November 29, 2022

Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-0058-NC – Request for Information; National Directory of Healthcare Providers & Services
87 Fed. Reg. 61018 (October 7, 2022)

Dear Secretary Becerra and Administrator Brooks-LaSure:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Request for Information (RFI) regarding a national directory of health care providers and services. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 1.9 million Americans will be diagnosed with cancer this year and nearly 17 million Americans living today have a history of cancer.[1] For these individuals finding the right doctor is one of the most important factors in their treatment and has a direct bearing on the overall affordability of their care. Increasing and improving information available to consumers about in-network providers is critical to ensuring a more robust consumer-driven health insurance market.

We are pleased the Department is considering the creation of a National Directory of Healthcare Providers and Services (NDH). Consumers often find it challenging to find providers within their plan networks and, despite federal and state rules, provider directories are not always updated in a timely manner which can result in consumers inadvertently seeking care from an out-of-network provider. Having a well-maintained single repository of providers and the health plans to which they have contracted can help consumers make more informed choices.

An NDH can also aid researchers in a variety of health care service delivery research, particularly with regard to changes in the breadth of plan networks. Also, as noted in the preamble, it can reduce provider burden if the ultimate goal is to require providers to report any changes to the NDH system rather than multiple other systems.[2] Current provider directories require redundant reporting from providers, rarely support interoperable date exchange, and often contain inaccurate information that requires staff time to address. In addition, utilizing a single NDH could potentially save physician practices collectively over $1 billion annually.[3]

[1] American Cancer Society. *Cancer Facts & Figures 2022.* Atlanta: American Cancer Society; 2022.
[2] The Department estimates that providers must update their directory information for an average of 20 different payers per practice. 87 Fed. Reg. at 61019 (citing CAQH. 2019. The Hidden Causes of Inaccurate Provider Directories. Retrieved from https://www.caqh.org/sites/default/files/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf.
[3] Id.

As the Department contemplates the creation of an NDH we offer the following comments:

Consumer education is needed: If the intent of an NDH is to create a centralized hub for consumers to use when selecting a provider, we support the concept. We also note that as part of the development of an NDH, the Department will need to undertake a significant education campaign to inform the public about the NDH and how to appropriately use it – such as how to find an in-network provider (much the way plan directories work today).

We note there is potential for confusion with an NDH (that does not exist with a traditional plan directory) in that some providers may be in-network with certain plans operated by an issuer and not other plans operated by the same issuer. Consumers tend to think of their health insurance in terms of issuer name and not necessarily the name of an individual plan. In addition, individual plan names can be similar and it may be confusing for consumers to find the provider network associated with their individual plan. We urge the Department to undergo extensive consumer testing in the development and use of a consumer-facing tool.

Phased-in approach: Assuming the Department is envisioning that an NDH would eventually replace health plan provider directories as a source of information for consumers, we strongly urge the Department to phase-in the availability of an NDH. This means that for a period of time providers and issuers will have to maintain existing provider directories and simultaneously maintain data within an NDH. This phase-in approach is necessary as it will take time for consumers to transition from accessing provider directories from their issuer to accessing information from an NDH. This transition could be streamlined if issuers simply link to an NDH. In the long run phasing in the NDH will allow the Department to address any potential challenges that could arise.

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

1. 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)?

From a consumer perspective, first and foremost any public facing website should contain accurate information in a manner that is easy to understand and searchable. Consumers need basic information about providers – such as the provider's name, office location, phone number, etc. -- in order to make an informed decision. More detailed information is provided in response to question 5 below. The information will need to be updated periodically and each entry should contain a date and time for which it was last updated.

Consumers are interested in knowing whether their provider is in their plan's network, but also what their particular plan's cost sharing associated with a visit to a particular provider. Simply notifying consumers that cost sharing for primary care physicians is $X and specialty visits is $y may be insufficient as some providers may serve as both primary care and specialty care (for example, some states require OB-GYNs to be treated as primary care physicians in certain circumstances). Also, we note that an increasing number of plans utilize tiered provider networks thus making it more challenging for consumers to ascertain expected cost sharing obligations for a particular provider.

The creation of an NDH will allow the Department the opportunity to conduct oversight on plan network adequacy. HHS should collect information on a plan-by-plan basis on the number of providers (by specialty) who leave a plan's network during the course of a plan year. While there are many reasons why a provider may leave a plan's network during the course of a plan year, nonetheless it can be disruptive for patients who utilize the services of that provider, particularly when the absence of the provider disrupts the patient's ability to access specialized care. With respect to information collected for internal purposes, HHS should collect data on

providers who have been removed from plans for disciplinary reasons.

2. We want an NDH to support health equity goals through 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?

Issues related to health care are often confusing to individuals, particularly individuals for whom English is not their native tongue. We note that in the recently proposed Section 1557 proposed rule[4] the Department proposed requiring the notice of availability of language assistance services be provided in the 15 most spoken languages in the relevant state and not just the most common languages spoken in the United States as a whole in order to better ensure more diversity of languages being offered. ACS CAN supported that proposal and recommended the notice be provided in large type (at least 18-point font), which will assist individuals with visual impairment, and be clearly identifiable on the beginning of any document.[5] A consumer-facing NDH should comply with these Section 1557 requirements.

The development of an NDH should also prioritize including, whenever possible, information on the cultural competencies and languages spoken by the providers listed. Greater diversity in the medical workforce has shown the potential to improve health outcomes for patients that come from populations that have been historically under-resourced and/or experienced discrimination and bias in treatment and care delivery. Providing a comprehensive list of diverse providers is an important mechanism to increase access to care for historically marginalized populations because these providers (e.g., providers of color) are more likely to deliver healthcare in underserved communities. Culturally appropriate services that should also be listed could include, but are not limited to, a provider's ability to serve patients with disabilities and providers that serve patients at facilities that self-identify as being welcoming to LGBTQ+ individuals.

We also advise that the development of an NDH for rural regions of the country be as comprehensive as possible. Cancer patients and survivors who live in rural communities are more likely to have limited incomes and to die from cancer than their urban counterparts. Relative to urban areas, the roughly 61 million people who live in rural areas have a higher rate of poverty, unemployment and are more likely to be uninsured. These barriers to accessing care these communities face are exacerbated further by the fact that more than 180 rural hospitals have closed since 2005.[6] As such, ensuring NDHs include an accurate and diverse list of rural providers is essential for patients to know what services are available to them in geography underserved areas.

3. How could a centralized source for digital contact information benefit providers, payers, and other stakeholders?

While an NDH could minimize provider burden and save costs, this goal will only be realized if a significant majority of providers utilize the NDH. If providers choose not update information in an NDH, then the tool is not useful to consumers or other stakeholders. It is unclear from the RFI whether the Department is contemplating requiring providers and issuers to use an NDH. At the very least, we would urge the Department to strongly incentivize providers and issuers to use the tool. The Department should consider providing technical assistance to providers and issuers to facilitate the take up rate of the tool.

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[4] HHS. Nondiscrimination in Health Programs and Activities. Proposed Rule. 87 Fed. Reg. 47824 (Aug. 4, 2022).
[5] American Cancer Society Cancer Action Network. Comments on Section 1557 Proposed Rule. Oct. 3, 2022. Available at https://www.fightcancer.org/sites/default/files/acs_can_comments_section_1557_final.pdf.
[6] Christensen, Jen (2021). "How the pandemic killed a record number of rural hospitals", CNN. https://www.cnn.com/2021/07/31/health/rural-hospital-closures-pandemic/index.html.

4. We have heard interest in including additional healthcare-related entities and provider types beyond those providers included in current CMS systems or typical payers' directories. We request comment on entities that may not currently be included in CMS systems.

We would caution the Department to initially focus on the development and usefulness of an NDH focusing primarily on information regarding physician practices. However, we see the long-term benefit of developing an NDH with an eye toward including additional health care-related entities. Once the initial NDH has proven successful, we would urge the Department to include other health-related entities such as pharmacies, allied health care professionals, and mental health professionals and local community-based organizations that provide social services and support to patients and their families.

5. What provider or entity data elements would be helpful to include in an NDH for use cases relating to patient access and consumer choice (for example, finding providers or comparing networks)? Would it be helpful to include data elements such as provider languages spoken other than English?

Consumers would need basic information for the provider's practice such as the name, gender, office location(s), phone number(s), electronic means of communication (including email and website), affiliations (medical groups, facilities and participating facilities). In addition, an NDH should also provide information on the provider's years of practice, languages spoken other than English (if applicable), whether the provider offers telehealth services, whether they are accepting new patients and the plan networks to which the provider belongs.

An NDH should also provide information on a provider's specialty and sub-specialty (if applicable). We caution that the field of medicine has evolved such that a provider's primary board certification may not entirely reflect their clinical domains of practice. An NDH should also allow a provider who operates in multiple disciplines to reflect their robust practice experience. For example, for a general surgeon who currently is practicing as a hospice medical director, should be permitted to list their expertise in an NDH both in general surgery and their hospice work.

6. What provider or entity data elements would be helpful to include in an NDH for use in cases relating to care coordination and essential business transactions (for example, prior authorization requests, referrals, public health reporting)?

Ultimately, once an NDH has been created, tested, and utilized by consumers and stakeholders, we believe the tool could have uses beyond a provider directory. This goal is laudable and could help to streamline prior authorization requests and reduce the timeframe by which consumers often have to wait for their resolution. However, we caution that the creation of an NDH is a large undertaking and the Department should initially focus on creating a workable, consumer-friendly NDH before shifting to focus on any downstream benefits.

7. Understanding that individuals often move between public and commercial health insurance coverage, what strategies could CMS pursue to ensure that an NDH is comprehensive both nationwide and market-wide?

We would strongly urge the Department to develop an NDH that is capable of providing consumers with information on a nationwide basis. Consumers may move during the middle of a plan year for a variety of reasons and may need the ability to search for providers beyond an immediate market. In addition, creating an NDH that has nationwide search capability can serve as a resource to family and caregivers who may reside outside a patient's immediate area.

CONCLUSION

Thank you for the opportunity to comment on the Request for Information related to a national directory of healthcare providers and services. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network