Charles N. Kahn III
President and CEO

December 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: CMS–0058–NC; Request for Information; National Directory of Healthcare Providers & Services; 87 Fed. Reg. 61,018 (October 7, 2022)

Dear Administrator Brooks-LaSure:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to comment to the Centers for Medicare & Medicaid Services (CMS) about the above referenced Request for Information (RFI) and we provide our specific comments below.

The FAH appreciates CMS' leadership in considering establishment of 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. We support CMS in its goal to provide consumers with directories that contain aggregated information about healthcare providers, facilities, and other entities involved in patient care, and agree that updated, accurate directories are crucial resources for consumers and the healthcare industry that can help

consumers choose a provider, compare health plan networks, audit network adequacy, and coordinate patients' care, as discussed throughout the RFI.

While the FAH lauds the vision of an NDH, we have concerns that such an effort may be too ambitious and burdensome and, as a practical matter, may not be able to effectively accomplish its mission, while at the same time unnecessarily diverting limited federal resources which could be better utilized to remedy existing shortcomings with provider directories. Moreover, if health plans (including group health plans, health insurance issuers, and governmental managed care plans) are not legally required to participate in the NDH and remain free to require contracted providers to separately report directory information to the plan, the NDH would create significant burdens while failing to achieve critical efficiencies.

As discussed, instead of building and establishing an NDH, the FAH believes it would be more prudent under existing legal authority for CMS to focus on those aspects of provider directories that currently need improvement and develop appropriate remedies that are most helpful for improving consumer care and access to that care.

Development of an NDH is Premature and the Significant Barriers to Achieving Its Goals May Result in Burden that Exceeds Its Value

In theory, an NDH has the potential to address harmful and significant gaps and inaccuracies in current provider directories, reduce provider burden, improve patient access and care coordination, and facilitate enforcement of critical network adequacy requirements. ***But, as a practical matter, an NDH without mandated plan participation would exacerbate providers' regulatory burdens and confuse patients.***

The FAH is very concerned that the RFI does not address mandatory plan participation as an essential element for a successful NDH. As CMS suggests in the RFI, it has not yet concluded that "adequate legal authority exists to establish an NDH."[1] Even if CMS were to conclude that it has the authority to *establish* an NDH, that would not itself be sufficient. Rather, in order for the value of an NDH to be realized (and the burdens justified), CMS must have the authority to broadly *mandate participation* by governmental and commercial plans and issuers. Such a participation mandate for an NDH must preempt and supersede all other reporting requirements so that no plan is permitted to require by contract or otherwise separate provider reporting of directory information, and legislation granting the authority to impose this critical participation mandate may be an essential prerequisite to the NDH.

Without this authority, health plans may have little financial or other incentive to transition their internal operations and health information systems to rely on NDH data rather than provider reporting. And, without broad adoption of NDH reporting standards, as discussed above, the NDH would become simply one more reporting directory, resulting in further fragmentation and confusion for patients and providers and without the corresponding value that is envisioned.

[1] 87 Fed. Reg. 61,019. Oct. 7, 2022.

In addition to the appropriate legal authority, development of an NDH would require enormous federal resources, along with private sector investment in health information systems and supporting operations and workflow. If adequate resources are not available, the benefits of the NDH would not be realized.

Finally, the technical framework of an NDH would depend upon standards for exchanging directory data that may not yet be available. For example, the RFI seeks information on how to ensure that an NDH improves interoperability by promoting adoption of the Trusted Exchange Framework and Common Agreement (TEFCA). While we strongly support TEFCA and the promotion of interoperability, this initiative is in its infancy and widespread adoption remains a goal for the future.

These barriers are significant, and while an NDH may be achievable and beneficial in the future, we believe it may be too ambitious at this time. Therefore, we urge CMS to prioritize utilizing its resources to address existing and extensive issues with health plan provider directories and inadequate networks, as discussed below.

Solutions to Existing Provider Directory Inaccuracies Should Be Prioritized Over Development of an NDH

As discussed in the RFI, provider directories often contain inaccurate information. The RFI outlines at length CMS findings that demonstrate these inaccuracies. For example, the RFI notes that "[o]ver five plan years beginning in plan year (PY) 2017 through PY2021, CMS found that no more than 47 percent of the provider entries we reviewed from the machine-readable provider data files included a complete set of accurate telephone numbers, addresses, specialties, plan affiliations, and whether the provider is accepting new patients."[2] The RFI also summarizes key findings from CMS' study of the accuracy of information in Medicare Advantage Organizations' (MAOs') online directories.[3] Over three review rounds, CMS "identified at least one deficiency in 45 percent, 55 percent, and 49 percent of listed locations."[4] CMS further notes that "[s]ignificant types of identified inaccuracies included providers who did not practice at the listed location, providers who did not accept the plan at the listed location, incorrect phone numbers or addresses, and mistaken "accepting new patients" flags."[5]

In response to these CMS audits and findings, the FAH has previously commented that many plans have failed to maintain accurate information with respect to network hospitals, post-acute care facilities, and other facilities, information which is particularly critical to enrollees for whom the choice between an in-network and out-of-network facility can have serious financial consequences. Similarly, we expressed our concern that some plans use "networks within a

[2] Id. at 61,020 (citing CMS, Machine-Readable Provider Directory Review Summary Report Plan Years 2017-2021 (March 22, 2022), https://www.cms.gov/files/document/2017-2021mrpdsummaryreportfinal508.pdf).
[3] Id. at 61,020 (citing CMS, Online Provider Directory Review Report (Nov. 28, 2018), https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf).
[4] Ibid.
[5] Ibid.

network" that are often far narrower than the provider network depicted in the provider directory. These subnetworks magnify enrollee and beneficiary confusion, particularly in light of the endemic errors in provider directories identified by CMS.

Inaccurate and stale provider directories—particularly those that fail to present subnetwork information for downstream organizations—may also create barriers to effective enforcement of network adequacy requirements by presenting an illusion of compliance with network adequacy standards. Downstream organizations are often affiliated with their own contracted or employed physician or provider groups, and the sub-capitation arrangements create a financial motivation for downstream organizations to direct care to a particular physician or provider group. As a result, these provider groups often become the enrollees' de facto provider network, making the in-network status of other providers illusory. Thus, enrollees may have selected a particular MAO plan on the basis of its provider network, only to realize later that a downstream organization will discourage enrollees from accessing particular providers. Moreover, the downstream organization's subnetwork may not meet the network adequacy standards to which the MAO is subject.

Given the extensive and long history of inadequate and inaccurate health plans provider directories and related inadequate networks, we urge CMS to first focus on working with stakeholders to better understand and identify the problems and potential remedies for establishing timely, updated, and accurate provider directories and adequate networks, including for networks within networks.

We urge CMS to then prioritize developing remedies and engaging in enforcement action to ensure directories are accurate and up to date and networks are adequate. This can occur in areas where CMS has clear authority, for example, regarding MAOs. CMS could work with stakeholders to determine how best to construct MAO directories to ensure the MAO provider directory timely and accurately includes each provider's name, address, and office hours. And this initiative could focus on providing enrollees with additional valuable and actionable data that the plan already collects or can easily access, such as: (i) a provider's average wait time; (ii) whether the provider is accepting new patients; (iii) quality scores (e.g., star ratings); and/or (iv) conflicts of interest (e.g., physician ownership). This type of targeted effort would optimize CMS and federal resources, while achieving tangible and improved benefits for patients and providers.

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The FAH appreciates the opportunity to submit these comments on this important initiative affecting patient access to care. If you have any questions, please contact me or any member of my staff at (202) 624-1500.

Sincerely,