical to allow listed entities, particularly providers, to delegate or authorize other individuals, either in their organization or intermediary organizations, to submit directory data on their behalf to reduce burden and ensure that data submission is feasible, timely, and accurate. CMS is using the term "listed entities" to refer to individuals and groups whose data could be available in an NDH. CMS requests comments on current industry best practices for delegating authority and aspects of this functionality that could be used with an NDH.

Success of the NDH depends on its comprehensiveness. A centralized data hub will only be valuable if it contains accurate and complete information. Achieving the provider buy-in to ensure the NDH reduces burden will require that the new system simplifies data submission and

streamlines current processes. We recommend that CMS continue to allow providers to delegate authority for data submission on their behalf. **Continuing to allow approved vendors to update the information for providers will avoid creating new burden. However, any solutions or delegation should be vendor agnostic.**

Summary Recommendations:

- Continue to allow approved vendors to update information on the behalf of other entities.
- Ensure the NDH is vendor agnostic and entities have options when choosing a vendor.

VII. Technical Considerations for an NDH

CMS notes that the technical approach to establishing an NDH could leverage work the federal government has already done, in collaboration with industry stakeholders and standards development organizations, to develop healthcare directory information exchange standards. CMS could build on existing work to develop FHIR-based standards for healthcare directories. For years, ONC has collaborated with HL7, an ANSI-accredited standards development organization, to support the scalability and industry adoption of FHIR standards for use in a healthcare directory.

In 2016, HL7, in cooperation with the ONC and FHA Healthcare Directory initiative, developed and published the Validated Healthcare Directory (VHDir) IG. The VHDir IG was developed to describe the technical design considerations for collecting, validating, verifying, and exchanging data from a healthcare directory. The IG also provides technical guidance for a FHIR API for accessing data from a validated healthcare directory. Building on this initial work, FAST has collaborated with HL7's Patient Administration Work Group to develop and maintain new FHIR IGs to further describe data attestation and verification processes. They have also collaborated on standard API for local directories to make verified data available to stakeholders: the National Directory Endpoint Query IG, the National Directory Exchange IG, and the National Directory Attestation and Validation IG.

CMS notes it could also build on work by FAST, which has identified numerous technical challenges associated with directories, particularly related to digital contact information, and conducted research, stakeholder engagement, and key technical development activities to establish the framework and capabilities needed for a scalable NDH. In their proposed directory technical solutions document, FAST also identified CMS as the appropriate potential maintainer of an NDH.

CMS states it could leverage this work to serve as the technical foundation on which to develop a FHIR API-enabled NDH. Additionally, using FHIR standards would help align an NDH with the technical standards at 45 CFR 170.215 finalized by ONC in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program final rule (85 FR 25642).

AHIP appreciates the work CMS, ONC, HL7, and others have done to develop technological solutions to the challenges to provider directories.

Data Standards and Implementation Guides

We appreciate CMS seeking to leverage existing work where possible, but also urge it to be open to additional ideas. As we noted above, we believe CMS should establish a TEP Panel to work through the advantages and disadvantages of different technological approaches. CMS should also include a broad group of organizations in its request for proposals to support the initiative to explore the role different technologies could play at each stage of the system. Finally, CMS should also be mindful that not all providers or payers will have the same level of capabilities and resources, so providing options for how to connect may be most workable.

We generally support the use of FHIR to create foundational exchange standards for nationwide interoperability in areas where standards do not already exist. The creation and adoption of an NDH that uses FHIR-enabled APIs could be a meaningful step forward in reducing the burden of creating and maintaining accurate provider directories at scale. The use of FHIR for the NDH offers several advantages. First, healthcare organizations can use FHIR as the foundational exchange standard and make data available via FHIR APIs. Next, organizations using FHIR implement standardized approaches to manage identity, endpoint discovery, security, and exchange. Exchange partners can dynamically identify and access FHIR servers maintained by or on behalf of healthcare organizations. Finally, the use of FHIR offers a consistent experience when interacting with other organizations.

As a first step to the creation of the NDH, CMS should look to the work of FAST. FAST is cross-industry collaborative that was launched in late 2017 in response to an industry-recognized need to address shared FHIR scalability challenges and is now an HL7 Accelerator. **The work of FAST could be leveraged to serve as a foundation and starting point for the NDH.**

Leveraging the work of FAST, CMS should support the creation of a validated, verified national directory with federated or distributed access. A federated rather than centralized approach could allow multiple stakeholders to contribute information, thus reducing burden and allowing the NDH to support additional use cases in the future.

In the FAST architecture, providers and other healthcare organizations contribute attested information and declare relationships. Next, information submitted to the central data hub is verified. Authenticated end users could then request data on other organizations from the central hub and use it to update their own applications (e.g., a network directory maintained by a specific health insurance provider or a consumer facing tool developed by a third-party application). The federated model developed by FAST would allow end users to contribute potential updates to the information contained in the centralized data hub while allowing the opportunity to verify such updates. This could allow the data in the centralized hub to remain accurate and up to date as multiple parties will have the opportunity to flag errors or outdated information.

We agree CMS should explore the use of the relevant DaVinci implementation guides. The Validated Healthcare Directory (VHDir) IG could serve as a starting point. However, policies have not been published regarding supporting different versions of the standards and IGs. Additional work is needed to ensure that users of this technology understand the baseline,

upgrade path, and maintenance requirements. Moreover, the IGs are limited to address the data transport and security, not to process around the subject or how the data is maintained at rest. CMS should also explore how best to leverage FAST's work to develop and maintain the National Directory Endpoint Query IG, the National Directory Exchange IG, and the National Directory Attestation and Validation IG. The IGs could serve as starting points in the development of the NDH.

CMS should make technical specifications for the NDH publicly available. This should include release of detailed specifications on how CMS will quality check the data. Transparent specifications and processes will ensure stakeholder buy-in and acceptance and allow stakeholders to build systems that align with the NDH.

Potential Future Work

We recognize that building an NDH will be a complex undertaking. As noted above, **AHIP supports the creation of a public-private partnership to oversee the design and implementation of the NDH. To support the NDH technically, CMS should further invest in the DaVinci Project's standards development and FAST to identify scalable solutions to speed adoption.** For example, more work is needed to fully flesh out the standards underpinning bulk data sharing.

CMS should also build the NDH to allow the system to grow and adapt to future use cases. We suggest that CMS solicit bids from an array of contractors to explore different technologies on which to base the NDH with future use cases in mind rather than simply consolidating its existing systems. Emerging technologies, such as blockchain, could offer advantages like greater privacy protections while allowing more users to contribute data to the NDH.

Regardless of the underpinning technology, accuracy of the information in the NDH will be essential to its success. **CMS could also explore how artificial intelligence (AI) and machine learning could facilitate the maintenance of accurate information in the NDH.** AI could be utilized to proactively identify information that could be inaccurate; especially regarding alternative sources of information that could be mined and compared to the NDH.

Interactions with Other Systems

Provider directories require numerous data points to be useful to consumers. Consumers need information on what services a provider offers, where they are located, what days they see patients at certain locations, and if they are accepting new patients. We believe a public-private partnership between the federal government, providers, payers and solutions vendors is needed to streamline collection of this information and improve its accuracy.

CMS should work with ONC to explore how the ONC Health Information Technology Certification Program could support interactions between the NDH and other HIT products such as EHRs and practice management systems. Ensuring that healthcare providers can use data generated by their EHRs to populate some of the required information in the NDH

could reduce data entry burden. Similarly, many providers already use practice management or scheduling solutions. Allowing these systems to interact and share data with the NDH could improve the accuracy of information on some of the most challenging data fields to collect in current provider directories: when and where providers are seeing patients and accepting new patients.

Functionality to Consider

The FAST work outlines the need for organization to delineate billing hierarchies. **We believe CMS will need to collect not just each provider's NPI, but also the Tax ID/NPI combinations under which they may bill for services.** In addition, it would be helpful to harness these disclosed relationships to facilitate the exchange of information. **For example, the NDH could allow organizations to "follow" each other as supported in various social media platforms.** This functionality could then be leveraged to allow organizations to receive alerts if another organization they have a relationship with submits updated information to the NDH, to request updates to meet federal or state requirements, and to flag potentially inaccurate information for corrections.

User Experience

The value of the NDH would be its comprehensiveness. If it can only be used or accessed by a subset of providers or does not include information need by private plans on the basic information, it would not alleviate the need for duplicative systems and processes and would be much less valuable. Ease of use will be essential to ensuring the broad adoption necessary to creating a useful NDH. **We recommend CMS work with stakeholders, including the public-private partnership that would provide oversight to the NDH, to facilitate a positive user experience for the NDH.** Data entry should be easy and frictionless. The design of the NDH should also consider the needs of providers who may be less technologically advanced or have fewer resources (e.g., may not have an EHR system or staff that can manage data entry).

As noted above, in addition to the design of any user interface, there are several technical strategies that could be developed to improve the user experience such as allowing the NDH to interact and interoperate with systems providers already use that may have important information such as EHRs and practice management systems. For example, the NDH could leverage EHR information to understand which providers are part of a group and what locations a provider sees patients at and scheduling systems to better understand which days a provider may be at a certain location.

CMS could also leverage technical standards to improve user experience. Allowing for bulk uploads and downloads would facilitate the transfer of information for all stakeholders. Large groups could more easily share updates about multiple providers while payers could download information for multiple providers in their networks. **CMS should work with HL7 to update the IGs to define a bulk data exchange.**

Summary Recommendations:

- Support the creation of a validated, verified national directory with federated or distributed access.
- Explore how to leverage the work of FAST as a basis for the NDH.
- Explore the use of the relevant DaVinci implementation guides.
- Build the NDH to allow the system to grow and adapt to future technologies. This could allow the NDH to collect additional data and support novel use cases.
- Work with ONC to explore how the ONC Health Information Technology Certification Program could support interactions between the NDH and other HIT products such as EHRs and practice management systems.
- Work with a public-private partnership to ensure ease of use for the NDH and a positive user experience.

VIII. Phased Approach to Implementation

CMS states that the primary goal of an NDH would be to serve as a “centralized data hub” for accurate directory information in the healthcare market. To achieve that goal, CMS is seeking comments on a potential phased approach to establishing an NDH, in alignment with IT industry best practices. CMS would assess the agency’s statutory authorities to establish an NDH and take appropriate action. The initial phases of implementation would focus on consolidating and verifying existing data, building trust, and gaining industry buy-in. Subsequent phases would build on that foundation by incorporating additional data elements, listed entity types, and functionality while maintaining trust in the integrity of the system and data. CMS believes this phased approach would allow CMS to gather consumer and industry input while focusing on scalability, data validity and governance, ethics, and equity for needed agency action or NDH development.

AHIP supports a phased approach to establishing an NDH. Creating and implementing an NDH will require cooperation and input from numerous stakeholders. Moreover, an NDH will only be successful if it is adopted broadly. If the NDH does not meet the need of both payers and providers or does not have the flexibility to avoid one-off asks for information, it will not achieve its desired purpose.

To ensure the system meets stakeholder needs, AHIP recommends the creation of a public-private partnership to oversee the development and maintenance of the NDH. This partnership should be multistakeholder in nature to ensure feedback from a range of parties, while focusing on the core needs of the key stakeholders responsible for maintaining directory information: payers, providers, approved vendors, and government representatives. To build trust and avoid conflicts of interest, the NDH and any solutions to develop and implement it should be vendor agnostic.

We recommend CMS focus the first phase of implementation of the NDH on a use case addressing provider contact and demographic information. As a starting point, CMS could begin with a system to collect and share information on both payer and provider digital endpoints to support implementation of the CMS Interoperability rules and advanced explanations of benefits (AEOBs), then expand to a broader set of provider contact and demographic

information. This would allow CMS to build and test the system with a new set of data to obtain proof of concept.

Once tested with digital endpoints, the NDH could expand to include all the information that is necessary for compliance for federal provider directory requirements across product line (e.g., Medicare, commercial, Medicaid). Such an approach would minimize the frequency with which a provider would need to change or validate information and efficiently share the information across payers in an automated fashion, allowing the NDH to quickly begin to reduce the burden of creating and maintaining provider directories. Additional phases could bring in a large scope of stakeholders, such as a broader definition of providers, as well as support additional use cases such as licensing and credentialing.

As noted above, **we urge CMS to ensure that the NDH is designed with user experience mind.** The ability for providers to enter information needs to be very easy. Providers will be more likely to update data if it is easy to do so and the experience is frictionless. As noted above, bulk uploads and interoperability with could be technological solutions to ensuring ease of use. Similarly, allowing payers and providers to work with approved vendors could allow for easier implementation of the NDH. Stakeholder input, including guidance from the overseeing public-private partnership, could provide iterative feedback into the design and implementation of the NDH to facilitate broad uptake.

Summary Recommendations:

- Use a phased approach to implementation of the NDH. The first phase of implementation of the NDH should focus on a use case addressing provider contact and demographic information.
- Create a public-private partnership to oversee the development and maintenance of the NDH.

IX. Risks, Challenges, and Prerequisites

CMS notes challenges associated with establishing an NDH include, but are not limited to, project planning and scoping, stakeholder and collaborator engagement, development risks, use of existing identifiers (for example, NPI or TIN), data publication, system maintenance, and stakeholder adoption.

As CMS considers the creation of an NDH, there are numerous issues to take into account. Ease of use will be key to implementation and avoiding the inadvertent creation of additional burden will be key to adoption. CMS should also consider the impact of COVID-19 on provider strain in exacerbating existing challenges with low provider response rates to directory update requests. While challenges with provider directory accuracy and timely updates existed prior to the COVID-19 pandemic, health care providers face increased demand at the same time as ongoing staff shortages, burnout, turnover, and other extreme challenges due to the ongoing public health emergency. These factors have made provider response rates and compliance with new provider directory requirements very challenging. While in the long-term, the NDH may reduce burden, implementation should be balanced with other solutions to reduce the short-term burden of a new solution. **CMS should continue to examine ways to minimize the administrative burden of**

provider directory requirements on providers and plans, such as an interoperable infrastructure, that will encourage efficient and correct information while also leveraging resources like vendors and data science in addition to traditional methods like phone, fax, and email.

Another potential issue is variation between federal policies governing provider directories, as well as variation between federal and state policies. Moreover, accreditation bodies such as the National Committee for Quality Assurance maintain requirements for provider directories. **CMS should work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines to ensure the NDH meets all relevant requirements or has the capability to allow organizations to collect additional data points that may be required to meet State requirements or business needs.**

CMS should also consider ways to align the NDH with state policies to minimize redundancy and burden. CMS should begin its effort by creating an asset map of what information is already available and how it is being collected to ensure it is leveraging best practices. Additionally, **the NDH and any state provider directories should be interoperable.**

Summary Recommendations:

- Examine ways to minimize the administrative burden of provider directory requirements on providers and payers.
- Work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines.
- Work with States to ensure the NDH and any state provider directories are interoperable.

X. Conclusion

AHIP appreciates CMS exploring solutions to improve the accuracy of provider directories while reducing burden for all stakeholders. CMS should create an NDH using a federated model overseen by a public-private partnership to ensure the system meets the needs of both the public and private sectors. As a starting point, the NDH could collect and share the digital endpoint information necessary to implement the CMS Interoperability Rules, the ONC Information Blocking Rule, and the requirements of No Surprises Act. Once proof of concept is established, CMS could expand the NDH to collect the contact and demographic information payers are required to collect to meet current directory requirements. The NDH could then expand to support additional use cases.

CMS should also ensure there are incentives to use the NDH. CMS should streamline current directory requirements to ensure the NDH will allow payers to meet regulatory obligations and provide a safe harbor for payers using information from the NDH that is found to be incorrect. CMS should work with states to ensure they also offer similar protections. CMS should also implement concordant requirements on healthcare providers to ensure they update the NDH regularly.

The work of FAST provides a valuable starting point for building the infrastructure for the NDH. CMS should leverage this work while exploring how new technologies such as blockchain could allow for the collection of additional data while maintaining privacy.

AHIP agrees with a phased implementation of the NDH. The table below outlines our vision for how the NDH could be developed and implemented:

Table A: AHIP Framework for NDH Phasing

Phase	Entities	Data Collected
One	Payers, Providers currently included in payer directories or with whom payers contract	Contact information, information on services offered, demographic information (e.g., name, race/ethnicity, location, etc.)
Two	Payers, providers as defined by the Information Sharing Rules	Payer and provider digital endpoints
Three	Other organizations on a voluntary basis	Additional use cases such as credentials and licensing information