



(202) 546-9707
USPIRG.org
Info@USPIRG.org

The Honorable Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC

December 6, 2022

Re: Request for Information; National Directory of Healthcare Providers & Services (CMS-0058-NC)

Dear Administrator Brooks-LaSure,

On behalf of U.S.PIRG (the Public Interest Research Group) and our state affiliates, I am writing in support of the creation of a National Directory of Health Providers & Services (NDH).

Provider directories are key tools for insured individuals to access their covered health services. As your Request for Information explained, consumers use “provider directories and online searches more than any other resource (such as word-of-mouth or physician referrals) to research healthcare providers.”¹ Patients rely on the information about specialty and network status in choosing their doctors and hospitals. But today’s plan directories are often inaccurate, missing key information or include errors and outdated data. And most directories don’t include other key information that patients care about - provider’s language ability, cultural/diversity sensitivity training, and whether they have been subject to any medical license disciplinary actions.

We submit the following comments in response to the Request for Information, Docket RIN 0938-ZB72, issued October 7, 2022.²

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

We fully support the creation of a robust national directory system that contains key information important to insured families, academic researchers and federal regulators. The information in the directory should be accessible to all constituencies, including the general public. We recommend the development of an NDH that meets the following goals:

¹ Federal Register

<https://www.federalregister.gov/documents/2022/10/07/2022-21904/request-for-information-national-directory-of-healthcare-providers-and-services#print>

² See Note 1.

A tool for insured individuals to find cost-effective providers. Patients’ out-of-pocket costs are highly dependent on their ability to identify and use in-network providers. If they cannot find a provider in their network, they are obligated higher co-pays, co-insurance and in many situations are responsible for an out-of-network balance bill. Today’s health plans often fail to give insured patients accurate and easy-to-use provider directories. As a result, insured people have difficulty finding a needed provider covered under their insurance plan. We urge the Department to create an NDH that is accessible to patients to identify network providers.

A tool for insured patients and health plans to identify providers who meet the highest levels of quality care and professional standards. Patients want to find providers with an excellent record in providing high quality health services to improve their chances of getting effective and safe treatment. Although health providers report many quality and safety information to federal and state regulators, this information is not always public and can be hard to find. We urge the Department to create an NDH that links to quality and patient safety data collected by states and the federal governments.

A tool for researchers and regulators to collect the numbers of licensed, active providers by specialty and by geographic area and to assess plans’ network size and breadth. Patients need robust networks that allow them to select high quality providers close to home. A single database of providers and their affiliated network would enable regulators to effectively evaluate the adequacy of health plan networks. For the 2023 plan year, CMS has proposed new network adequacy standards through regulations³ and guidance⁴. We urge the Department to create an NDH that can serve as the source of the information needed to assess and enforce network adequacy.

A tool for the public, plans and providers to improve accuracy and allow for swift updates and corrections to network directories. Provider directory data has often been found to be inaccurate or out of date. We urge the Department to create an NDH that allows providers and plans to submit changes efficiently and for consumers to report errors and omissions they discover.

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)?

- **What data elements would be useful to include in an NDH to help patients locate providers who meet their specific needs and preferences?**
- **Would it be helpful to include data elements such as provider languages spoken other than English, specific office accessibility features for patients with disabilities and/or limited mobility, accessible examination or medical diagnostic equipment, or a provider's cultural competencies, such as the National Committee for Quality Assurance's Health Equity accreditation (though we note that these data elements may be difficult to verify in some cases)?**

³ Federal Register, <https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023>

⁴ CMS, <https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf>

Today's families often find themselves in new health plans or in new geographic areas because of the complexity and cost of our health care system combined with the transient nature of our U.S. workforce. With each move to a new town or switch to a new health plan, people must pick new providers. They seek well-trained, high quality doctors that respect and understand them. A strong patient-doctor relationship is more likely to result in better care and better compliance with treatment plans.⁵ The NDH should include basic information such as provider's education, specialty and certifications, office location, hours, as well as network affiliation and hospital privileges. But that isn't enough. The directory should include other details such as provider language, other language access supports, and information about cultural and religious competencies or training.

Patients also need and deserve information relevant to making an informed decision about the quality of care they should expect from each provider. Under today's fragmented system of collecting patient safety and provider quality of care measurements, this information is hard to find and as a result, patients and plans don't always consider those factors when choosing a provider. The NDH must include information or link to quality measures maintained by CMS or state regulators, disciplinary actions, hospital privilege revocations or limitations and malpractice history of each provider. Patient satisfaction survey information should also be included. For example, the National Practitioner Data Bank and the DocInfo website⁶ include critical information about physicians such as malpractice payouts, state medical board adverse license actions and hospital privilege actions. A recent report, to which U.S. PIRG contributed, shows that the 64 state medical and osteopathic boards' vary significantly in how they share that information with the public.⁷ A properly designed NDH could put this life-saving information in one location.

As the NDH is developed, it should continue to be updated to include new helpful data points that might be developed around value of care (cost and quality) or other safety and quality measurements. The NDH could and should be a tool that employers and plans could use to build networks that emphasize inclusion of high quality, low cost providers.

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?

The key to the success of an NDH is accuracy. Providers and plans must be held accountable to keep the information updated. If the public can't rely on the database to give them the most up-to-date information, they might not be able to obtain the care they need. Staying in-network is a key decision factor for many insured families when picking a provider because of the financial implications of paying the added costs of choosing care outside of their plan's network. For example, if a patient needs a specialist and that specialist's information is not in the directory, they may not get the care they need because they can't afford what they think will be an out-of-network service. Alternatively, although current rules protect patients from out-of-network costs if the directory incorrectly identifies a provider as in-network, most people don't know to take a dated screenshot of the provider directory in case they need to later prove they relied on that information.

⁵ "The Eroding Trust Between Patients and Physicians", Medical Economics, 10 April 2018, <https://www.medicaleconomics.com/view/eroding-trust-between-patients-and-physicians>

⁶ <https://www.docinfo.org/>

⁷ Carol Cronin, Lisa McGiffert, "Looking for Doctor Information Online", January 2022.

<https://www.patientsafetyaction.org/wp-content/uploads/2022/03/Looking-for-Doctor-Information-Online-1-7-22.pdf>

In addition to these consumer concerns, directory inaccuracy hampers its public health functions. Regulatory oversight of network adequacy requirements won't be effective if the directory fails to reflect the true picture of scope and breadth of practicing, licensed providers. And if the directory is to be used to measure and evaluate the numbers of licensed, active providers across the nation, the NDH should be designed in a way that eliminates duplicates, and captures the full list of providers working in geographic areas.

To ensure providers and plans have the incentive to keep their information updated, we recommend this trifecta of incentives:

1. **Provider incentive:** As a requirement of state professional licensure, health care providers should be required to submit a screenshot of their profile in the database, reflecting their updated information. The annual or bi-annual renewal of professional licenses could act as a useful reminder for professionals to update the directory.
2. **Plan incentive:** Plans should be held accountable for updating their networks through active oversight and frequent audits of network adequacy. If plans fail to include all of their networked providers, they will fail to meet the network adequacy standards.
3. **Consumer watchdog:** Insured individuals are a key to enforcement. They are most likely to be the first to recognize an error in network status and should be given an easy way to report inaccuracies and report the plan or provider to the NDH.

What specific functionality or use cases, including any not discussed here, would it be helpful for CMS to consider developing within an NDH?

An accurate comprehensive NDH could be used by federal and state agencies to communicate with providers about important safety information. For example, the Food and Drug Administration and Product Safety Commission issue periodic safety warnings and fraud alerts. The NDH could be used as a communication tool to get warnings about dangerous cribs or tainted supplements into the hands of health practitioners immediately.

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?

We encourage CMS to grow the directory to include all types of providers that patients use frequently and seek for themselves, such as nurse practitioners, dental, vision and hearing care professionals, midwives and mental health professionals. The RFI anticipates a phasing-in of data in the national directory. We recommend that CMS prioritize the most commonly used services and build from there over the next five years.

Beyond identifying providers associated with specific organizations, and organizations that may be under the umbrella of a single health system, what other relationships would be important to capture and why?

CMS currently houses the Open Payments database⁸ to increase transparency of payments made to physicians and others from certain businesses such as pharmaceutical and medical device companies. Linking this information to the NDH could assist in making families more aware of this resource and enabling them to be alert to potential conflicts of interest of their providers.

What entities or stakeholders should participate in the development of an NDH, and what involvement should they have? What stakeholders could have valuable feedback in the scoping and early implementation processes to ensure viability of an NDH and sufficient uptake across the healthcare industry?

We recommend that CMS conduct several patient and consumer focus groups prior to finalizing the data elements to include in the directory. The feedback from different consumer and patient stakeholders, representing a diverse range of ages, languages/culture, and education level is important to supplement the feedback you will receive through this RFI. Regulatory comments are not sufficient to reach a general public audience; this additional step is essential to involve the consumer end-user .

After development of the data points, we recommend that CMS engage state and community stakeholders in testing the public facing portion of the NDH to test ease of use. Groups/individuals to be involved in this evaluation phase should have a track record of consumer and public interest advocacy, a demonstrated interest in health care safety and quality improvement, and an awareness of diverse demographic groups (including issues related to health literacy).

Additional focus groups and solicitation of feedback from patients and families should continue every 2-3 years as the health system, plan designs and patient needs change.

Are there use cases for which an NDH could be used to help prevent fraud, waste, abuse, improper payments, or privacy breaches?

State attorneys general often prosecute Medicaid billing abuse and fraud. State licensing boards also discipline and fine health care professionals for fraud, waste and abuse. Capturing data in the directory from these state regulatory and prosecutorial actions would be helpful to consumers and plans to avoid providers who are under investigation or who have been convicted, penalized, or removed from state Medicaid systems for fraud and abuse.

Conclusion

On behalf of U.S. PIRG, I appreciate the opportunity to comment on the design and use cases for a national provider directory. We fully support the development of such an important tool that can help the insured public select providers in their health plan's network but also pick the best provider to meet

⁸ Open Payments, CMS. <https://www.cms.gov/openpayments>

their needs and priorities. Accuracy of the NDH is key to its success. We are willing to help support the further development of an NDH.

Thank you.

Respectfully submitted,



Patricia Kelmar, JD
Senior Director, Health Care Campaigns
pkelmar@pirg.org

PIRG is a federation of independent, state-based, citizen-funded Public Interest Research Groups in 25 states, whose role is to find common ground around the commonsense solutions that will make our 6 future healthier, safer and more secure. We are part of The Public Interest Network, which operates and supports organizations committed to a shared vision of a better world and a strategic approach to social change. Learn more at <https://pirg.org/>

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