



*Advancing Health in America*

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December 1, 2022

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Baltimore, MD 21244

***Re: CMS-0058-NC, Request for Information; Directory of Healthcare Providers & Services, vol. 87, October 7, 2022***

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and our clinician partners — including more than 270,000 affiliated physicians, two million nurses, and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) regarding the establishment of a national directory of health care providers and services (NDH). As discussed in the RFI, the NDH would serve as a publicly accessible centralized data hub for health care providers, facilities, and entity directory information. It is envisioned that the NDH would help patients navigate health plan networks and facilitate health information exchange and public health data reporting to advance equity goals.

**The AHA shares CMS' goals to improve patient access to provider information and to facilitate health information exchange and data reporting. We appreciate the commitment CMS has invested in striving to meet these objectives. However, we are concerned that adding one more provider directory requirement will not support patients in accessing the information they need about their care providers. In fact, adding an additional data source without sufficiently addressing how or why it differs from the myriad provider directories already in existence could further complicate patients' ability to access accurate information. Meanwhile, such a requirement would add considerable, duplicative**



**burden on providers. Additionally, we have significant reservations about the current state of readiness of the essential technology needed for a centralized data hub such as the NDH. As such, while we support CMS' objectives, we strongly encourage the agency to refrain from moving forward with the NDH at this time.**

CMS suggests that a centralized data hub such as the NDH could be used to assist patients, providers and plans in a number of ways. These include:

- to help patients identify in-network and out-network providers and specialty services;
- to help patients and providers coordinate the No Surprises Act Good Faith Estimates;
- to help providers and plans advance the use of electronic prior authorization; and
- to help reduce provider reporting burden while streamlining program integrity compliance audits.

While CMS asserts that the NDH would alleviate burden for providers, the agency does not adequately address how or why the NDH would improve upon the myriad data sets that already collect provider information. Further, CMS suggests that the NDH would exist alongside these other data sets and not replace them. For example, in the RFI, CMS describes two federal data systems that collect provider information, namely the National Plan and Provider Enumeration System (NPPES), which supplies the National Provider Identifier (NPI) to health care providers, and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), which providers and suppliers use to validate their Medicare enrollment and revalidation process. In addition, CMS catalogs other provider and health plan reporting requirements within CMS programs, such as Medicare Advantage, Medicaid and Children's Health Insurance Program managed care plans, and the Marketplace Qualified Health Plans. However, in the RFI, CMS fails to fully recognize other sources of government-collected provider information, such as state licensing board data, or data collected by insurers and third-party administrators of commercial and self-funded health plans.

Providers already submit a significant amount of data and information for various government and private databases, and it is unclear what the role of the NDH would be vis-à-vis these existing data sets or whether this data collection would offset any of the others. In addition, CMS fails to fully address how the quality of the NDH data would be an improvement over these existing data systems which have, admittedly, been plagued with inaccuracies. The success of the NDH would depend on providers submitting and validating information that meets the required data submission standards, including verifying the accuracy of the data. And yet, this is the same process used by the many versions of provider directories that exist today.

While CMS may be hoping for improved technology and data standards to assist in the accuracy of the data, those tools are far from ready. CMS points to using the HL7 Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (API) as the key to managing the provider and facility directory information. However,

the Office of the National Health Coordinator (ONC) and the Federal Health Architecture (FHA) have been working since 2016 to define the underlying architecture for a national provider directory using FHIR but have not yet completed their work. As a result, CMS acknowledges that an API-enabled NDH remains conceptual and has yet to be tested for broad-scale implementation.

**The AHA firmly believes that CMS should not proceed with implementing an NDH until there is greater clarity on how it will fit in among the other existing provider information data sets, especially with respect to how patients will know when to rely on the NDH versus their health plan’s provider directory. We also urge that CMS first address how the NDH can reduce — not contribute to — provider reporting burden and ensure adequate testing and standardization regarding health information and data transmission.**

Two recent examples of departmental and agency requests for information underscore the need to rethink an aggressive implementation timeline for the NDH. In March, the AHA submitted public comments on ONC’s RFI pertaining to the electronic prior authorization standards and implementation specifications.<sup>1</sup> In that letter, we commented that while we are supportive of solutions to reduce prior authorization impacts on patients and providers, we recommend that ONC collaborate with CMS to pilot the technologies and standards in health care information exchange to ensure functionality and prevent unnecessary provider burden.

In November, AHA submitted comments to CMS regarding the RFI on the No Surprises Act Advanced Explanation of Benefits (AEOB) and Good Faith Estimates (GFE).<sup>2</sup> In that letter, we commented that the entire FHIR-based API had not been sufficiently proven to be a solution to transmit AEOBs and GFE data. We further recommended that CMS assess the degree to which the FHIR-based API can be widely adopted and implemented by the varied market participants. Additionally, we urged that particular attention should be paid to the small, rural, and other providers who may struggle to implement new technology. These same comments apply to the NDH RFI.

In addition, the NDH RFI does not address how commercial health plans or state governments would utilize the NDH and their reporting obligations. Nor does the RFI address how the public would access the data. This lack of clarity suggests that the NDH would not replace current directories but would only add to the burden already borne by providers. While CMS asks if incentives would be appropriate to encourage provider participation, we raise concerns that incentives can turn into penalties. We strongly urge that CMS does not consider imposing incentives to become a pathway to “compliance sticks” when the utility of the NDH has not been proven. We also encourage CMS to consider, as an alternative, changes that could be made to existing reporting requirements rather than implementing an entirely new data set, such as including the location information of providers in NPI reporting. Lastly, we urge that

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<sup>1</sup> [AHA Comments on Potential Rulemaking to Improve Electronic Prior Authorization Processes | AHA](#)

<sup>2</sup> [AHA’s Response to CMS’ RFI: Advanced Explanation of Benefits and Good Faith Estimate for Covered Individuals | AHA](#)

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CMS carefully consider how the NDH may be used to advance health equity goals through data collection and ensure alignment and standardization of approaches to collecting demographic and social risk data so that all stakeholders use consistent definitions and standards.<sup>3</sup>

**Again, we appreciate CMS' focus on improving patients' access to accurate information about their health care providers; however, we urge that CMS carefully reconsider this proposal given the lack of clarity around objectives, need for further consideration about the additional burden it will place on providers, and the lack of technological readiness.** The AHA is pleased to be a resource on these issues and would welcome the opportunity to provide any additional information that would be helpful to the agency in its policy development. Please feel free to contact me if you have any questions or have a member of your team contact Molly Collins Offner, AHA's director of policy development, at [mcollins@aha.org](mailto:mcollins@aha.org).

Sincerely,

/s/

Ashley Thompson  
Senior Vice President  
Public Policy Analysis and Development

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<sup>3</sup> [AHA Response to "Make Your Voice Heard" RFI – Promoting Equity and Efficiency in CMS Programs | AHA](#)