



December 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore MD 21244-1850

RE: CMS-0058-NC -- Request for Information: National Directory of Healthcare Providers & Services

Comments submitted electronically via www.regulations.gov

Dear Administrator Brooks-LaSure:

The American Medical Informatics Association (AMIA) appreciates the opportunity to provide input to the Centers for Medicare and Medicaid Services (CMS) **Request for Information: National Directory of Healthcare Providers & Services**. AMIA commends CMS for soliciting input on the concept of establishing a National Directory of Healthcare Providers & Services (NDH). We acknowledge the potential benefit of a national directory to help connect patients with providers and reduce clinician reporting burden.

AMIA is the professional home for more than 5,500 informatics professionals, representing frontline clinicians, researchers, and public health experts who bring meaning to data, manage information, and generate new knowledge across the health and healthcare enterprise. As the voice of the nation's biomedical and health informatics professionals, AMIA plays a leading role in advancing health and wellness by moving basic research findings from bench to bedside, and evaluating interventions, innovations and public policy across settings and patient populations. Our comments below focus on general themes we believe the Agency should consider as it further contemplates the construct and perceived benefits of an NDH.

Stakeholders and Scope

CMS references a broad community of stakeholders that would benefit from the construct of an NDH. We encourage the Agency to consider limiting the stakeholder community, at least initially, to consumers/patients and providers. We understand that a goal of CMS in approaching a directory is to improve equity in care presumably from a patient perspective, and we recognize that the needs of various stakeholders may not align, necessitating focus on patients and providers at this time.

We further encourage CMS to be deliberate in refining and narrowing the scope of the NDH concept to ensure its functionality and utility from the outset. Over-population of data elements will not improve consumer/patient access to care, enhance patient choice, or help patients compare providers in any meaningful way. Over-population of data elements also will not reduce provider burden. We are further concerned that pulling from or collecting data from existing sources that are known to have flaws, may amplify those pre-existing concerns and could potentially amplify the complexity of data access as an unintended consequence.

CMS should strongly consider launching a directory in stages and limiting the directory initially to domains CMS controls. It will be crucial to integrate expertise from the informatics communities and organize a directory first around standards and information sharing, enabling the opportunity to build a more flexible and adaptable 21st Century foundation to improve, implement, and sustain provider directories.

Consumers/Patients

A stated purpose of this NDH concept is to facilitate access to care, and perhaps facilitate care coordination. Throughout the text of this RFI, there is significant reference to the technical aspects of an NDH, but there is no solicitation of feedback specifically directed to what the consumer/patient might find useful in the construct of an NDH. AMIA encourages CMS to focus more on consumer reaction to this proposal, and to conduct beneficiary town hall listening sessions or implement other targeted approaches to gather consumer feedback on the data elements that would be helpful to them under an NDH.

Data Quality

Overall, we believe CMS should place more emphasis on data quality and integrity versus emphasis on the collection of an extensive number of data elements that may not add any value for the consumer and may prove burdensome for clinicians. Merging information from currently available distinct databases, with the limitations of each noted by CMS throughout the RFI, will not likely yield any benefit to the consumer or ease provider reporting burden. We

share a specific concern that some of the data to be included, such as addresses that may not be publicly available by design, could inadvertently be released if databases were combined across domains. Again, we encourage CMS to narrow the purpose and scope of the registry.

Pilots

We encourage the Agency to conduct pilots of an NDS among multiple settings of care (community hospitals, large institutions, private practice), before implementing any such directory on a nationwide basis.

Interoperability

We urge CMS to undertake this initiative in close coordination with the Office of the National Coordinator (ONC) for Health Information Technology, to help further shape the concept, provide input on the technical framework of such a directory, and assess practical limitations given current standards for interoperability and health information exchange, and stakeholder adoption. It is important for CMS to more purposefully collaborate with the ONC to leverage the use of standards (USCDI, FHIR, etc.) to create this important aspect of HIT across the healthcare ecosystem. Further, CMS might seek feedback from federal lawmakers to ensure that an NDH is supported in future legislative efforts.

Below we provide input on some of the specific questions posed in the RFI.

III: National Directory of Healthcare Providers & Services Concept and Perceived Benefits

- What benefits and challenges might arise while integrating data from CMS systems (such as NPPEs, PECOS, and Medicare Care Compare) into an NDH? What data elements from each of these systems would be important to include in an NDH versus only being available directly from the system in question?

*It is unclear what benefits might ensue from data consolidation from multiple systems that have limitations of their own, as acknowledged by CMS. Different databases have distinct purposes and data elements. Would data be provider specific, institution focused, or from administrative claims data? For example, basing information on administrative claims data would not help patients access appropriate contact information for a provider. Utilizing licensing data, where clinicians may be using personal information that is not related to their clinical contact or sites of practice, is

another potential consideration in data consolidation that was proposed. This highlights the need to focus on the actual purpose of the directory and the intended stakeholders.

- Are there other CMS, HHS (for example, HPMS, Title X family planning clinic locator, ACL's Eldercare Resource Locator, SAMHSA's Behavioral Health Resource Locator, HRSA's National Practitioner Data Bank, or HRSA's Get Health Care), or federal systems with which an NDH could or should interface to exchange directory data? What are these systems, how should an NDH interact with these systems, and for what purpose?

*AMIA believes that HHS must be mindful and very deliberate in protecting the privacy and security of patients and providers. Releasing information publicly has unintended consequences. For physician and clinician information, we recommend that the physician or clinician be the gate-keeper and validator of any information that is to be released, to reduce potential risks. In the current environment, some patients and providers (for example, those seeking and those providing reproductive health care services) face security risks and intimidation tactics. Access to information about the physical location of these providers should be restricted to prevent targeting of people.

- 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, the Patient Unified Lookup System for Emergencies (PULSE) [\[73\]](#)) or public health?

*It would be beneficial for an NDH to interact with State Medicaid systems. Extreme caution must be exercised in any database merge to protect against the inadvertent release of a provider's personal data, such as home address or cell phone number. The same would apply to accessing state licensing and credentialing information systems. While such systems may offer useful information, safeguards must be in place to protect a provider's personal information.

- Added by the Cures Act, Section 3001(c)(9)(D)(i) of the PHSA requires ONC to create, annually update, and publish on its website a "list of the health information networks that have adopted the common agreement and are capable of trusted exchange pursuant to the common agreement." Are there beneficial ways an NDH could interface with such a list or provide additional information that may be useful, such as a directory of services?

*TEFCA is not yet mature and does not fit the purpose of this RFI. CMS, in several proposed rulemakings for 2022, acknowledged TEFCA limitations and sought ways to incentivize TEFCA adoption.

- 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)?

* AMIA encourages CMS to keep email addresses private and for internal use only. Given legal and operational privacy constraints, providers cannot respond to patient emails in the absence of secured systems, so patients could have uncertainty about whether their message was received. Making provider email addresses available to the public would subject providers to phishing and other cyber vulnerabilities.

- 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 consumers, 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? Industry private directories – have names, addresses, other information not listed elsewhere.

*Collection of proprietary data from industry and other sources could result in too many data elements that would not be relevant for consumers (patients). More information is not necessarily better information.

- We want an NDH to support health equity goals throughout the healthcare system. What listed entities, data elements, or NDH functionalities would help underserved populations receive healthcare services? What considerations would be relevant to address equity issues during the planning, development, or implementation of an NDH?

*Having access to information and receiving information does not equal health equity, in the same way that health care coverage does not equal access to care.

- 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?

*AMIA believes this directory should be focused, at least initially, on patients/consumers and providers.

- Would an NDH as described provide the benefits outlined previously?

*We are concerned that a generic statement of a provider 's specialty would not help patients gain access to the care they need. For example, a specialty designation of "Ophthalmologist" does not provide enough detail for a patient who has already seen an ophthalmologist and who now requires the services of a retinal specialist. A directory must be sufficiently detailed to recognize sub-specialist providers. Additionally, some clinicians have multiple specialties and practice at multiple locations. Information would need to be presented to the consumer in a clear and concise manner. Collecting provider billing address information will have no relevance to a consumer seeking care.

- Would an NDH as described reduce the directory data submission burden on providers?

*Based on the broad scope of this proposal, it is difficult to determine if an NDH would reduce provider burden. An infrastructure would need to be established to ensure ease of initial data submission and updates in real time, without burden on providers. Protocols would need to be established to allow delegation of data entry to staff, and with limitations on the frequency of required updates.

Further, CMS must recognize that a provider may have employment relationships with multiple entities. A provider may be a full-time hospitalist yet provide care part time in a private practice or other setting. Data submission could become quite complex for such providers. Additionally, patients seeking an initial point of care could be misled if, for example, CMS displays the information for a hospitalist.

- We have heard interest in including additional healthcare-related entities and provider types beyond physicians in an NDH-type directory beyond those providers included in current CMS systems or typical payers' directories? For example, should an NDH include allied health professionals, post-acute care providers, dentists, emergency medical services, nurse practitioners, physician assistants, certified nurse midwives, providers of dental, vision, and hearing care, behavioral health providers (psychiatrists, clinical psychologists, licensed professional counselors, licensed clinical social workers, etc.), suppliers, pharmacies, public health entities, community organizations, nursing facilities, suppliers of durable medical equipment or health information networks? We specifically request comment on entities that may not currently be included in CMS systems.

*AMIA believes that an NDH should be limited, at least initially, to providers recognized as practitioners under federal statute, or to patient-facing providers classified as suppliers (such as audiologists) under federal statute.

- What data elements would be useful to include in an NDH to help patients locate providers who meet their specific needs and preferences?

*Again, AMIA believes that a provider's medical specialty must be stated with enough specificity to indicate subspecialty practice. Additionally, only active practice locations should be considered for inclusion in an NDH, with exceptions for providers who are targeted for the services they provide (reproductive health). Billing or administrative office locations should not be listed in an NDH.

Thank you for your consideration of these views. If you require additional information, please contact Reva Singh, JD, MA, AMIA Vice President of Public Policy, at rsingh@amia.org.

Sincerely,

A handwritten signature in blue ink that reads "Gretchen P. Jackson". The signature is fluid and cursive, with the first name being the most prominent.

Gretchen Purcell Jackson, MD, PhD, FACS, FACMI, FAMIA
President and Board Chair, AMIA
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