AMERICAN ACADEMY OF FAMILY PHYSICIANS

December 2, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: RIN: 0938-ZB72; Request for Information: National Directory of Health Care Providers and Services

Dear Administrator Brooks-LaSure,

On behalf of the American Academy of Family Physicians (AAFP), representing more than 127,600 family physicians and medical students across the country, I write in response to the request for information on Establishing the First National Directory of Health Care Providers and Services, as requested on October 5, 2022.

The AAFP appreciates the Centers for Medicare and Medicaid Services' (CMS) interest in improving provider directories to reduce the administrative burden placed on physicians and more effectively help patients find in-network clinicians and health care facilities.

Provider directories serve a number of functions across the health care ecosystem. Plans collect information from physicians, other clinicians, and facilities to inform beneficiaries about where to seek in-network care in their community, provide practice information (e.g. phone number, address, and hospital affiliations), indicate whether a practice is accepting new patients, and more. Plans also use information from physicians and other providers to process billing, claims, and other expenses and to understand where gaps in available clinicians may exist.

However, most primary care physicians are in-network with several private payers, in addition to Medicaid, Medicaid managed care, Medicare, and Medicare Advantage plans. As a result, physicians are required to submit duplicative information to multiple sources, taking up valuable time that could otherwise be spent on patient care. Moreover, payers require some information that must be updated regularly, such as when a physician is accepting new patients. Practices report a significant amount of staff time working to update various directories and registries.[i] Physicians and other providers lack a streamlined and efficient way to provide such information to plans on a regular basis, leading to inaccurate or out of date information. As noted in the RFI, the accuracy of provider directories remains a significant challenge, leading to frustration among plans, physicians, and patients. Inaccurate directories create barriers to timely, affordable care for patients and additional administrative tasks for primary care physicians when referring patients to specialists or other services.

CMS requests public comment on whether a National Directory of Healthcare Providers and Services (NDH) would reduce the directory data submission burden on physicians and other clinicians and improve the utility of directories for patients. The goal of the NDH is to standardize and centralize

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directory information so physician practices only need to enter and update their information in one place. This information would then be used in the NDH but also made publicly available for other payers to use in their directories. Individual payers would be responsible for keeping their directory of in-network clinicians and facilities updated using NDH data. CMS also stated that this single-point data entry process would be aligned with other existing CMS systems that serve directory-like functions, like the National Plan and Provider Enumeration System (NPPES) and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), further streamlining administrative processes for physicians.

The AAFP supports the intent of developing an NDH, given the unnecessary time and expense demanded to update information for several directories maintained by various health plans. However, the AAFP has several specific concerns over its implementation, including universal participation across health plans, data collection platform accessibility, and privacy.

Given that CMS and HHS have limited oversight of commercial markets, the AAFP is concerned that not all insurers will participate in an NDH. While family physicians would benefit from a sole requirement to report to one centralized directory, the AAFP does not see a clear pathway to ensure an NDH does not become an additional directory among many, thereby creating additional administrative burden. CMS has previously mentioned the concept of barring participation in other directories if participating in the NDH, as a method to achieve a centralized directory. However, the AAFP does not support this method of enforcement as it places the decision-making and compliance on the physician and practice, rather than the plans who require duplicative information. Moreover, we expect plans would continue requesting additional information from in-network physicians, outside of any NDH as part of their contracting process. **Unless all health plans agree to participate in and use the information submitted to an NDH, it is likely it will become yet another directory for which physician practices must provide information**. CMS would need to ensure participation across payers for this to be effective and meaningfully reduce burden.

CMS suggests one standardized approach of using an Application Programming Interface (API) to collect and share standardized NDH data. The AAFP supports this approach so long as CMS ensures the API is affordable and accessible to practices, includes security measures, and relies on streamlined and consistent data use requirements. We agree that using an API could make NDH data more accessible for patients and could facilitate data sharing among practices, payers, vendors, and other health care stakeholders. APIs must always perform successfully in real-world testing in physician practice environments before implementation and broad use of the API are required. **If CMS chooses an API approach, the AAFP recommends placing compliance requirements on source systems such as EHR vendors to ensure physician practices can access and use the API.**

CMS also seeks feedback on the potential benefits of including data elements in an NDH such as demographic data, languages spoken, office accessibility, and services offered. **While the AAFP agrees that making information available about demographic and practice characteristics could help aid in patient decision-making; however, we are concerned that making some of these data public could threaten physicians' privacy, ability to practice, and particularly since an NDH will inherently include the address of the physicians' practice. CMS should take a balanced approach that enables physicians and other clinicians to voluntarily report most information and only requiring the inclusion of certain data elements that are essential to accessible care.**

The AAFP would support the NDH requiring clinicians and facilities to report languages offered in a standardized format. This could include additional information, such as whether a translator will be physically present or accessed via audio/video or audio-only technology. We would also support the required reporting of other office accessibility considerations, such as accommodations for individuals with disabilities. These are crucial factors for patients to ensure that physician practices and other facilities are equipped to provide accessible, inclusive, person-centered care. Requiring reporting of these data elements could also aid health insurers in identifying accessibility gaps in their networks.

The AAFP recommends an NDH allow clinicians and facilities to voluntarily report services that are offered in each location. However, **an NDH should not require this information to protect physicians and practices from prosecution, violence, and other challenges.** Under some state laws, physicians who provide abortion and other reproductive health services or gender-affirming care for minors could face time and cost-consuming lawsuits, criminal charges, loss of their medical license, and other negative ramifications which take physicians away from their practice and their patients. Allowing voluntary reporting provides some protection for these physicians, though CMS should consider other privacy and security measures that could be implemented to provide further protection.

Physicians and other clinicians should also have the option to report demographic data, like race, ethnicity, gender identity, or LGBTQ+ status since these factors could be helpful for patients in choosing where to seek care. However, **reporting of physicians' personal demographic data should always be voluntary and optional, not required by CMS.** Further, **privacy and security measures must be taken to ensure physicians do not face discrimination, violence, or other harmful treatment as a result of sharing demographic or practice information that is helpful to their patients. These measures must be in place and tested in a real-world environment before an NDH is implemented.**

Thank you for the opportunity to provide comments on the RFI. We look forward to working with CMS on these recommendations. For additional questions, please contact Meredith Yinger, Manager of Regulatory Affairs, at myinger@aafp.org.

Sincerely,

Sterling Ransone, Jr., MD, FAAFP
American Academy of Family Physicians, Board Chair

[i] CAQH Explorations. "The Hidden Causes of Inaccurate Provider Directories." 2019. https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf