TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

December 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244

Submitted Via *Federal Register*

Dear Administrator Brooks-LaSure,

The Texas Medical Association (TMA), which represents our more than 56,000 physician and medical student members, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) on the National Directory of Healthcare Providers and Services (NDH) posted to the *Federal Register* on Oct. 7, 2022.

TMA has comprehensive policy regarding health plan provider directories, which informed our recommendations to establish an NDH. To provide CMS context, we have provided the full policy for reference:

Health Plan Provider Directories

All health plans should maintain current and accurate provider directories. To maintain the directories, the health plans should adhere to certain guidelines:

- All health plans should use the credentialing information they obtain from physicians to maintain their provider directories.
- All health plans should use one primary address as a point of contact when verifying information that will be used within their provider directory. This primary address should be designated by the physician either through the credentialing process or the contracting process with the health plan.
- All health plans should clarify how they categorize physicians by specialty within their provider directories and how physicians may request to be listed under a separate or additional specialty.
- All health plans should clarify how they accept, review, and implement changes to their provider directory if the changes are submitted by health plan enrollees. The health plan should offer the opportunity for physicians to review and approve these changes before publication. The review period should be no

shorter than 30 days from the date of notification to the physician about the proposed changes.

- All health plans should offer physicians both online and written processes for updating their provider directory information if the information changes before the physician's next recredentialing cycle. These processes should be easily accessible on the public portion of the health plan website and included in the health plan's administrative guide. Physicians should be able to submit changes at least 30 days in advance of the effective date. The health plan should provide written acknowledgement to show receipt of the changes as requested, a date as to when the changes take effect, and if the changes will also require a change in the physician's contract agreement with the health plan.
- All health plans should not terminate or remove physicians from their provider directories during the Medicare and Qualified Health Plans yearly open enrollment time frames that the Centers for Medicare & Medicaid Services establishes.
- All health plans should not use the accuracy of the information in the provider directories as the sole basis of terminating or removing the physician from their network(s).
- All health plans that list physicians under multiple practice locations shall verify that all the practice locations are applicable to the physician.

The Texas Medical Association opposes any health plan processes that place an undue administrative burden on the physician to maintain the accuracy of health plan provider directories.

TMA opposes any health plan processes that penalize a physician who relies on a health plan directory to locate or make a referral to an in-network provider.

Overarching Comments

TMA commends CMS for exploring the feasibility of establishing a centralized, accurate, complete, and fully operational national provider directory listing the physicians, facilities, and health care providers participating in all public and private health plans. As noted in the RFI introduction, updating multiple provider directories is not only burdensome but also costly, resulting in an average annual cost of nearly $5,000 per practice. Wasteful administrative spending contributes to higher health care costs. Thus, establishing a well-managed, accurate, centralized directory could achieve our mutual goal of reducing wasteful spending without impacting patient care or access.

However, realizing a high-functioning NDH will be fraught with challenges, necessitating a multi-stakeholder process to design and pilot the directory before launching nationwide. Physicians should be compensated for their time when testing or piloting the directory.

Feedback on specific questions posed by CMS:

CMS questions	TMA response to CMS questions
What benefits and challenges might arise while integrating data from CMS systems (such as NPPES, PECOS and Medicare Care Compare) into an NDH versus only being available directly from the system in question?	Physician practices may have multiple tax ID numbers (TINs)/addresses depending on payer type – Medicare Part B, Medicare Shared Saving Program (MSSP), Medicare Advantage (MA), Affordable Care Act plan, Medicaid. This is especially true for those participating in value-based care opportunities. It will be important to determine whether the TIN or National Provider Identifier is the key identifier and the implications associated with each.
Are there systems at the state or local level that would be beneficial for an NDH to interact with, such as those for licensing, credentialing, Medicaid provider enrollment, emergency response (for example Patient Unified Lookup System for Emergencies (PULSE) or public health?	The Texas Association of Health Plans oversees a Medicaid credentialing application that the Texas Medicaid managed care organizations (MCOs) use. The MCOs that also operate private plans agreed that those plans eventually would use the same application for credentialing physicians, thus reducing the administrative burden of maintaining accurate provider directories for the MCOs and private plans. With almost 50% of Medicare participants opting for Medicare Advantage plans, the MA link will be very important.
What types of data should be publicly accessible from an NDH (either from a consumer-facing CMS website or via an API) and what types of data would be helpful for CMS to collect for only internal use (such as for program integrity purposes or for provider privacy)?	CMS should not deviate from what is currently publicly available. Linking to value-based programs such as MSSP accountable care organizations (ACOs) or ACO Reach is helpful. Also, for the public, the directory should indicate the MA plan in which physicians participate (if any).
Are there particular data elements that CMS currently collects or should collect as part of an NDH that we should not make publicly available, regardless of usefulness to consumer, due to its proprietary nature? To the extent that an NDH might collect proprietary data from various entities, what privacy protections should be in place for these data?	CMS should not deviate from what is currently publicly available. Any necessary updates should go through the regulatory process with public input.
How could NDH use within the healthcare industry be incentivized? How could CMS incentivize other organizations, such as payers, health systems, and public health entities to engage with an NDH?	Technology that works well and brings efficiency and cost savings will be used without additional incentives. For the NDH to succeed, TMA strongly encourages CMS to establish meaningful incentives for all payers to participate, including ERISA-regulated plans. Without all payers participating, the data will be of minimal value.

	TMA does not support mandatory use.
How could CMS evaluate whether an NDH achieves the targeted outcomes for its end users (for example, that it saves providers time or that it simplifies patients' ability to find care)?	If and when CMS develops an NDH, the agency should convene a multi-stakeholder workgroup to design and test the NDH's feasibility. Stakeholders must be engaged from the outset of NDH planning, not just the final testing phase. Early and frequent input regarding the design will help ensure optimal NDH functionality and minimize potential problems later. Likewise, once developed, NDH must be tested by diverse stakeholders to ensure it works as intended. If it does not work in the manner intended, the project should be abandoned until all stakeholders agree it brings the intended efficiencies to provider directories.
Would an NDH as described reduce the directory data submission burden on providers?	As described, an NDH would reduce physician burden. Physicians must routinely update multiple payer directories and even then, physicians will be in network and have a patient's claim denied because of out-of-network status. There must be a reliable, accurate, timely directory. Whatever process is in place to appeal and correct information, it must operate in a way that quickly resolves issues to the satisfaction of involved stakeholders.
How could a centralized source for digital contact information benefit providers, payers, and other stakeholders?	It is possible that entities that distribute digital addresses could feed that information to the NDH. What at times becomes problematic is that a digital address may go to a practice address and not an individual physician within that practice. If a physician changes practices, it may be burdensome to ensure the digital address is also updated. As long as there is one place to update this and the one place becomes the source of reliable information, it should benefit users. Physicians may have multiple digital addresses assigned to them. TMA cautions that digital addresses should not be publicly available so that companies offering services cannot use these addresses for marketing. Vendors and external entities should be prohibited from using digital addresses for marketing, with penalties for those that violate the rules.
What provider or entity data elements would be helpful to include in an NDH for use cases relating to care coordination and essential business transactions	The digital address will be helpful for referrals and public health reporting.

(for example, prior authorization requests, referrals, public health reporting)?	
What specific health information exchange or use cases would be important for an NDH to support?	Health information exchanges would be a stakeholder and should be consulted as a stakeholder if an NDH is developed. Also, hospital and ACO affiliations would be relevant.
Are there types of data transactions or use cases beyond those already discussed that would be helpful for an NDH to support?	CMS should not try to boil the ocean. A good first start would be to combine data already in the various payer directories and making sure that operates smoothly before attempting to add other types of data transactions.
Beyond using FHIR APIs, what strategic approaches should be taken to ensure that directory data are interoperable?	The directory should be built on a platform that is nimble and can adjust to newly adopted technologies.
Are there use cases for which it would be helpful for an NDH to support state and local governments?	During times of emergencies and disasters, there may be use cases for state and local governments to access and query the directory.
Are there use cases for which an NDH could be used to help prevent fraud, waste, abuse, improper payments, or privacy breaches? Conversely, are there any concerns that an NDH, as described, could increase the possibility of those outcomes, and, if so, what actions could be taken to mitigate that risk?	Downloadable options present risks, such as use of information for marketing, phishing, and ransomware attacks.
Beyond identifying providers associated with specific organizations, and organizations that may be under the umbrella of a single health system, what other relationships would be important to capture and why?	All health plan (including MA) and ACO participation.
We have received feedback that individual providers may not use their individual digital endpoints in many cases where the communications involve patients receiving institutional care. How can we associate group- or practice-level digital contact information with appropriate providers to ensure that data get to the right place?	The admit, discharge, and transfer (ADT) feeds sent to physicians via digital addresses have quickly become burdensome because of multiple notifications per patient and useless information. Physicians have indicated primarily needing discharge information with diagnosis to assist with patient follow-up care. ACO linkage ensures communication gets to the ACO management team for ACO Reach, MSSP, Bundled Payments for Care, and the like.
What types of entities should be encouraged to use data from an NDH? For what purposes and why?	CAQH, to make sure its information matches what is published in the NDH. Payers use CAQH to credential.
What are some of the functions or features of current provider directories that work particularly well?	• Location entry to help minimize the search results • Search by plan type • Provider name/Facility name search • Search by specialty

What are some of the lessons learned or mistakes to avoid from current provider directories of which we should be aware?	Payers do not always do a good job of accurately maintaining network status, which is confusing to patients. Payers are sometimes slow to update when a physician changes practices. Physicians and/or their employers are often slow to update their practice status. As different entities collect different information, it will be important for CMS to work with stakeholders to determine which data fields are maintained in a standardized format.
How can data 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?	Minimizing the places to update information will reduce burden. Currently providers have to update with CAQH every 120 days PLUS verify the payer directories every 90 days. Centralize it so the information updates in one space and feeds to the rest.
What are barriers to updating directory data in current systems that could be addressed with an NDH?	Multiple log-ins to provider portals are barriers. When there is staff turnover, the user names and passwords do not always transfer as intended. There need to be ways to securely regain access in a timely manner. It is also difficult to locate some payer directories.
What are current and potential best practices regarding the frequency of directory data updates?	Physicians are expected to verify data every 90 days and notify payers 90 days prior to any changes to prevent payment issues.
What concerns might listed entities have about submitting data to an NDH?	An undertaking of this magnitude would need strong security to ensure minimal downtime. If downtime exceeds more than an hour, there needs to be a contingency plan in place for users. The time it takes to update the NDH needs to be minimized given the numerous payers and providers participating. This information is vital for both patients and providers and needs to be updated in real time to ensure the accuracy when referring patients and scheduling appointments.
Are there entities that currently exist that would be helpful to serve as intermediaries for bulk data verification and upload or submission to an NDH? If so, are there existing models that demonstrate how this can be done (for instance, the verifications performed through the Federal Data Services Hub)?	Possible entities are: • State medical boards • TIN-based organizations for individual physicians • Medical societies • State Medicaid agencies

How could CMS and ONC ensure that an NDH improves interoperability by promoting the adoption of TEFCA and supporting participating health information networks and healthcare entities? What are key opportunities for an NDH and TEFCA to work together in a mutually beneficial fashion?	Since the NDH is not a health information exchange but rather a repository of information, it is difficult to comprehend how TEFCA is promoted. The digital address is helpful, but that already exists within NPPES.
Are there use cases for providers accessing an NDH through their EHRs and, if so, what are the technical requirements?	Many practices rely on their EHR for practice operations. If EHR vendors become a conduit for sending and receiving NDH data, there should not be extra cost to physicians for this functionality.

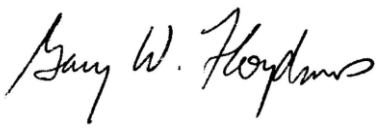
As CMS contemplates an NDH, it should bear in mind the following standardized information is necessary for a directory:

1. What insurance plans a physician accepts
2. Details on insurance type (e.g., HMO, PPO)
3. If accepting new patients
4. Patient restrictions (e.g. only accepts adult patients)
5. Office hours
6. Languages spoken
7. Physician specialty and sub-specialty
8. Virtual appointments available

For a nationwide provider directory to succeed, it will be imperative that all public and private health plans, including ERISA plans, be required to systematically submit timely information, while also allowing physicians and health care providers to easily resolve any inaccuracies. Unless there are practice changes, physicians should only be required to review and update the directory information annually. If a health plan makes a change to a physician's profile, the physician should receive a notification prompting a review of the change. Any changes should clearly indicate reason and the source authorizing the change.

TMA appreciates the opportunity to comment on the RFI as CMS considers a National Directory of Healthcare Providers and Services. Any questions may be directed to Shannon Vogel, associate vice president of health information technology, by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,



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