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June 16, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Thomas Keane, MD, MBA
Assistant Secretary for Technology Policy
National Coordinator for Health Information Technology
Department of Health & Human Services

Submitted electronically via www.regulations.gov

RE: Request for Information; Health Technology Ecosystem [RIN 0938-AV68]

Dear Administrator Dr. Oz and Assistant Secretary Dr. Keane:

AHIP is the national association that represents health insurance plans that provide coverage, services, and solutions for over 205 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market. AHIP appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Technology Policy (ASTP) on the Health Technology Ecosystem Request for Information (RFI). We agree fully that effective and responsible adoption of technology can empower patients to make better decisions for their health and well-being.

AHIP and its members fully support the underlying goal of moving toward a health care system in which data flow seamlessly and securely among appropriate stakeholders to the benefit of all Americans. To that end, we appreciate efforts by CMS and ASTP to implement policies that enhance the amount of health data available through digital channels and give patients secure, more seamless access to their health information. We also recognize the importance of building a robust information exchange infrastructure to support improved prevention and chronic disease management as well as to enhance Value Based Care (VBC) models.

Health plans today are making significant investments in technology and tools, including standards-based application programming interfaces (APIs), that can better connect payers, providers, and patients to ensure data flows securely and seamlessly and manual processes such as phone calls and faxes are a thing of the past. To make this modernized digital environment a reality, it is crucial that CMS and ASTP address the current gaps in infrastructure and policy, that stand to impede progress and reinforce existing inefficiencies and information silos.

While our detailed responses to specific questions in the RFI are attached, our high-level recommendations include:

- **Use trust frameworks to support high-value information exchange.** ASTP should address concerns limiting health plan participation in the Trusted Exchange Framework

and Common Agreement (TEFCA), including limited use cases, cumbersome policies, and outdated technical standards. ASTP also should ensure information blocking is not permitted within TEFCA by preventing providers and their vendors from charging health plans fees to obtain clinical and quality data.

- **Build the necessary infrastructure to support interoperability through a public-private partnership.** To support successful implementation of the APIs required in the Interoperability and Prior Authorization final rule, CMS should employ modern technology to build a national directory of health plans and providers with both traditional information such as addresses and newer information such as digital endpoints to enable interoperability. We are also attaching our response to CMS's 2022 RFI; National Directory of Healthcare Providers & Services to share more information on thinking around the NDH.
- **Incentivize adoption and use of technology across payers, providers, and vendors.** To ensure implementation of electronic prior authorization, ASTP should quickly finalize the HTI-2 proposal to establish requirements for electronic health record developers to include Prior Authorization API functionality and capabilities in their technologies as part of the ONC Health IT Certification Program. CMS should consider a Condition of Participation or implement performance-based measures to more rapidly move providers towards adoption of electronic prior authorization.
- **Focus on voluntary testing of health plan interoperability requirements.** ASTP should not finalize the HTI-2 proposal to add health plan API certification criteria to the existing ONC Health IT Certification Program, which would be unnecessarily burdensome and could inappropriately and impermissibly convey significant information blocking penalties. ASTP should instead focus on making available opportunities to test the APIs at scale across plans, providers, and third-party applications through its Inferno program.
- **Ensure a feasible transition to digital quality measures.** This transition should include working with stakeholders to rework TEFCA to facilitate the exchange of quality data, promoting measure alignment across public and private payers, and ensuring the U.S. Core Data for Interoperability includes the necessary data elements to calculate high-value measures.
- **Integrate technology into VBC models.** CMS should provide waivers and embed incentives within models to encourage adoption of technologies that enhance value. It should also strive for greater alignment in data standards and make targeted investments in infrastructure, technical assistance, and interoperable tools to support VBC participants.

Thank you for your consideration of our input. AHIP appreciates your efforts to engage stakeholders as you identify interoperability and technology infrastructure priorities. We look forward to working with you to advance these goals, including opportunities to support innovation in health care. If you have questions, please ask your team to contact me at dlloyd@ahip.org or 202-778-3246.

Sincerely,

Danielle A. Lloyd

Danielle A. Lloyd
Senior Vice President, Private Market Innovations & Quality Initiatives

Attachment 1
AHIP Detailed Comments

D. Payers

PA-1. *What policy or technical limitations do you see in TEFCA? What changes would you suggest to address those limitations? To what degree do you expect these limitations to hinder participation in TEFCA?*

AHIP and its members support the goal of establishing a nationwide "network of networks" to support data sharing across the health care system. Investing in efforts to modernize the health care data infrastructure will create an ecosystem where data flows seamlessly among stakeholders to the benefit of the patient. A national network would permit federal agencies, states, and private sector organizations alike to easily connect and share information to improve care, achieve efficiencies, and reduce costs.

For example, such an ecosystem could play a critical role in meeting the Trump Administration's goal to "Make America Healthy Again" by improving care coordination for chronic diseases, increasing adherence to preventative care, and harnessing new data sources becoming available from innovative technology. It could also help overcome the infrastructure challenges impeding the implementation of the Application Programming Interfaces (APIs) required by the CMS interoperability rules by offering a digital endpoint directory, patient consent mechanisms, and patient look-up services. In addition, a national network could advance other priorities such as digital quality measurement, credentialing, public health reporting, research and other use cases.

However, to date health plan participation in the Trusted Exchange Framework and Common Agreement (TEFCA) has been hampered by limited use cases, cumbersome policies, and outdated technical standards. While there are new use cases that include health plans, they are still largely tilted toward providers receiving data from health plans. In addition, there are ongoing features of TEFCA of concern to plans including:

- the ability of responding nodes to charge fees beyond what the Qualified Health Information Networks (QHINS) will charge,
- the inability to support Fast Healthcare Interoperability Resources (FHIR)-based exchange,
- misalignment with the CMS interoperability rules,
- an inability to control what data must be exchanged, such as requiring the disclosure of confidentially negotiated rates, and
- HIPAA clarifications and protections related to disclosures.

The Assistant Secretary for Technology Policy (ASTP) and CMS should resolve these issues to facilitate more active health plan participation in TEFCA and unlock its broader potential or determine a different path for establishing a national network. Either way, health plans need to be more actively involved in the process as central stakeholders. Should the administration continue to support TEFCA as the central means to establish a national network, additional health plan representatives should be included in TEFCA advisory groups and plan

representatives should be considered for chair roles. Moreover, these representatives should come directly from health insurance companies or their trade associations, rather than vendors, so that TEFCA can directly hear the needs of health plans.

Remove Extraneous Fees for Data Exchange

We appreciate the efforts of ASTP and the Sequoia Project to make TEFCA more useful to payers. In particular, we appreciate the final SOP XP Implementation: Health Care Operations including the HCO HEDIS Reporting (HCO-HED) and HCO Quality Measure Reporting (HCO-QM) exchange purposes. Allowing health plans and health care providers to use TEFCA to support performance measurement will improve health care quality and safety for patients. This will also increase the value of participation in TEFCA for health plans and reduce burden on health care providers.

However, we are very concerned the SOP: XPs Version 3.0 will allow health care providers (as responding nodes) to charge health plans for the data necessary to support these essential functions. Quality measurement is critical to ensuring patients receive safe, timely, and effective care, allowing health plans to best serve their members, and promoting performance improvement among providers. TEFCA has great potential to reduce the burden on both plans and providers to locate and exchange the data necessary to support measurement. However, allowing providers to charge fees for this data will be a significant impediment for plans to the use of the HCO-HED and HCO-QM exchange purposes. Currently, plans work with providers in their contracting processes to outline the provider's responsibilities to share data with the plan to support HEDIS reporting as well as quality measurement more broadly. As written, the SOP will require plans to separately negotiate fees with all providers from whom they may need data in order to exchange data through TEFCA. This would require significant rework and would substantially increase the plan's costs, reducing the value of participating in TEFCA.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule recognizes that Health Care Operations are necessary to support treatment. While the Privacy Rule allows for reasonable, cost-based fees, this model is outdated under a TEFCA exchange supported by Fast Healthcare Interoperability Resources® (FHIR) application programming interfaces (APIs). Data exchange via API will not require the manual labor that was previously necessary to find charts and make photocopies or send secure files. If TEFCA works as envisioned, it should not require any extra effort from a healthcare provider to respond to a plan's request for data under the HCO-HED or HCO-QM uses cases and thus will not necessitate payment to compensate a provider or associated employee for the time and materials required to respond to a request.

Charging fees when extra work is not required is also against the spirit of information sharing. The 21st Cures Act defines information blocking as, "a practice that interferes with, prevents, or materially discourages access, exchange, or use of electronic health information." While the Cures Act Final Rule does create an exception that allows for the charging of fees, the rule also notes fees must be reasonably related to costs and specifically excludes fees to perform

an export of electronic health information via the certified HIT.[1] **Sending data for quality measurement and HEDIS via TEFCA will be analogous to an export of EHI and not related to the development of technologies and provision of services that enhance interoperability**.

We also note that the SOP XP Version 3.0 was not put out for public comment. Public comment is critical to ensure all stakeholders have the opportunity to express their concerns on draft policies. Public comment is even more important when all stakeholders are not equally represented in closed meetings. As stated in our January 19th letter, AHIP urges RCE to bring health plans more actively into the process as central stakeholders in the development and use of TEFCA. Additional health plan representatives should be included in TEFCA advisory groups and plan representatives should be considered for chair roles. Moreover, these representatives should come directly from health insurance companies or their trade associations rather than vendors who cannot accurately speak to the needs of health plans.

I**nformation should be freely available to support the provision of high-quality health care.** Quality measurement is an essential health plan function to ensure members receive timely and effective care. Plans should not be required to pay more to be able to perform these crucial safety checks, especially as healthcare quality shortcomings in the United States are well-documented and have grown worse during the COVID-19 pandemic.[2] Plans play a critical role in helping providers identify and address quality gaps and should be able to easily access the data they need to do so, without undue burden. Quality measurement is a key function of health plans in administering value-based payment arrangements, including providing clinical decision support and performance dashboards to providers to assist in their quality improvement activities.

We urge ASTP and the Sequoia Project to revise the TEFCA SOPS to not allow responding nodes to charge fees for the Health Care Operations exchange purposes. These fees undercut the purpose and usefulness of TEFCA and diminish the potential benefits to health plans.

Promote FHIR-Based Exchange

TEFCA's architecture is a well-intentioned but outdated and structurally constrained approach when compared to more contemporary, scalable models like FHIR-based APIs and value-added intermediaries. Currently, TEFCA is designed around document exchange, as opposed to discrete data. While we appreciate ASTP and the RCE taking steps to support FHIR, we would encourage the use of fully FHIR-based exchanges. The current protocol uses an IHE exchange with an option to use FHIR to request data. The workflow primarily uses IHE transactions to find an endpoint and for patient matching. As TEFCA evolves, the SOPs should be updated to include FHIR-based transactions.

Accelerating the adoption of FHIR-enabled exchange through TEFCA would allow impacted payers to leverage the network to meet CMS Interoperability and Prior Authorization final rule requirements. Prioritizing the exchange of FHIR resources through the Health Care Operations

[1] Cures Act Final Rule: Information Blocking Exceptions (healthit.gov)
[2] How does the quality of the U.S. health system compare to other countries? - Peterson-KFF Health System Tracker

SOP would align with current CMS requirements on impacted payers, providing a clear benefit to TEFCA participation. Moreover, using FHIR would better enable the tailoring of data requested and returned to better reflect the specific need consistent with HIPAA.

CMS should ensure TEFCA is based on Fast Healthcare Interoperability Resources (FHIR) standards. The current QHIN-Facilitated FHIR exchange as currently implemented in TEFCA is limiting as only uses FHIR for support services, not the actual information exchange. This approach can be described as IHE in a FHIR envelope. Plans need to move to FHIR to meet the requirements of the Interoperability rules and an IHE exchange is of limited use. **ASTP should phase out document-based exchange (e.g., IHE) and require exchange via FHIR APIs as soon as practicable.**

ASTP should also explore ways to allow stakeholders to use current QHIN-based FHIR solutions such as the endpoint directory, record location services, and the security certificate infrastructure but do a point-to-point exchange. This would allow stakeholders to access some of the benefits of TEFCA without the current drawbacks of exchange through the QHINs.

<u>Ensure Alignment with the CMS Interoperability Rules</u>

As noted above, TEFCA could help facilitate implementation and adoption of the CMS-mandated APIs. **However, we are concerned that the current misalignment between the TEFCA SOPs and the requirements of the CMS Interoperability and Prior Authorization final rule hinder this possibility.** For example, the final rule and the SOP appear to reference different versions of the United States Core Data for Interoperability (USCDI) and implementation guides (IGs). We note the CMS Interoperability and Prior Authorization final rule, and the ONC HTI-1 final rule require the use of USCDI version 3 after January 1, 2026. Thus, plans in federal programs may wish to move to version 3 voluntarily to leverage TEFCA to meet the CMS interoperability requirements. **While advancing required versions too quickly may inadvertently pose a barrier for voluntary commercial plan participation, allowing plans in federal programs and providers to voluntarily move forward would strike a balance between the different organizations' needs.** It is our understanding that version 3 is backwards compatible so having some organizations move ahead before others would not impede interoperability.

The frequent update cycle for USCDI creates substantial implementation challenges. CMS and ASTP could consider extending the interval between updates as changes introduce additional data elements that increase burden on both payers and providers. ASTP could also consider creating a process to identify and remove low-value or outdated elements. Additionally, we recommend requiring clear justification and/or business cases for any newly proposed data elements.

There also appears to be variation in the security protocols required for TEFCA and those recommended via the HL7 Da Vinci Payer Data Exchange (PDEX) FHIR Implementation Guide.

Do Not Force the Disclosure of Negotiated Rates

Current TEFCA policies require participants to exchange whatever data is required by the current Common Agreement and SOPs. Participants have no control over what is exchanged. We remain very concerned that the HCO SubXP-1 SOP does not contain language clarifying that provider remittances and enrollee cost sharing are not required to be included in adjudicated claims despite the CMS Interoperability rules explicitly excluding such information in exchanges with health care providers or other payers. Requiring public disclosure of pricing data could have potentially negative competitive effects that could hinder fair negotiations and drive up prices. According to the Federal Trade Commission (FTC), "…transparency is not universally good. When it goes too far, it can actually harm competition and consumers. ."[3]

We strongly believe that health insurance providers should not have to disclose confidentially negotiated rates to participate in TEFCA. Such forced disclosures of pricing data risks undercutting competition and driving up health care prices, causing serious disruption to our health care system to the detriment of consumers. **The RCE should reinstate that exclusion and clarify that no data on provider remittances and enrollee cost sharing is required to be shared.**

Clarify Responsibilities Related to HIPAA and Disclosures

TEFCA needs additional safeguards for data protection and adoption. **OCR, ASTP, and the RCE should update TEFCA governance documents to define responsibilities for participants and QHINs related to disclosures and third-party vetting.** This is vital to ensure trust in the network as participants are not able to choose who they will share data with or set up relationships with as business associates. It is important to address the protection of all participants and QHINs and to ensure trust of this voluntary data exchange network. It should be clarified that QHINs lead the evaluation and certification of participants and have responsibility for the data they exchange, including if information is disclosed to bad actors. For example, ASTP should clarify the TEFCA data sharing guidelines with a revised "minimum necessary" definition and a create reciprocal response obligations for all participants. Under current rules, providers can decline to respond to health plan operations requests, while health plans are obligated under TEFCA to respond to provider requests.

This could include clarity on responsibilities for participants and QHIN's related to disclosures, including for incidents such as:

- **When there is a breach at an endpoint (for example, a threat actor has compromised a participating provider endpoint and queried other participants' systems).** The industry and TEFCA participants would benefit from aligned

[3]Koslov, T. and Jex, E.; *Price transparency or TMI?;* Federal Trade Commission Blog; Jul 2, 2015 2:31PM; **https://www.ftc.gov/news-events/blogs/competition-matters/2015/07/price-transparency-or-tmi.**

understanding of responsibility. Our interpretation is that this would fall on the compromised endpoint. However, this is dependent on the notion that networks approved by TEFCA coordinators have reasonable security measures in place, so any disclosure a participant makes to a seemingly valid request would be permitted under HIPAA.

- **If a QHIN improperly permits a threat actor to become a participant.** Similar to the example above, it should be clarified that if a QHIN follows all required processes to be validated for exchange, any participant's disclosure to the third-party threat actor would be permitted.

PA-2. *How can CMS encourage payers to accelerate the implementation and utilization of APIs for patients, providers, and other payers, similar to the Blue Button 2.0 and Data at the Point of Care APIs released by CMS?*

See above for how a functioning national network could facilitate implementation of the CMS-required APIs.

Do Not Implement Payer Certification within the Health IT Certification Program

The 2024 ONC Health, Data, Technology, and Interoperability (HTI-2) proposed rule expands ONC's Health IT Certification Program by adding voluntary certification of CMS-required health plan APIs. AHIP opposes adding a payer API certification to the existing ONC Health IT Certification Program. Congress did not grant ONC the ability to extend the Health IT Certification Program to payers, voluntarily or not, which could inappropriately and impermissibly convey significant information blocking policies. Moreover, this regulation would inappropriately create a whole new regulatory framework and compliance schema resulting in significant additional time needed to implement and burden that could hamper the desired policy goal of promoting interoperability across health plans, providers, and patients. ONC should focus instead on making available opportunities to test the APIs at scale across plans, providers, and third-party applications through its Inferno program. **AHIP urges ASTP to not finalize the HTI-2 proposal to add health plan API certification criteria to the existing ONC Health IT Certification Program.**

Promote Adoption of the Prior Authorization API

Advancing adoption of electronic prior authorization is a quintessential example of how the use of technology could drive improvements in quality, cost, and burden. Prior authorization allows health insurance providers to promote safe, timely, evidence-based, affordable, and efficient care. Prior authorization can reduce inappropriate care by preventing unsafe or low-value care and targeting where care may not be consistent with the latest clinical evidence. Unsafe, low-value, or care that is not evidence-based can contribute to potential harm to patients and unnecessary costs.

However, the prior authorization process can be burdensome to providers, patients, and health insurance providers. AHIP has supported CMS's efforts to improve the prior authorization process through the development of APIs. However, these policies will only be successful if they

are adopted by providers and providers have the technology infrastructure. **Therefore, it is critical that ASTP finalize its proposal in the HTI-2 proposed rule to establish specific requirements for electronic health record (EHR) developers to include Prior Authorization API functionality and capabilities in their technologies as part of the ONC Health IT Certification Program.**

We appreciate CMS adopting attestation-based measures for the Merit-based Incentive Payment System (MIPS) and the Promoting Interoperability Program as a first step to promoting adoption of the Prior Authorization API. As CMS explores transitioning from attestation-based measures to performance-based measures in the Promoting Interoperability program, we urge the agency to consider transitioning the Electronic Prior Authorization measure from an attestation-based measure to a performance-based measure as originally proposed in the Promoting Interoperability and Prior Authorization rule or ideally, a Condition of Participation (CoP) requiring the use of the Prior Authorization API. Tying this measure to performance or a CoP, rather than attestation of a single use of the API will encourage providers to repeatedly use the Prior Authorization API, accelerating adoption and streamlining the prior authorization process for all stakeholders.

Finally, CMS should work with stakeholders to consider best data options for public reporting related to these measures on the *Care Compare* website. Sharing this data could help consumers choose providers who could better facilitate their care by adopting ePA and allow payers to understand providers' willingness to implement standards-based ePA and explore solutions to increase adoption. Appropriately designed public reporting may also incentivize provider adoption of ePA.

Address Risks to Patient Privacy

AHIP recognizes the potential of APIs to give patients access to their health data, a valuable tool to help them engage in their health and health care. However, with these new opportunities come new threats to patient privacy. New entity types, such as app developers, that are now common in the marketplace were not contemplated, let alone included, as covered entities within the traditional Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health (HITECH), and 42 CFR Part 2 rules.

These new entities can be collecting, using, disclosing, and disseminating consumer health data for the purpose of monetizing it, and yet consumers are generally unaware that the data are outside these regulatory protection frameworks. AHIP continues to be very concerned about the potential for bad actors to exploit data gained via the APIs and the potential consequences for patients and their families. This risk grows exponentially as additional data elements are required to be shared with third-party apps not governed by the health care privacy legal requirements. For example, sensitive patient data, at an individually identifiable level, shared by a payer with an app developer under these new CMS required policies can be freely sold or disclosed as long as it is noted in the consumer terms and agreement provided by the app (which can be changed at any time). A 2021 study in the BMJ found that 88% of a set of 20,991 apps could access and

potentially share personal data.[4] This study also found that 28.1% (5,903) of the analyzed apps did not offer any privacy policy text, and at least 25% (15,480) of user data transmissions violated what was stated in the privacy policies. In addition, research shows that third-party apps pose an unprecedented risk to consumers' privacy given their ability to collect user data that is highly valuable to commercial interests as well as their ability to re-identify consumers in other de-identified datasets. **Moreover, consumers are also often unaware that the more individually identifiable data released, the easier it becomes for de-identified data to be reidentified**. Below, we provide some detailed suggestions.

Privacy and Security Regulatory Framework

While we support efforts to improve individuals' access to their PHI through the existing Patient Access APIs, we believe a national privacy framework to ensure that health care data obtained by non-HIPAA regulated third-party apps and services is held to high privacy and security standards should be a critical requirement for APIs. AHIP supports expanding legal requirements to entities that collect, use, disclose, or store individuals' health and health-related information (including social needs). To coordinate with transparency and interoperability efforts, privacy requirements should be designed and applied across all entities capturing, maintaining, or disclosing health and health-related information to allow the exchange of health information without reducing privacy protections. **We urge HHS to work with Congress to enact a national privacy law to protect patients that leverages existing enforcement mechanisms, retains the HIPAA Privacy and Security Rules as the governing privacy framework for health care information held by health plans and providers, robustly protects consumer health data not currently covered by HIPAA, prevents the proliferation of conflicting state privacy laws, and does not include private right of action.** In the absence of a national privacy law, we recommend that FTC's authority and scope of oversight be expanded to offer a privacy and security structure that mirrors HIPAA to include entities that currently are not subject to privacy and security requirements. Such a process should be parallel to HIPAA but should not create additional requirements for entities already covered by the HIPAA and HITECH Act framework.

Data Elements

The risk to a person's privacy and cybersecurity grows exponentially as more data is shared. ONC continues to add new data elements to the United States Core Data for Interoperability (USCDI) continues to expand, several of which provide personally identifying information that would not provide value to consumers. For example, in USCDI version 3, the health insurance information data class includes information about a person's relationship to the subscriber and group identifier. These data elements would provide data about a person's spouse or parent and where they are employed. Consumers already know this information, but third-party apps could use it to identify someone in a different data set or even re-identify a de-identified data set. The use case for USCDI is somewhat different; it is geared toward what should be available in a standardized manner in an EHR where the data is safely protected by HIPAA. **Rather than**

[4] Tangari, G., Ikram, M., Ijaz, K., Kaafar, M. A., & Berkovsky, S. (2021). Mobile health and privacy: cross sectional study. bmj, 373.

adopting versions of the USCDI wholesale, CMS and ONC should consider the contribution of each data element and whether it is necessary to share through the Patient Access API and expose to the risk of passing to a third-party app that is not covered by HIPAA.

Member Education

All stakeholders, including payers, should play a role in patient education regarding data sharing. For example, in many cases payers have created alert systems to notify consumers when they are about to authorize making their data available to third-party apps. However, we believe HHS, leveraging public programs (e.g., Medicare, Medicaid, CHIP, etc.), in collaboration with other government entities, should take the lead in educating consumers on their rights, the risks, and benefits to accessing data via third-party apps.

As noted above, CMS and OCR should develop materials for consumers to provide information about their rights under HIPAA and the interaction with these innovative technologies and modern processes. HHS, collaborating with the Federal Trade Commission (FTC), should take the lead in making consumers aware of the risks and implications of granting data sharing access to third-party apps not regulated by HIPAA and how to lodge complaints specific to those apps. Given CMS' experience implementing the Medicare Blue Button 2.0 initiative as well as the associated consumer education campaign, it is well-situated to leverage lessons learned and apply them to this broader effort including consumer education. This will also provide consumers with a streamlined government resource they can reference throughout their healthcare journeys. CMS could also use its authority to share the information it obtains from its vetting process for Medicare data to establish ratings of third-party apps on its website. We recognize that the agency developed some resources[5] based on the rules, but we believe easy-to-understand documents with a consumer focus would help explain complex regulations in practical, common situations. These materials could be used across payers and providers for consumer education and would avoid the appearance of implied endorsement of an app. It should be made clear to consumers that HIPAA protections do not apply and that the health care or health insurance provider furnishing the data on their behalf are not responsible for the privacy or security of the data obtained by third-party apps, sold by the third-party apps, or when such data are used for secondary uses. These materials should also alert and inform patients on the limitations and risks related to allowing access to Substance Use Disorder (SUD) records and disclosures that are subject to the federal 42 CFR Part 2 rules, as well as information about other sensitive conditions (e.g., HIV status, mental health conditions), and state laws and regulations that can impact privacy and security because they have specific rules for certain types of health data (e.g., what services minors can access without parental consent).

CMS gained expertise through the launch of Blue Button and there is a strong consumer need for information about third-party apps. CMS should use the expertise the agency gained through the Blue Button launch to set up a voluntary program by which third-party apps could demonstrate--in a manner to be determined by CMS--their compliance with essential consumer protections.

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[5] https://www.cms.gov/files/document/patient-privacy-and-security-resources.pdf and https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index

CMS should then publicize the third-party apps that have done this on its website and use the website as part of its education campaign (e.g., "before you install this app, give it a check up on HHS-App-Doctor.com.")

National App Certification

We appreciate CMS encouraging app developers to follow current best practices such as the CARIN Alliance's Code of Conduct and the ONC Model Privacy Notice (MPN) as a "stop gap" measure. However, such attestations are not sufficient to protect patients as adoption is not only voluntary, but there also is no legal recourse by patients or payers should an entity violate the terms of the attestation. While this may be one option, CMS should not preclude or exclude other private sector initiatives that may be more robust.

The CARIN Code of Conduct Accreditation Program (CCCAP)[6] conducted by the Electronic Healthcare Network Accreditation Commission (ENHAC) is an emerging private-sector solution that seeks to validate that the entity is following the attestation, which is one step further. However, given impacted payers cannot currently deny requests from third-party apps that are not accredited, the accreditation is more of a marketing tool to boost consumer confidence. Moreover, if accredited entities fail to meet their obligations, the payers still have no legal recourse on behalf of themselves or consumers. The only penalty for the entity would be losing accreditation as it is not tied to any sort of regulatory framework. Plus, payers do not know which third-party apps have applied but failed such an accreditation process, so it only captures the positive aspects when we really need to know the negative ones.

Given that the Interoperability final rule did not allow payers to deny a request, CMS should work with ASTP, OCR and the FTC to establish a regulatory framework and process to vet and potentially certify third-party apps in line with the CCCAP for the privacy and security of the information contained and the adequacy of their consumer disclosures. Such a certification process could either be done directly by the FTC or the FTC could work with stakeholders to establish a private sector process that has the support of the government. A second alternative is that since CMS gained expertise through Blue Button and there is a strong consumer need for information about third-party apps, CMS could use the expertise gained to set up a voluntary program by which apps could demonstrate their compliance with essential consumer protections. CMS should then publicize the third-party apps that have done this on its website and use the website as part of its education campaign. By establishing a new system that provides for app oversight, the FTC and/or CMS could ensure third-party app developers understand the expectations of their products and ensure patients receive consistent information and understanding on which apps may be the best choice for their needs.

CMS should also work with other federal agencies to ensure that third-party apps that are known to put at risk the information systems of health insurance providers, or that are violating the terms of their consumer privacy information, are listed in a centralized reporting site, so that providers and health insurers can be aware of them and take appropriate precautions.

[6] https://www.ehnac.org/carin-code-of-conduct-accreditation-program/

PA-3. *How can CMS encourage payers to accept digital identity credentials (for example, CLEAR, ID.me, Login.gov) from patients and their partners instead of proprietary logins?*

A person's health data is extremely sensitive, and a breach can have life-altering consequences such as discrimination and blackmail. As such, the privacy and security of member data is a key priority for AHIP and its members. Payers must exercise due diligence and care relative to third parties' access to highly-privileged member data. The privacy of member data is a paramount responsibility and a major concern for health plans and the consumers they serve.

Ensuring a person's health data is not shared with the wrong person requires confirming the identity of the person asking for access to the data as well as matching records to the correct person. Patient records may be scattered across hospitals, physician offices, health plans, pharmacies, and public health agencies. Without a universal patient identification system in the United States, matching a person to the appropriate records can be challenging.

We appreciate CMS and ASTP's efforts to explore solutions to increase appropriate stakeholders' access to digital health data and to ensure a smooth implementation of the APIs required under the Interoperability rules. **To address these concerns, CMS should advance the HL7® FHIR at Scale Taskforce (FAST) initiatives to address the ongoing challenges of patient matching and identity management, digital identity, security and authentication, and access to the necessary digital endpoints.** FAST recognizes there is not one single patient identifier accepted industry-wide. Therefore, FAST identified approaches that should be adopted in cross-stakeholder API exchange. These approaches should be matured and tested prior to the APIs becoming mandatory.

Additionally, CMS and ASTP should address underlying challenges to the adoption of digital identity which will be foundational to secure and scalable interoperability. This includes gaps in governance such as inconsistent identify proofing methodologies, lack of current participation in federated identity models, and misalignment across CMS programs, TEFCA, and third-party API authentication mechanisms. We also urge CMS and ONC to explore emerging cryptographic technologies, including person-centric digital identities anchored to verified personal identifiers (e.g., identity wallets or cryptographic credentials). These models are already being piloted across industries and offer scalable, privacy preserving alternatives to legacy credentialing systems.

CMS should also balance the ease of digital identity solutions with patients' concerns about privacy and sharing personal data. For example, many of the digital identity credential solutions highlighted in the RFI require extensive personal information from users, which would likely be perceived as intrusive and consequently lead to low adoption.

<u>Identity Management</u>

The fragmented nature of health records makes identity management and standardized digital identity implementation difficult. While we recognize that digital identity credentials could

facilitate API access and use, payers must be able to trust these solutions meet the same level of rigor and offer the confidence associated with proprietary methods. Digital identity credentials must be shown to meet HIPAA requirements for how personal health data (PHI) is accessed, stored, and shared as well as state-laws. Absent foundational control over the source of truth of these external methods, a new credential's credibility, integrity, and effectiveness may produce sub-optimal results, and undue risk. For example, payers need to ensure the person they know as a member is the one associated with the credential. Moreover, a single login across multiple platforms can compound bad outcomes if compromised. Other industries, such as banking and aerospace, have likewise been reluctant to take on this risk, and have raised similar concerns relative to trust and control.

To build trust in digital identity solutions, CMS could also work with NIST to update its digital identity guidelines and develop a framework for voluntary adoption in the health care sector. We also encourage CMS and ASTP to think about the challenges of digital identity broadly when exploring solutions to facilitate API adoption. While digital credentials could be one solution, we also encourage the agencies to consider the full range of identity challenges and solutions. To reduce the challenges of accessing decentralized data, CMS should also work with ASTP to continue to expand TEFCA adoption to reduce the need multiple logins while minimizing barriers to payer access to EHRs from EHR vendors. CMS could also encourage payers to adopt digital identity solutions through consent requirements and integration with existing logins to provide seamless transition.

Facilitate Patient Matching

It is essential that patient records are matched accurately to promote patient safety, support robust privacy, and reduce costs. **We urge HHS to work with Congress to remove the outdated appropriations rider that prohibits HHS from spending any federal dollars to promulgate or adopt a national unique patient health identifier standard.** Removing this prohibition will provide HHS the ability to work with the private sector to explore potential challenges and identify a complete national strategy around patient identification and matching that protects patient privacy and is cost-effective, scalable, and secure. Patient matching rules will be particularly critical where a consumer no longer has credentials to electronically access their health information from their former health insurance provider or other entity that holds their health data. As noted above, we believe the HL7 FAST Solutions hold promise to facilitate patient matching.

We appreciate ASTP's work with standards development organizations and other stakeholders on the Project US@ ('Project USA') Technical Specification Final Version 1.0., which is a unified, cross-standards, health care specification that could be used across industry for representing patient addresses (mailing, physical, billing, etc.) to improve patient matching. We are also monitoring the new CARIN Alliance Digital Identity Initiative sponsored by HHS, which is aimed at addressing patient matching within TEFCA and beyond. However, such efforts have not fully resolved the difficulties of patient matching.

Payer-to-Payer Consent Management Process

Upstream to challenges of identity and matching is the need to obtain consent for data exchange. The Payer-to Payer API has been challenging to implement largely due to issues around patient identification, matching, authorization, authentication, and consent. Heretofore, payers often have had to rely on employers, federal programs, or state programs to authenticate if someone is who they say they are at enrollment whereas the new process seeks to also authenticate and authorize at the plan level. Consent is also needed, per the final rule, to share the data across payers, yet there is no standard process for obtaining this consent or sharing it. Also, in the absence of unique patient identifiers for health care and concerns with using social security numbers that also risk financial information, payers and providers issue proprietary identifiers that hinder patient matching and interoperability as discussed above. In addition, payers generally use an X12 transaction for coordination between payers and providers, but there is not a transaction geared toward exchanges between payers. In practice, a communication between payers occurs stating "Jane Doe has asked that I access your plan data, do you have the records for the same Jane Doe, if so, here is her consent, and can you forward the records electronically." For example, members currently may need to authenticate themselves using their username and password in both the sending and receiving systems which can add burden. Thus, further work is needed to create solutions to these challenges for successful implementation.

The CMS Interoperability and Prior Authorization rule imagines using the enrollment process to collect permission from a member to share data through the Payer to Payer API. There are a number of logistical challenges to collecting such data at enrollment. Currently, enrollment is done electronically through either the X12 834—Benefit Enrollment and Maintenance transactions, as required by HIPAA, or through the processing of paper forms or other formats such as PDFs or spreadsheets. Thus, there is currently no consistent way to modify the collection of the necessary data. The use of paper forms not only risks inaccurate or incomplete data to successfully identify the payer and the enrollee but also would be prohibitively burdensome. Moreover, there would be logistical and regulatory challenges to modifying the existing enrollment forms.

CMS should work with stakeholders to develop processes to collect the necessary new information, including member consent, prior payer information, and prior payer member ID data if available or member demographic information sufficient for matching, if not
CMS should modify Healthcare.gov and the enhanced direct enrollment process to capture this information. CMS should also work with states to implement a consistent solution across Medicaid enrollment processes to avoid inconsistencies in what data is collected and how. CMS should also provide guidance and best practices to the states to avoid the creation of over 50 formats and processes for Medicaid and CHIP agencies to share this information with payers. Finally, Medicare should also ensure this information is adequately captured when a new beneficiary enrolls or changes plans/programs. To streamline this going forward across all of these lines of business, we urge CMS to work with X12 to leverage the X12 834 in Loop 2750 to handle the opt-in and prior/concurrent payer in the version 8060 before it goes into rulemaking.

CMS should also continue to allow payers to communicate with enrollees through tools they currently leverage, such as existing payer portals. For example, a patient as the ability to request the record transfer not just at enrollment but also later. **A safe harbor for payers permitting members to enroll in P2P API data exchange when they log in to their online member account would allow payers to use proven processes and protected technologies to collect the necessary information from patients.** Existing portals, which patients are familiar with, could be leveraged to allow the patient to opt-in to the data exchange through their portal and provide standardized information about their previous and/or concurrent payers to complete the transaction. Such a patient-driven approach could streamline the opt-in process and resolve several of the technical challenges around patient matching and identifying other payers. Using existing portals could also allow payers to follow-up with patients to correct errors or to collect additional data if records cannot be located.

PA-4. *What would be the value to payers of a nationwide provider directory that included FHIR end points and used digital identity credentials?*

As noted above in our responses on TEFCA, implementing the vision or data seamlessly shared across the trusted ecosystem will require an easily accessible, universal directory that payers and providers can use to find each other's digital endpoints. The CMS-required APIs, the ONC 21st Century Cures Act final rule, digital quality measurement, and potentially the Advanced Explanation of Benefits (AEOB) rules, are all predicated on access to digital endpoints. **We urge CMS to work in partnership with the private sector to establish a national directory of plans and providers that solves not only the need for digital endpoints but also demographic data in general.** A national directory could serve as a source of truth and alleviate the current burdensome processes and inaccuracies of existing provider directories. CMS could start with collection of the digital endpoints and then broaden out to other elements once established.

<u>Establish an NDH to Resolve Current Directory Challenges</u>

Provider directories are necessary to identify physicians and non-physician practitioners along with their basic demographic information (e.g., education, address, etc.) for credentialing, payment, quality measurement, and consumer transparency purposes. Currently, the federal government maintains several databases of clinician information that often contain inaccurate or conflicting information, including National Plan and Provider Enumeration System (NPPES), the Medicare Provider Enrollment, Chain, and Ownership System (PECOS), and the *Care Compare* website.

Health plans also maintain their own directories reflecting their networks. Despite regular checks with clinicians, inaccuracies remain in these directories. Now, additional information is needed from both providers and health plans including their "digital addresses" to exchange electronic health information.

A public-private partnership between the federal government, providers, health plans and vendors is needed to streamline collection and improve the accuracy of the existing provider

information and add the newly required information for both providers and health plans. This will create efficiencies for the Medicare and Medicaid programs, improve the accuracy of information on which consumers rely, reduce provider burden, and decrease compliance costs for plans in federal programs.

CMS previously issued a request for information soliciting public comments on establishing 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. This information is critical to inform shopping for health care coverage and maximizing the value of health coverage. Every patient and consumer should easily find a clinician or facility skilled in the type of care they seek, is convenient to consult, and is comfortable to work with. To achieve this goal, health care and health insurance providers, including the federal government, must work together to ensure that directories include the most accurate and up-to-date information available about in-network providers.

Maintaining accurate directories is a shared responsibility between clinicians, facilities, and payers. Despite the best efforts of plans, including direct outreach to providers, advanced analytics and artificial intelligence methods, and electronic solutions, the directories remain far from 100 percent accurate. **We believe a public-private partnership between the federal government, providers, payers and solutions vendors is needed to streamline collection of this information and improve its accuracy.** A cohesive, national approach to building a technology-enabled infrastructure will help ensure accuracy, reduce burden, and improve efficiency.

Health insurance providers work continuously to improve provider directories and are subject to several federal requirements across various insurance lines of business (e.g., Medicare, Medicaid and the commercial health insurance markets) to keep provider directories up to date. In addition, today at least thirty-nine states also impose state-specific provider directory requirements.

Health insurance providers have found two formidable barriers to ensuring accurate provider directory information (1) health care providers often do not consistently provide updates and they may provide inaccurate information, and (2) there is no single source-of-truth for provider information that can be leveraged to verify provider information.

AHIP agrees that CMS could play an important role in improving the accuracy of provider directories and reduce the burden of collecting and maintaining the information needed to support them. CMS could reduce burden and improve accuracy through standardization, technology, provider education, and support. **CMS should explore the establishment of a national directory; however, we urge CMS to consider the needs of the private sector in such a database and ways to leverage existing initiatives and enhance standardization.** Stakeholders across the healthcare industry both contribute to and require the information the NDH could contain. The federal government should consider the potential burden for providers associated with populating and maintaining the NDH if the private payer system remains as is because their needs are not met by the solution. Minimizing the burden of gathering and

maintaining the necessary data to support an NDH will require a solution that addresses the needs of all stakeholders.

To ensure it meets the needs of the private sector, CMS should develop the NDH using a federated model supported by a public-private partnership rather than centralized control by CMS. An NDH that uses a federated model could serve as a national data repository with access by providers, payers, states, and approved vendors. To maximize the efficiency and burden reduction, some entities like states and vendors could be given the ability to add information to the NDH. Moreover, such a model would allow connections with other data management systems such as EHRs as well as scheduling and practice management systems that providers may already be using. These systems contain important information that could support provider directories without requiring providers to enter information in multiple locations. Without the ability to engage all stakeholders, a federal, centralized solution that does not incorporate the needs of the private sector will reinforce fragmentation, not alleviate burden.

CMS should work with stakeholders including private plans, providers, and vendors to develop and implement a meaningful framework for the NDH. AHIP supports the creation of an NDH and believes the framework will work most effectively through a public-private partnership that meets the needs of both public and private payers to maximize value to all stakeholders. To accomplish this, **CMS should establish a Technical Expert Panel (TEP) to develop technological approaches and identify necessary policy changes to support this work.** To promote a diverse set of input, this TEP should include a representative sample of health insurance providers as well as other relevant stakeholders such as providers, states, vendors, and consumer groups.

Stakeholders across the industry are working to address the current challenges of provider directories. Health insurance providers have invested in the use of advanced analytics and vendors continue to develop innovative products that can enhance current provider directories. CMS should explore ways to leverage existing efforts and support additional efforts to standardize data elements so the NDH can build on what is currently working. To explore how advanced in technology and interoperability could mediate the current challenges to directories, CMS should invest additional funds to increase the efficiency and adoption of scalable technological solutions for provider directories, such as the Health Level 7 (HL7) FHIR at Scale Taskforce (FAST) accelerator and consideration of the FAST National Healthcare Directory Implementation Guide.

<u>Prioritize a Digital Endpoints Use Case to Facilitate Adoption of the CMS Required APIs</u>

The NDH could rapidly facilitate efficient implementation of the CMS Interoperability rules. As of now, directories are not comprehensive and must be cobbled together to cover even a portion of the necessary sites.

An endpoint describes the technical details of a location that can be connected to for the delivery/retrieval of information. Sufficient information is required to ensure that a connection can be made securely, and appropriate data transmitted as defined by the endpoint owner.2

Improved interoperability across the system offers the opportunity for all parties involved in a patient's care to have better information to coordinate services. Easier access to digital endpoints would allow more timely data exchange across the system. A directory of payer and provider FHIR endpoints, for example, is critical to being able to "find" the organizations required for sharing data.

As interoperability progresses and an NDH evolves in future iterations, additional organizations could share contact information to facilitate better relationships with community-based organizations and other services that are crucial to addressing social drivers of health but may be outside of the traditional scope of the healthcare system. Better digital contact information could also facilitate the use of technology to streamline healthcare payment and administrative functions. For example, easier access to digital endpoints could support the transition to electronic prior-authorization.

Building a system to allow easy access to digital endpoints will be essential to the success of TEFCA. For stakeholders to successfully share data through the QHINs it will be necessary to have access to digital endpoints to complete the transaction. The NDH could be an opportunity to allow a more efficient means of exchange of digital endpoint information and could be leveraged to support the implementation of TEFCA.

We note that CMS should work with providers and other stakeholders to educate and improve understanding of digital endpoints and how they work. It is common for individual clinicians to think this is their e-mail or web address.

PA-5. *What are ways payers can help with simplifying clinical quality data responsibilities of providers?*

Quality measurement plays a critical role in ensuring health care services are safe, effective, affordable, and efficient. Both public payers and health plans depend on quality measures to ensure they are purchasing high-value services and working with high-quality providers. However, calculating quality measures can involve a cumbersome process to extract and submit data. Payers are exploring numerous strategies to reduce the burden of measurement on providers while continually working to improve the quality-of-care members receive.

a. How interested are payers and providers in EHR technology advances that enable bulk extraction of clinical quality data from EHRs to payers to allow them to do the calculations instead of the provider-side technology?

As detailed below, we believe aligned quality measures and digital quality measures (dQMs) have the potential to reduce measurement burden and allow the assessment of aspects of care that cannot currently be measured. The CQMC noted that FHIR data standards will play a key role in advancing interoperable data for measurement, given the ONC interoperability requirements and CMS' Digital Quality Measurement Strategic Roadmap.[7] The Workgroup recommended measure-driven prioritization of data elements as a high value, high-priority activity.

[7] CQMC Digital Measurement Final Report

Ideally, the EHR will contain all the necessary data elements in standardized fields specified in FHIR which would all be contained in the USCDI. This would reduce the effort needed to collect quality data while allowing closer to real-time measurement to support quality improvement work. This could allow payers to share analytics and performance more frequently and effectively to provide better quality signals to providers. However, this vision will require a robust technology infrastructure, including the necessary data elements readily available in the EHR without extra fees, a national network to support data exchange, and a directory of digital endpoints. We appreciate the steps ASTP and CMS has taken to implement this vision and look forward to working with the agency to continue to advance digital quality measurement.

Adopting bulk FHIR exchanges will require building trust between payers and providers and will need to meet a payers' business needs. However, if implemented properly, bulk FHIR has the potential to facilitate the exchange of clinical quality data. However, as outlined below, bulk FHIR should be implemented alongside efforts to increase payers' access to EHR data such as including new requirements in the HIT Certification Program to facilitate quality measurement, standardizing necessary data elements and adding them to USCDI, and increasing access through TEFCA or bidirectional APIs. Increased access to clinical data in the EHR would allow payers to assist in care coordination in a more timely manner and reduce the burden of important patient safety activities such as prior authorization and quality measurement.

ASTP could play an important role in facilitating the adoption of bulk FHIR through the Health IT Certification by creating standards-based libraries of clinical concepts, that everyone can access without having to pay exorbitant licensing fees. This collaboration should also include CMS to promote standardization with Medicare fee for service to ensure all payers are aligning with updated clinical standards. The current lack of standardization causes fragmentation between providers and payers. By codifying medical policies and making them interoperable, CMS and ASTP could create an industry standard library for payers and providers. For example, ASTP could work with stakeholders to ensure that USCDI contains the necessary data elements to calculate quality measures across both public and private payers, allowing it to serve as a library for measure developers when creating dQMs.

However, CMS and ASTP should also work with payers to mitigate the risks of bulk FHIR transactions. For example, the Interoperability rules require payers to both store and send large amounts of data. Requesting bulk FHIR transactions could increase a payer's storage needs and costs. Moreover, larger datasets increase the risk of exposure in the case of a break. CMS and ASTP should work with payers to find solutions to the large and costly amounts of data that payers must store under the Interoperability rules, such as allowing payers to use TEFCA, rather than maintaining the Payer-to-Payer data on their own servers.

b. In what ways can the interoperability and quality reporting responsibilities of providers to both CMS and other payers be consolidated so investments can be dually purposed? Are there technologies payers might leverage that would support access to real time quality data for healthcare providers to inform clinical care in addition to simplifying reporting processes?

In some respects, we believe the question in a) above is a false choice. It may be that organizations other than either the payer or the provider are conducting the calculations. For example, it could be a registry, state, regional collaborative, or a combination thereof depending on the measure. The key is to ensure the EHR is structured to capture FHIR resources, the measures are constructed based on these elements, there are APIs that can be accessed by these organizations on behalf of the provider and payer, and that data can be returned to the EHR to inform care. We should remain somewhat agnostic to who the actor is and focus on what the process is to accomplish the goal.

The CQMC has recognized that misalignment challenges go beyond the measures themselves to differences in the data aggregation and measure reporting infrastructures for value-based models. The CQMC's measure model alignment efforts aim to reduce redundancy and improve the clarity and usability of quality measures used across different healthcare settings and payers.[8] This includes aligning the quality measures themselves, as well as the technical aspects of data collection, reporting, and interpretation.

Align Quality Measures Across Payers

As value-based purchasing efforts have scaled in both the private and public sectors, so has the number of performance measures providers are required to report. The increased reliance on performance measures as part of these models has led to a proliferation of measures and a corresponding increase in burden on providers collecting the data, confusion among consumers and purchasers seeing conflicting measure results, and operational difficulties among payers. To address these concerns, AHIP launched the Core Quality Measures Collaborative (CQMC), a public-private partnership between AHIP and the Centers for Medicare & Medicaid Services (CMS). The membership is comprised of over 70 member organizations health insurance providers, primary care and specialty societies, consumer and employer groups, and other quality collaboratives. CQMC is a membership driven and funded effort with additional funding provided by CMS and AHIP. The CQMC works to identify Core Measure Sets– parsimonious sets of scientifically sound measures that efficiently promote a patient-centered assessment of quality and should be prioritized for adoption in value-based purchasing and alterative payment models across payers. **We recommend CMS continue to work with CQMC on aligning quality measurement, which would reduce the complexity of reporting requirements for providers.**

Promote Bidirectional Access to Clinical Data

Currently, data collection, transmission, and aggregation are fragmented and multiple barriers limit alignment. The current lack of common data element standards interferes with the aggregation of data from different environments for quality measurement purposes. In addition, it adds to provider and payer burden to capture the data needed for measurement and to calculate and report on measures.

[8] Core Quality Measures Collaborative: Aligning Approaches to Measure Models

As noted above, TEFCA has great potential to reduce the burden to collect and share quality data. **However, ASTP should work with its RCE to ensure stakeholders can access data for quality measurement without undue fees.** As noted above, this significantly reduces health plans' ability to participate in TEFCA and share clinical quality data.

CMS should also explore ways to use the APIs created by its Interoperability rules to support the exchange of digital quality measures, including FHIR-based electronic clinical quality measures (eCQMs) such as allowing plans to use an API to access EHR data needed for HEDIS measures. CMS should make the Provider Access API bidirectional to support the exchange of information between impacted payers and providers. This bidirectional API could facilitate the access and sharing of claims data from payers to providers to support population health and quality measurement as well as support access and the exchange of clinical information from providers to payers for quality measurement.

Ensure a Reasonable Timeline to Transition to Digital Quality Measures

Technologies such as digital measures have potential to reduce burden; however, implementing them before the necessary infrastructure is readily available risks complicating clinical quality data collection and unfairly penalizing plans and providers.

We continue to hear concerns about the rapid pace the National Committee for Quality Assurance (NCQA) is pursuing for transition to electronic clinical data systems (ECDS) measures. Plans are experiencing significant implementation challenges outside of their control. Moreover, the rapid transition has increased the measurement burden on providers, especially those practicing in rural areas or in smaller groups that may lag in EHR adoption and have limited infrastructure to support the move to ECDS. The current lack of interoperable data standards required to support electronic data exchange for quality measurement and the limited data sharing infrastructure between provider and plan systems create additional barriers. While AHIP is hopeful that TEFCA could alleviate some of these challenges, the ability to charge fees for data under the agreement and the additional administrative complexity that it creates, limits the ability of TEFCA to advance digital quality measurement. Given these challenges, moving to exclusive ECDS reporting would risk missing key data, especially from smaller providers and rural practices, and would increase the administrative burden on both plans and providers.

We support CMS's efforts to address these issues and encourage the agency to advance work to make the necessary data to calculate quality measures more easily available and available in standardized formats. For example, CMS could work with ASTP to add data elements from United States Core Data for Interoperability (USCDI) + Quality into the baseline USCDI so they are available in EHR and through tools like the APIs that impacted payers are required to build on the CMS Interoperability and Prior Authorization final rule. CMS should also look to the work of the Core Quality Measures Collaborative's (CQMC) work to identify measures to prioritize for conversion to FHIR and which necessary data elements to calculate core measures are available in FHIR resources.

F. Value-Based Care (VBC) Organizations

Digital Health Adoption

VB-1. *What incentives could encourage APMs such as accountable care organizations (ACOs) or participants in Medicare Shared Savings Program (MSSP) to leverage digital health management and care navigation products more often and more effectively with their patients? What are the current obstacles preventing broader digital product adoption for patients in ACOs?*

The burden of keeping pace with evolving technology can be a barrier for smaller practices, safety net providers, and health plans that may not have the necessary financial resources readily available to invest in new systems or regular updates. To encourage ACOs and other VBC participants to leverage digital health tools to drive care improvements, **HHS should continue to offer prepaid shared savings to ACOs[9] and explore additional opportunities to leverage upfront investments like prospective payments** to support building data infrastructure, staffing, and technology.

VB-2. *How can key themes and technologies such as AI, population health analytics, risk stratification, care coordination, usability, quality measurement, and patient engagement be better integrated into APM requirements?*

Responsible use of AI can increase access to quality care, improve health outcomes, improve the consumer experience, and reduce administrative costs. **VBC models offer a unique environment for scaling AI tools that promote quality but may necessitate reimbursement to offset costs incurred by providers.** Certain VBC models provide payment to providers that is not constrained by fee-for-service billing codes to cover reimbursement for each service or expense. Further, utilization and cost impact concerns that may arise from reimbursement for AI tools are mitigated by the total cost of care (TCOC) construct of VBC arrangements that embed accountability into provider payments. Lastly, the CMS Innovation Center has broad authority to implement regulatory waivers, including site-of-service limitations, for VBC models it tests, which can provide for well-monitored, flexibility to enable care aided by AI technology that endeavors to drive down costs while increasing quality.

Effective participation in VBC arrangements requires certain technical capabilities to adequately manage and monitor performance, however both health plans and providers have varying levels of experience and internal capabilities to invest in and operationalize technologies. Thus, flexibility in program design is necessary depending on where participants are in their journeys. Moreover, digital health needs may vary based individuals' local and unique needs, whether tools are patient-facing or geared toward provider use. Rather than integrate new, one-size-fits-

[9] *See, e.g.,* Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments

all requirements into APM design, **AHIP recommends HHS focus its efforts on federal policies that support greater alignment in data standards and targeted investments in infrastructure, technical assistance, and interoperable tools.** A focus on alignment of data content and exchange standards can make it easier for technologists to build solutions that automate manually intensive processes and streamline solutions necessary to promote effective data sharing and usability with the ultimate goal of improving care delivery and health outcomes. Aligning data standards also supports more seamless care coordination and more individualized interventions. Additionally, **instead of imposing more requirements on participants of models that are premised on flexibility, we encourage HHS to integrate incentives for APM participants to utilize technology to meet shared goals.**

Quality measurement is essential to the transition to VBC to ensure that quality and costs are both improved by APM models. The ACO/Core Quality Measure Set is one of several core measure sets developed by the CQMC, specifically tailored for Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), and Primary Care providers. The intent is to focus on the most meaningful and broadly applicable performance measures that can drive improvement and align incentives. **Adoption of the measures in the CQMC ACO/PCMH/Primary Care Core Set could provide consistent quality signals while reducing the resources required to collect data and calculate measures**.

CMS already integrates risk, quality, and patient engagement into many of its VBC programs[10], however it could **encourage care coordination by implementing incentives for ACOs and other VBC participants**. Many health plans have explored ways to enhance care coordination for their enrollees; we encourage HHS to look to success in the private market for ways to incent these activities within the Medicare programs.

VB-3. *What are essential health IT capabilities for value-based care arrangements? What other health IT capabilities have proven valuable to succeeding in value-based care arrangements?*

Data sharing is fundamental to the success of VBC operations. The collection and bidirectional sharing of data between and among health plans, VBC entities, and participating practices can help to inform patient care decisions, quality performance, operations, and financial accountability. AHIP, the American Medical Association (AMA), and the National Association of Accountable Care Organizations (NAACOS) launched a partnership to advance the adoption of VBC through development and publication of voluntary best practices informed by the real world experiences of participants. The first phase of this work focused on data exchange, the findings of which are published in a playbook of voluntary best practices to encourage more robust data sharing, *The Future of Sustainable Value-Based Care and Payment: Voluntary Best Practices to Advance Data Sharing.*[11] **HHS should leverage this playbook as a foundational**

[10] *See, e.g.*, 42 CFR 425.300, *et seq*.
[11] The playbook reflects input from diverse stakeholders—including national and regional health plans, large and small provider organizations, and physicians—and offers actionable recommendations to reduce administrative burden, improve alignment, and promote equitable, high-quality care delivery.

framework to support and incentivize digital health adoption within VBC programs, including ACO participants:

- **Create an Interoperable Data Ecosystem**: Adopt consistent content and exchange standards to simplify and expand data sharing.
- **Share More Complete, Comprehensive Data**: Empower VBC participants with complete, accurate, and consistent data that paints a more comprehensive picture of a patient population.
- **Improve Data Collection and Use to Advance Health Outcomes for All**: Collect and share data to identify and address health disparities as well as barriers to care beyond the clinical setting, while ensuring transparency, appropriate use, and confidentiality.
- **Share Timely, Relevant, and Actionable Data**: Prioritize sharing focused insights and data early, often, and in accessible ways, to improve care.
- **Make Data Methodologies, Calculations, and Context Readily and Easily Available**: Share detailed information on how and what data were derived from to foster trust among VBC participants in the data they receive, use, and by which performance is measured.

Consistent with these recommendations, **we encourage HHS to endeavor to share more comprehensive reports based on claims data** to provide VBC participants with greater insights into patient clinical information, including information on other providers and facilities visited by their patients to support care coordination efforts and inform efforts to control costs and improve quality.

The Provider Access API created by the CMS Interoperability and Prior Authorization final rule could play an important role in enhancing data sharing once the issues outlined earlier in our letter such as a digital endpoint directory and national network are resolved. Providers will have access to population health files that will allow them to calculate quality measures on an interim basis and identify gaps in care. **CMS could increase the value of this API but making it bidirectional so health plans can support these efforts and reduce the effort required by providers to submit data for quality measures.**

Despite a strong commitment to improving data sharing across the health care system, there are challenges outside of health insurance providers' and clinicians' control that frustrate or slow the free flow of information. For example, **EHR vendors should be encouraged to capture data based on industry standards and prioritize sharing information in discrete data fields so that providers can use information and share it with payers**. If EMRs are communicative and interoperable, payers can join in the flow of data. This sharing of information should be placed in the context of HIPAA and the HITECH Act, which establish rules about using identifiable and de-identified data.

VB-4. *What are the essential data types needed for successful participation in value-based care arrangements?*

Data is needed across several types of organizations in the ecosystem such as providers, payers, states, public health agencies, community-based organizations and the like. Essential data types include:

- **Claims data** to support financial calculations, attribution, quality measurement, and monitoring utilization trends
- **Clinical care documentation in EHRs** to manage chronic conditions and coordinate care, enable care gap identification and population health analytics, and support interventions
- **Admit, Discharge, and/or Transfer (ADT) feeds** to assist with proactive care coordination, reduce avoidable readmissions, and improve care continuity
- **e-Prescribing data** to improve medication reconciliation
- **Pharmacy coverage benefit inquiry/response** to encourage cost effective prescriptions and medication adherence
- **Patient reported data** to support improved patient satisfaction and patient empowerment
- **Patient access API** to support data portability and improve transparency
- **Quality measure reporting** to tie financial incentives to quality performance and enable continuous improvement in quality outcomes

Data should be shared in a timely, comprehensive, and standardized format to be actionable for VBC participants.

VB-6. *What specific health information technology capabilities that could benefit APMs are not currently addressed by existing certification criteria and standards that should be included under the ONC Health IT Certification Program?*

CMS and ASTP should explore ways to use the Health IT Certification Program to facilitate reporting of FHIR-based eCQMs. Ensuring EHRs can capture the necessary data, support calculation of measures, and facilitate reporting will help move quality measurement into the clinical workflow and reduce provider effort. To maximize the burden reduction on providers, ASTP should work with stakeholders, including health plans, to ensure the quality measurement related requirements in the Certification Program also allow providers to calculate and report measures for health plans. Health plans use measures to ensure their members receive high quality care and use the results of measures to drive improvements when necessary. However, misaligned measures and technology tools that do not support the measurement needs of all payers will lead to continued fragmentation and continued burden.

Any new requirements in the Health IT Certification program should also consider how health plans use quality measures. The Health IT Certification program could be used to address issues such as limited data interoperability across different systems to help reduce the level of effort needed to access and collect data. Building requirements and standards that allow plans to use FHIR-based eCQMs could facilitate alignment across payers, reducing provider burden.

ASTP and CMS could also explore ways to use data from the Internet of Things to improve patient care. Exploring ways to bring this data into the EHR could allow providers to monitor patients in real time and intervene to address health issues and promote wellness. Health plans could also use this data to support members and as a new data source for quality improvement efforts.

VB-7. How can technology requirements for APMs, established through CEHRT or other pathways, reduce complexity while preserving necessary flexibility?

Technology can be both a enabler and a barrier to VBC and APM adoption. As noted above, improved ability to calculate and report digital quality measures through EHRs could make it easier for providers to adopt VBC. However, overly stringent requirements to adopt specific technologies could discourage providers who are not well-resourced from participating in VBC arrangements. For example, small practices, rural providers, and community health centers may not have the financial resources to purchase health information technology.

For example, requiring CHERT and the Promoting Interoperability requirements can be a hindrance for providers to participate in the Medicare Shared Savings Program. **CMS should continue to allow flexibilities for certain providers, small practices, rural practices to facilitate participation.** CMS should also consider implementing waivers for small practices, it is more difficult to engage with these providers at times given their limitations. Additionally, CMS could explore opportunities for small practices and rural providers to implement CEHRT affordably.

Similarly, requiring ACOs to report on all-patient, all-payer eCQMs dramatically increases the burden participate in MSSP and report the necessary quality measures given the current lack of infrastructure and commensurate requirements on vendors through the Certification Program. **As detailed elsewhere, ASTP should add requirements to the Certification Program to facilitate digital quality measurement.** ASTP and CMS should work use pathways such as the CMS APIs and TEFCA to facilitate data access, patient matching, and directory services.

VB-11. *What specific interoperability challenges have you encountered in implementing value-based care programs?*

Facilitating data sharing between payers and providers could reduce the effort required to participate in VBC programs. As noted above, payers have limited access to EHR data, creating a need for manual or duplicative processes to extract and send clinical quality data. This data is necessary to calculate the performance measures that underpin VBC programs.

CMS and ASTP should explore ways to promote avenues for better data sharing between payers and providers. As noted above, we appreciate ASTP and its Recognized Coordinating Entity (RCE) creating TEFCA SOPS for HEDIS Reporting and Quality Measure Reporting (HCO-QM) exchange purposes. Allowing health plans and health care providers to use TEFCA to support performance measurement will improve health care quality and safety for patients. This will also

increase the value of participation in TEFCA for health plans and reduce burden on health care providers.

CMS should also explore ways to use the APIs created by its Interoperability rules to support the exchange of FHIR-based eCQMs. CMS should make the Provider Access API bidirectional to support the exchange of information between impacted payers and providers. This bidirectional API could facilitate the access and sharing of claims data from payers to providers to support population health and quality measurement as well as support access and the exchange of clinical information from providers to payers for quality measurement.

VB-13. *What improvements to existing criteria and standards would better support value-based care capabilities while reducing provider burden?*

As noted above, health plans depend on quality measures to build their value-based care programs. Increasing performance measure alignment will serve to accelerate the adoption of VBC and APMs. Clinicians and providers are more willing to participate in VBC and are able to focus their resources on areas requiring true improvement rather than on calculating slightly different measures for each payer they work with and deciphering varying measure results on the same clinical topic. Secondly, aligned measures also results in aligned improvement goals and focuses efforts on outcomes that are most important. Aligning program requirements and goals across payers reduces provider burden, can bolster provider buy-in, and help sustain participation in models, thereby driving long lasting transformation. As noted above, AHIP works with CMS to convene the CQMC to develop sets of quality measures that should be prioritized for adoption in VBC programs.

Improved interoperability could also facilitate the adoption of VBC programs by reducing the effort required to capture and share the necessary data elements to calculate quality measures. As noted above, CMS work with ASTP to add data elements from USCDI + Quality into the baseline USCDI so they are available in EHR and through tools like the CMS required APIs. **CMS should also look to the work of the CQMC work to identify measures to prioritize for conversion to FHIR and which necessary data elements to calculate core measures are available in FHIR resources.**

CMS and ASTP should also explore ways to promote data sharing to reduce the burden of measurement and VBC participation. While the Provider Access API is an important step, making this API bidirectional would make it easier for plans to collect data required for performance measurement. CMS and ASTP should also remove barriers to participation in TEFCA such as unnecessary fees to promote better data sharing.

VB-15. *How could a nationwide provider directory of FHIR endpoints help improve access to patient data and understanding of claims data sources? What key data elements would be necessary in a nationwide FHIR endpoints directory to maximize its effectiveness?*

As noted above, we strongly support the creation of an NDH. An NDH will allow payers and providers to more easily locate each other’s digital endpoints to facilitate data sharing.

ASTP and CMS could also explore ways to facilitate use of an NDH and encourage its adoption. For example, adding a trusted framework on top of the directory could make users more comfortable with the directory, facilitating its adoption and improving its usability.

Better data sharing could reduce the efforts providers must make to calculate quality measures and participate in VBC arrangements. Improved access to data could also help providers calculate quality measures on their own and understand and improve their performance closer to real-time increasing the likelihood of earning rewards or avoiding penalties in VBC arrangements.

Data Elements Needed

Success of an NDH will require the ability to allow flexibility. Stakeholders may need different pieces of information to meet local requirements or to support individual business needs. As such the NDH should include functionality to allow extensibility of the data elements required. That is, organizations should be able to establish a relationship and have the ability to ask for additional data elements beyond a core set of data elements all entities would be required to report. Without the ability to allow extensions to meet individual needs, stakeholders will still need to find ways to share these extra pieces of information, thereby limiting the value proposition of a single place for providers to maintain the data. Designing the NDH to support a core set of data elements with the ability to customize would avoid organizations asking for additional information outside of the NDH and maintain a streamlined system.

CMS should also consider how frequently each piece of information is likely to change and how often updates may be needed. Some pieces of information are unlikely to change very often. While provider location and contact information may change more frequently, certain facilities, such as hospitals and ambulatory surgery centers, are unlikely to relocate multiple times over the course of a year. For these types of data elements that will not change often or at all, CMS should work with stakeholders to define such facilities and use enforcement discretion to allow flexibility to provide updates to the NDH on an annual basis unless necessary due to a change (e.g., a change in name or ownership of the facility). In addition, CMS should exempt telehealth, virtual providers, or other home health and mobile providers who do not provide services in a bricks and mortar location from such requirements as they do not provide services at a physical location. However, providers with a bricks and mortar location who also offer telehealth services should share information about the availability of such services in the NDH. CMS should work with stakeholders to identify which pieces of information are more dynamic and likely to change frequently and develop strategies to promote more consistent updates to the NDH.

We also caveat that CMS should work with stakeholders to develop the core set of data elements supported by the NDH. Below we share the health insurance provider perspective and feedback on potential data elements. As noted above, CMS should create a public-private partnership to oversee the NDH. Such a partnership could support work to develop the core set of data elements as well as potential extension elements that may be required.

Contact Information

First CMS should include data elements that capture a provider's location, including all addresses at which a provider practices as well as whether the provider offers telehealth services, including which modalities are available. Currently, payers are required to collect information on address, city, state, and ZIP code. However, location is a frequently changing field and current data collection efforts do not capture the associated nuances with location information. **To improve the usefulness and accuracy of information, addresses must be tied to purpose in the NDH.** For example, beyond collecting just an address, the NDH should collect follow-up information to help users understand how best to use that information. For example, addresses should be tied to questions such as:

- Do you receive mail at this address?
- Do you see patients or take appointments in this location?
- Does this location offer accommodations for people with disabilities?

More granular location information tied to purpose would allow payers to create more accurate provider directories with the information pulled from the NDH.

Today most provider demographic databases have one entry per provider, which means that usually one address is included. We know that many providers work out of multiple clinic sites and may have a business address that is different from any of these care sites. Along with the ability to have multiple addresses and address types associated with a provider, we would discourage CMS from using a postal address as the location index in the NDH. How addresses are entered creates a plethora of opportunities for errors that will require active management and data cleaning—and would likely be prohibitive given the potential size of this resource. Suitable identifiers should be included in the NDH to ensure it is clear whether or not two records are for the same location, taking into consideration that there are often many ways to indicate the same street address through abbreviations, vanity spellings, etc. Standard identifiers could also help clearly indicate which provider-to-organization affiliations are valid at which locations. Ideally, the location should be a unique code of some sort that corresponds to the postal address but is not the address itself. There will also need to be a location designation for telehealth services.

Beyond information on location, the NDH should collect other contact information including telephone number, including which number should be used to schedule appointments, website URL (if applicable), and fax number. CMS could also ask providers to verify if they would like payers to publish their information in the payers' directories and provide a time stamp that indicates when information was last updated. CMS should also consider publishing a schedule of update and verification frequency so stakeholders have consistent expectations for when updates may occur.

Digital Endpoints

Information on digital endpoints is becoming increasingly essential as we move towards an interoperable health care system. A key challenge to implementation of the current

interoperability and data sharing requirements is the lack of a way to easily look up another organization's digital endpoints. The NDH could play a key role in promoting interoperability and information sharing by ensuring digital endpoints are easily accessible. Additionally, all stakeholders would need these provider endpoints to be verified and validated as to their association to the represented provider on an ongoing basis. Addressing the verification and validation process through the NDH could streamline this process and make it more efficient.

Information on Individual Providers

The NDH could also be leveraged to collect information on provider demographics and the services offered. Again, the NDH should collect all information payers currently need to meet federal regulations on provider directories. For example, the NDH could collect information on a provider's specialty and what services they offer (e.g., if telehealth is offered or if an obstetrician is currently only offering gynecological services). The NDH should also collect information to support consumer's choice in a provider such as information on cultural and linguistic capabilities and office/location accessibility under the Americans with Disabilities Act (ADA). The NDH could also collect basic demographic information such as gender from providers as required by current directory regulations. CMS could explore building enhanced demographic data fields to support the collection of information on additional data elements such as race and ethnicity. However, these data elements that could be considered sensitive to the provider or not required for compliance with federal provider directory regulations should allow for a choice not to respond at this time given the risk of discouraging use of the NDH.

A future phase of the NDH could also collect information required for accreditation and credentialing purposes. **We recommend CMS build the NDH so that data entry could expand but focus on core data elements in phase one. Information collected from facilities in the initial phase could focus on the facilitate type, accessibility, and services offered.**

Relationships

Understanding clinician relationships is a significant challenge in producing accurate provider directories. A clinician may practice independently as well as part of a group. Moreover, clinicians may have privileges at one or more hospitals. **The NDH should collect information to allow payers to easily discern clinician relationships to provide better information to consumers. Collecting information on group name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN) will allow payers to determine relationships between clinicians and groups.** CMS could also explore collection information on where a clinician has hospital privileges.

There are instances where a provider in a location is affiliated with multiple provider organizations. Their participation in a plan's network and their willingness to take on new patients will vary by what organization with which they are affiliating their care—even though it is the same provider at the same address. For this reason, we also believe the NDH must capture all organizational affiliations of a provider, such as, all the tax IDs under which the provider can

bill, but CMS should gather additional stakeholder feedback to ensure this captures the necessary detail for all NDH users.

CMS should also develop ways for healthcare providers to share data that enables other stakeholders to understand the relationships among individual providers who may practice different specialties but are part of a group. For example, an anesthesiologist that does not see patients directly or a radiologist that would never see the patient but would read the reports and images.

CMS should also explore ways the NDH could provide information on when a clinician leaves a group or practice. Currently it can be challenging for payers to determine if a clinician has left a group to join a new practice or if a clinician is no longer practicing due to retirement, death or a career change. Better information on terminations and the reason why could help payers offer better information to consumers. Information on whether a provider participates in Medicare (has Medicare ID) and/or Medicaid (has a Medicaid ID) would also be useful. In addition, it would be useful to collect information on any state provider identification numbers.

Modalities Available

The COVID-19 pandemic accelerated the use of telehealth and has brought telehealth access to the forefront. More clinicians are offering telehealth services, and some providers have moved their practices entirely online. Consumers have also become more accepting of telehealth, and some may prefer to receive services via telehealth in certain circumstances. For example, many consumers prefer the flexibility and privacy of receiving behavioral health services via telehealth. As such, payers need better information from providers about whether they offer telehealth services and if they are accepting new patients via telehealth. **We recommend that the NDH consider a data element for providers to share information on the modalities of service available.** We note this would also be valuable as a way to promote better access and health outcomes for all.

Accepting New Patients

Another frequently changing and challenging to collect data element is whether a provider is accepting new patients. We recognize this information is essential to consumers, however, whether a provider is accepting new patients can change quickly and depends on several factors. For example, a clinician may have limited ability to take on complex cases, is only accepting new patients via telehealth or is on short term disability or parental leave. Even within a health plan, a provider may be accepting new patients under one product (e.g., employer PPO coverage), while not accepting new patients under another (e.g., an ACA HMO plan). For each provider, this may result in hundreds of combinations that may change frequently.

There is value in the NDH collecting information from providers on whether they are collecting new patients but in the initial phase of the work should only focus on broad information on provider availability. While we recognize this information would be very general, it could be useful for payers to understand which healthcare providers are not accepting

new patients at all (e.g., the provider may be preparing to retire, or the practice is full). The NDH should include whether the provider is accepting new patients, but for any initial version should be a binary (yes/no) or trinary (accepting patients for all products, not accepting patients for any products, accepting patients depending on the product) as selected by the provider. Payers or third-party application developers could build upon that information and build tools that direct consumers a digital endpoint where they could determine if that provider is accepting their specific insurance.

Information Not to Collect through the NDH

CMS should not mandate the collection information on payers' networks or insurance acceptance through the NDH. While we see the potential value in allowing organizations to note relationships through the NDH (e.g., to request updated information or to receive notification when information is updated), this information should not be used as a proxy for information on networks from payers. We define networks as what insurance networks a particular provider participates in. Instead, CMS should build the NDH so that payers can pull information and supplement it with their information on network status to ensure accurate and consistent information is provided to members of a health plan. However, CMS could build the NDH with extensionality in mind so that payers could collect additional information from providers using the same user interface that is unique to the plan and would assist with connecting the information to network specific information at the same time. These data added via extensions would only be stored with the payer requesting it, not with the NDH.

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Attachment 2
AHIP Comments in Response to CMS's December 2022 NDH RFI

December 6, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted electronically**:** http://www.regulations.gov

RE: Request for Information; National Directory of Healthcare Providers & Services — AHIP Comments

Dear Administrator Brooks-LaSure:

Every American should be able to easily find a clinician or facility skilled in the type of care they seek, that is convenient to access, and with whom they are comfortable. That is why AHIP[1] and its health insurance provider members are committed to making accurate provider directory information available to all Americans. Health care and health insurance providers, including the federal government, must work together to ensure that directories include the most accurate and up-to-date information available. This information is essential to help people shop for health care coverage and make their care more affordable. Guided by this commitment, we offer our vision for a National Directory of Healthcare Providers & Services (NDH).

AHIP appreciates that CMS has created this forum for dialogue on this priority. Maintaining accurate directories is a shared responsibility between clinicians, facilities, and health insurance providers. Despite the best efforts of health insurance providers, including direct outreach to providers, electronic solutions, advanced analytics and artificial intelligence methods, and ongoing validation and audits, the directories remain imperfect.

Health insurance providers work continuously to improve provider directories and are subject to several different and varying federal requirements across various types of coverage (e.g., Medicare, Medicaid and the commercial health insurance markets). In addition, at least 39 states also impose their own state-specific provider directory requirements.

[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

That experience shows there are two formidable barriers to ensuring accurate provider directory information:

- Providers often do not consistently provide updates to their contact information, and they may provide inaccurate information.
- There is no single source-of-truth for provider information that can be leveraged to verify what is contained in directories.

Americans need a public-private partnership between the federal government, providers, payers and vendors to streamline collection of this information and improve its accuracy. A cohesive, national approach to building a technology-enabled infrastructure will help ensure accuracy, reduce burden, and improve efficiency. This approach also could serve as a source of truth that health insurance providers could leverage to build more accurate directories.

We agree that CMS should explore the creation of an NDH. However, its success will depend on the NDH meeting the needs of both the private sector as well as the federal government. Meaningfully reducing the burden for everyone of collecting and maintaining the necessary data will require a solution that addresses the needs of all stakeholders.

We agree it is essential to reduce the burden of collecting and maintaining directory information to ensure it is comprehensive and up-to-date. However, in our experience, burden reduction alone is not a significant enough incentive to ensure providers consistently update their information in a timely and accurate way. As such, we urge CMS to explore appropriate measures to ensure accountability of providers for updating the NDH to ensure success.

The success of the NDH will also depend on its use. We recommend the NDH become the source of truth for basic provider information (e.g., provider contact information such as name and address, information on services offered and qualifications, and demographic information such as gender required under current regulations and guidance). To ensure acceptance and use of the NDH, CMS and other federal agencies should hold health insurance providers harmless if they use data from the NDH in their provider directories. Otherwise, payers will need to continue to verify these data independently to comply with various federal and state requirements, adding administrative work with little value for patients and consumers.

We agree with CMS that health insurance providers should continue to spearhead the collection of certain information like network status, as they are the source of truth based on their contracts with providers. However, for this to work, CMS will need to collect more information in the NDH than it would to support Medicare. For example, CMS should collect all addresses at which a provider practices, not just where they accept Medicare. This will permit private plans to leverage the NDH, without having to ask providers the same questions separately, and cross walk it to their needs. This also means that only private plans will have all of the data elements patients and consumers need. Thus, consumer-facing directory tools for enrollees or consumers shopping for a plan should also remain in the purview of the private plans. If CMS tries to recreate this information in the NDH for consumer use, it will add administrative burden,

complexity, and cost for insurance providers, and the information will inherently be lagged compared to the plan tools.

CMS also should continue to examine other ways to minimize the administrative burden on providers and plans that will encourage efficient and correct information while also leveraging resources like vendors and data science, such as an interoperable infrastructure. There are also multiple opportunities to reduce variation between federal policies governing provider directories, as well as variation between federal and state policies. As part of this work, CMS should work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines. Together, we can ensure the NDH meets all relevant requirements or has the capability to allow organizations to collect additional data points that may be required to meet state requirements or business needs.

AHIP and its members look forward to working with CMS to develop an NDH through a public-private partnership that will help reduce administrative burden and costs for everyone, which in turn will help make coverage and care more affordable, while also permitting providers to spend more of their time caring for patients. We thank CMS for considering the potential of an NDH and stand ready to partner with you to make this vision a reality. If you have any questions, please contact me at (202) 778-3246 or at dlloyd@ahip.org.

Sincerely,

Danielle A. Lloyd, MPH
Senior Vice President, Private Market Innovations & Quality Initiatives

Attachment

ATTACHMENT
AHIP DETAILED COMMENTS

I. Establishment of an NDH

CMS issued a request for information (RFI) soliciting public comments on establishing 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. CMS believes the establishment of an NDH could reduce the burden of collecting and maintaining directory information and improve the accuracy of such information by reducing the number of locations providers need to update their data. CMS believes the agency could potentially alleviate some of these burdens and improve the state of provider directories through a CMS-developed and maintained, Application Programming Interface (API)-enabled, national directory.

Every patient and consumer should easily find a clinician or facility skilled in the type of care they seek, is convenient to consult, and is comfortable to work with. To achieve this goal, health care and health insurance providers, including the federal government, must work together to ensure that directories include the most accurate and up-to-date information available about in-network providers. This information is critical to inform shopping for health care coverage and maximizing the value of health coverage. Guided by this commitment, we offer our vision for a National Directory of Healthcare Providers & Services (or NDH).

Maintaining accurate directories is a shared responsibility between clinicians, facilities, and payers. Despite the best efforts of plans, including direct outreach to providers, advanced analytics and artificial intelligence methods, and electronic solutions, the directories remain far from 100 percent accurate. **We believe a public-private partnership between the federal government, providers, payers and solutions vendors is needed to streamline collection of this information and improve its accuracy.** A cohesive, national approach to building a technology-enabled infrastructure will help ensure accuracy, reduce burden, and improve efficiency.

Health insurance providers work continuously to improve provider directories and are subject to several federal requirements across various insurance lines of business (e.g., Medicare, Medicaid and the commercial health insurance markets) to keep provider directories up to date. In addition, today at least thirty-nine states also impose state-specific provider directory requirements. **Health insurance providers have found two formidable barriers to ensuring accurate provider directory information (1) health care providers often do not consistently provide updates and they may provide inaccurate information, and (2) there is no single source-of-truth for provider information that can be leveraged to verify provider information**

AHIP agrees that CMS could play an important role in improving the accuracy of provider directories and reduce the burden of collecting and maintaining the information needed to support them. CMS could reduce burden and improve accuracy through standardization, technology, provider education, and support. **CMS should explore the establishment of a national directory; however, we urge CMS to consider the needs of the private sector in**

such a database and ways to leverage existing initiatives and enhance standardization. Stakeholders across the healthcare industry both contribute to and require the information the NDH could contain. The federal government should consider the potential burden for providers associated with populating and maintaining the NDH if the private payer system remains as is because their needs are not met by the solution. Minimizing the burden of gathering and maintaining the necessary data to support an NDH will require a solution that addresses the needs of all stakeholders.

To ensure it meets the needs of the private sector, CMS should develop the NDH using a federated model supported by a public-private partnership rather than centralized control by CMS. An NDH that uses a federated model could serve as a national data repository with access by providers, payers, states, and approved vendors. To maximize the efficiency and burden reduction, some entities like states and vendors could be given the ability to add information to the NDH. Moreover, such a model would allow connections with other data management systems such as electronic health records (EHRs) as well as scheduling and practice management systems that providers may already be using. These systems contain important information that could support provider directories without requiring providers to enter information in multiple locations. Without the ability to engage all stakeholders, a federal, centralized solution that does not incorporate the needs of the private sector will reinforce fragmentation, not alleviate burden.

CMS should work with stakeholders including private plans, providers, and vendors to develop and implement a meaningful framework for the NDH. AHIP supports the creation of an NDH and believes the framework will work most effectively through a public-private partnership that meets the needs of both public and private payers to maximize value to all stakeholders. To accomplish this, **CMS should establish a Technical Expert Panel (TEP) to develop technological approaches and identify necessary policy changes to support this work.** To promote a diverse set of input, this TEP should include a representative sample of health insurance providers as well as other relevant stakeholders such as providers, states, vendors, and consumer groups.

Stakeholders across the industry are working to address the current challenges of provider directories. Health insurance providers have invested in the use of advanced analytics and vendors continue to develop innovative products that can enhance current provider directories. CMS should explore ways to leverage existing efforts and support additional efforts to standardize data elements so the NDH can build on what is currently working. To explore how advanced in technology and interoperability could mediate the current challenges to directories, CMS should invest additional funds to increase the efficiency and adoption of scalable technological solutions for provider directories, such as the Health Level 7 (HL7) FHIR at Scale Taskforce (FAST) accelerator.

Summary Recommendations:

- Take further steps to move towards the NDH's creation in consultation with stakeholders.
- Employ a federated model for the NDH and create a public-private partnership between the federal government, providers, payers and solutions vendors.

II. Potential Use Cases for an NDH

CMS solicits comments on potential use cases for an NDH, what data elements could be collected through the NDH, and what entities could participate in an NDH. As noted above, AHIP believes there is value in establishing an NDH. If properly built an NDH could benefit stakeholders across the healthcare sector.

Contact Information and Services Offered

As a first phase for the NDH, AHIP supports developing a system to update and share provider contact information (e.g., name, address), information on services offered and qualifications (e.g., specialty, education) and other demographic information (e.g., gender, race, ethnicity) required under current regulations and guidance.[1] This initial use case would improve the availability and accuracy of such information to reduce the burden of maintaining provider directories.

More accurate provider contact and demographic information would support the creation of better provider directories for consumer use. Consumers depend on the directories created by their payers (both public and private) to support their choice of a healthcare provider. However, AHIP members have noted that data such as provider contact information can change frequently, and it can be challenging for payers to ensure its reliability and validity. This is compounded by the challenge of providers not updating data and no single source-of-truth for provider information. The lack of consistent updates and inability to easily verify provider information means that information that changes frequently is more likely to be inaccurate. AHIP members note that a provider's contact information and service location may change often. For example, information such as practice addresses, affiliated providers within a group practice, phone numbers, and office hours are often not current and are not updated in a consistent and timely manner. Furthermore, many large multi-specialty group practices do not maintain accurate service locations and hours of operation for providers who work out of more than one location. However, we recognize that this is essential information for consumers to find a healthcare provider who offers services that are accessible for them. **The creation of an NDH could allow healthcare providers to update essential information such as their contact and demographic information in one location that could then be updated throughout other systems through interoperable networks as opposed to the provider need to update with each payer they contract with, minimizing the burden of such updates and ideally encouraging providers to make necessary updates consistently.**

CMS should also consider state regulations and individual needs when developing the required data elements for the NDH. We also note there is variability across state Medicaid provider files regarding the availability, file format, content, and accuracy of provider demographic and contact information. While we encourage alignment with federal directory requirements as a starting point, we recommend CMS to work with State Medicaid agencies to align provider data files with data in the NDH. Otherwise, Medicaid managed care organizations and other

[1] For example, Section 116 of the Consolidated Appropriations Act, 2021 requires the name, address, specialty, telephone number, and digital contact information for each provider.

stakeholders working with the Medicaid program will continue to need to ask providers for additional information.

Digital Endpoints

The NDH should also be a system to collect and share information on digital endpoints from providers and payers to support implementation of the CMS Interoperability rules and potentially the advanced explanations of benefits (AEOBs). Better and more accessible information on digital endpoints will facilitate the exchange of health information and support a transition to technological solutions such as electronic prior authorization (ePA). We note that CMS should work with providers and other stakeholders to educate and improve understanding on digital endpoints and how they work.

The CMS Interoperability and Patient Access Final rule and the ONC 21st Century Cures Act Final rule represented important steps towards improved information sharing. However, sharing data over the pathways created by these rules depends on payers and providers being able to find each other's digital endpoints. Digital endpoints are essential to the implementation of requirements such as the payer-to-payer data exchange and AEOBs.

An endpoint describes the technical details of a location that can be connected to for the delivery/retrieval of information. Sufficient information is required to ensure that a connection can be made securely, and appropriate data transmitted as defined by the endpoint owner.[2] Improved interoperability across the system offers the opportunity for all parties involved in a patient's care to have better information to coordinate services. Easier access to digital endpoints would allow more timely data exchange across the system. A directory of payer and provider FHIR endpoints, for example, is critical to being able to "find" the organizations required for sharing data.

As interoperability progresses and an NDH evolves in future iterations, additional organizations could share contact information to facilitate better relationships with community-based organizations and other services that are crucial to addressing social drivers of health but may be outside of the traditional scope of the healthcare system. Better digital contact information could also facilitate the use of technology to streamline healthcare payment and administrative functions. For example, easier access to digital endpoints could support the transition to electronic prior-authorization.

Building a system to allow easy access to digital endpoints will be essential to the success of the Trusted Exchange Framework and Common Agreement (TEFCA). For stakeholders to successfully share data through the Qualified Health Information Networks (QHINs) it will be necessary to have access to digital endpoints to complete the transaction. The NDH could be an opportunity to allow a more efficient means of exchange of digital endpoint information and could be leveraged to support the implementation of TEFCA.

[2] https://www.hl7.org/fhir/endpoint.html

Future Uses Cases

AHIP also sees potential future use cases for the NDH. Information on licensing, credentialing, and accreditation would require information and input from additional stakeholders and would go beyond what may be feasible in the first iteration of an NDH. However, CMS could explore building the NDH in a way that would allow organizations such as state medical boards, accrediting bodies, and educational institutions to add or verify information. CMS could explore building authentication capabilities into the NDH and allowing for the collection of additional data points to support the collection of information on licensing, credentials, and accreditation. Building the NDH in a way to support this type of information could streamline and enable many other use cases and further reduce the burden on providers and payers. We agree with CMS that information in the NDH should be verified against a primary data source, but this could be done by approved vendors to which providers could delegate their updates. If data could not be verified by a primary data source, then there should be a field indicating as such. However, verification process could also benefit from a federated model. Approved or certified vendors would also have the ability to verify and validate data that could be shared across the system.

Summary Recommendations:

- Develop a system to update and share provider contact information, information on services offered and qualifications, and demographic information required under current regulations and guidance as a first phase.
- Expand the NDH after this initial phase to collect and share information on digital endpoints and work with stakeholders to provide education and enhance understanding of digital endpoints.

Entities to Include

Overall, AHIP supports allowing a broad range of healthcare organizations to provide information into the NDH. From the health insurance provider perspective, the NDH should at minimum include information from all entities that payers are required to include in various directory requirements. In addition, over time all individuals and entities who have national provider identifiers should be included. In later stages, we agree there would be value in allowing other types of organizations who are not currently included in provider directories or specifically contract with health plans to also participate. For example, this could include Community Based Organizations. CMS should work with stakeholders to determine how best to phase in additional types of organizations who are not covered by current directory requirements and may have less experience reporting into current systems such as NPPES.

We support a broad definition of healthcare providers for whom participation would be available, but not required, for organizations not traditionally included in directories such as community-based organizations. We agree information on these organizations could be useful; however, we are concerned about placing new burdens on these groups, especially as the NDH is in an early stage. One approach for determining which providers to include in the NDH would be any provider that has a billing/contractual relationship with a payer. CMS could work with stakeholders to determine how to best incentivize participation in the NDH. For example,

penalties may be necessary for providers for whom payers are required to include information in directories, while incentives could be used to draw new organizations into the NDH.

After a phased in approach, CMS should ultimately include all provider types participating in the Medicare, Medicaid, and Marketplace (i.e., QHP) programs at minimum.

Summary Recommendations:

- Include at a minimum information from all entities that payers are required to include in various directory requirements. Ultimately expand the NDH to include all provider types participating in the Medicare, Medicaid, and Marketplace programs.
- Consider expanding the NDH to allow other provider types on a voluntary basis in initial phases as they build the capacity to report.

Data Elements Needed

Success of an NDH will require the ability to allow for flexibility. Stakeholders may need different pieces of information to meet local requirements or to support individual business needs. As such the NDH should include functionality to allow extensibility of the data elements required. That is, organizations should be able to establish a relationship and have the ability to ask for additional data elements beyond a core set of data elements all entities would be required to report. Without the ability to allow extensions to meet individual needs, stakeholders will still need to find ways to share these extra pieces of information, thereby limiting the value proposition of a single place for providers to maintain the data. Designing the NDH to support a core set of data elements with the ability to customize would avoid organizations asking for additional information outside of the NDH and maintain a streamlined system.

CMS should also consider how frequently each piece of information is likely to change and how often updates may be needed. Some pieces of information are unlikely to change very often. While provider location and contact information may change more frequently, certain facilities, such as hospitals and ambulatory surgery centers, are unlikely to relocate multiple times over the course of a year. For these types of data elements that will not change often or at all, CMS should work with stakeholders to define such facilities and use enforcement discretion to allow flexibility to provide updates to the NDH on an annual basis unless necessary due to a change (e.g., a change in name or ownership of the facility). In addition, CMS should exempt telehealth, virtual providers, or other home health and mobile providers who do not provide services in a bricks and mortar location from such requirements as they do not provide services at a physical location. However, providers with a bricks and mortar location who also offer telehealth services should share information about the availability of such services in the NDH. CMS should work with stakeholders to identify which pieces of information are more dynamic and likely to change frequently and develop strategies to promote more consistent updates to the NDH.

We also caveat that CMS should work with stakeholders to develop the core set of data elements supported by the NDH. Below we share the health insurance provider perspective and feedback on potential data elements. As noted above, CMS should create a public-private

partnership to oversee the NDH. Such a partnership could support work to develop the core set of data elements as well as potential extension elements that may be required.

Contact Information
First CMS should include data elements that capture a provider's location, including all addresses at which a provider practices as well as whether the provider offers telehealth services, including which modalities are available. Currently, payers are required to collect information on address, city, state, and ZIP code. However, location is a frequently changing field and current data collection efforts do not capture the associated nuances with location information. **To improve the usefulness and accuracy of information, addresses must be tied to purpose in the NDH.** For example, beyond collecting just an address, the NDH should collect follow-up information to help users understand how best to use that information. For example, addresses should be tied to questions such as:

- Do you receive mail at this address?
- Do you see patients or take appointments in this location?
- Does this location offer accommodations for people with disabilities?

More granular location information tied to purpose would allow payers to create more accurate provider directories with the information pulled from the NDH.

Today most provider demographic databases have one entry per provider, which means that usually one address is included. We know that many providers work out of multiple clinic sites and may have a business address that is different from any of these care sites. Along with the ability to have multiple addresses and address types associated with a provider, we would discourage CMS from using a postal address as the location index in the NDH. How addresses are entered creates a plethora of opportunities for errors that will require active management and data cleaning—and would likely be prohibitive given the potential size of this resource. Suitable identifiers should be included in the NDH to ensure it is clear whether or not two records are for the same location, taking into consideration that there are often many ways to indicate the same street address through abbreviations, vanity spellings, etc. Standard identifiers could also help clearly indicate which provider-to-organization affiliations are valid at which locations. Ideally, the location should be a unique code of some sort that corresponds to the postal address but is not the address itself. There will also need to be a location designation for telehealth services.

Beyond information on location, the NDH should collect other contact information including telephone number, including which number should be used to schedule appointments, website URL (if applicable), and fax number. CMS could also ask providers to verify if they would like payers to publish their information in the payers' directories and provide a time stamp that indicates when information was last updated. CMS should also consider publishing a schedule of update and verification frequency so stakeholders have consistent expectations for when updates may occur.

Digital Endpoints
Information on digital endpoints is becoming increasingly essential as we move towards an interoperable health care system. A key challenge to implementation of the current interoperability and data sharing requirements is the lack of a way to easily look up another

organization's digital endpoints. The NDH could play a key role in promoting interoperability and information sharing by ensuring digital endpoints are easily accessible. Additionally, all stakeholders would need these provider endpoints to be verified and validated as to their association to the represented provider on an ongoing basis. Addressing the verification and validation process through the NDH could streamline this process and make it more efficient.

Information on Individual Providers
The NDH could also be leveraged to collect information on provider demographics and the services offered. Again, the NDH should collect all information payers currently need to meet federal regulations on provider directories. For example, the NDH could collect information on a provider's specialty and what services they offer (e.g., if telehealth is offered or if an obstetrician is currently only offering gynecological services). The NDH should also collect information to support consumer's choice in a provider such as information on cultural and linguistic capabilities and office/location accessibility under the Americans with Disabilities Act (ADA). The NDH could also collect basic demographic information such as gender from providers as required by current directory regulations. CMS could explore building enhanced demographic data fields to support the collection of information on additional data elements such as race and ethnicity. However, these data elements that could be considered sensitive to the provider or not required for compliance with federal provider directory regulations should allow for a choice not to respond at this time given the controversial nature and risk of discouraging use of the NDH.

A future phase of the NDH could also collect information required for accreditation and credentialing purposes. We recommend CMS build the NDH so that data entry could expand but focus on core data elements in phase one. Information collected from facilities in the initial phase could focus on the facilitate type, accessibility, and services offered.

Relationships
Understanding clinician relationships is a significant challenge in producing accurate provider directories. A clinician may practice independently as well as part of a group. Moreover, clinicians may have privileges at one or more hospitals. **The NDH should collect information to allow payers to easily discern clinician relationships to provide better information to consumers. Collecting information on group name, National Provider Identifier (NPI), and Taxpayer Identification Number (TIN) will allow payers to determine relationships between clinicians and groups.** CMS could also explore collection information on where a clinician has hospital privileges.

There are instances where a provider in a location is affiliated with multiple provider organizations. Their participation in a plan's network and their willingness to take on new patients will vary by what organization with which they are affiliating their care—even though it is the same provider at the same address. For this reason, we also believe the NDH must capture all organizational affiliations of a provider, such as, all the tax IDs under which the provider can bill, but CMS should gather additional stakeholder feedback to ensure this captures the necessary detail for all NDH users.

CMS should also develop ways for healthcare providers to share data that enables other stakeholders to understand the relationships among individual providers who may practice

different specialties but are part of a group. For example, an anesthesiologist that does not see patients directly or a radiologist that would never see the patient but would read the reports and images.

CMS should also explore ways the NDH could provide information on when a clinician leaves a group or practice. Currently it can be challenging for payers to determine if a clinician has left a group to join a new practice or if a clinician is no longer practicing due to retirement, death or a career change. Better information on terminations and the reason why could help payers offer better information to consumers. Information on whether a provider participates in Medicare (has Medicare ID) and/or Medicaid (has a Medicaid ID) would also be useful. In addition, it would be useful to collect information on any state provider identification numbers.

Modalities Available
The COVID-19 pandemic accelerated the use of telehealth and has brought telehealth access to the forefront. More clinicians are offering telehealth services and some providers have moved their practices entirely online. Consumers have also become more accepting of telehealth and some may prefer to receive services via telehealth in certain circumstances. For example, many consumers prefer the flexibility and privacy of receiving behavioral health services via telehealth. As such, payers need better information from providers about whether they offer telehealth services and if they are accepting new patients via telehealth. **We recommend that the NDH consider a data element for providers to share information on the modalities of service available.** We note this would also be valuable as a way to promote health equity.

Accepting New Patients
Another frequently changing and challenging to collect data element is whether a provider is accepting new patients. We recognize this information is essential to consumers, however, whether a provider is accepting new patients can change quickly and depends on several factors. For example, a clinician may have limited ability to take on complex cases, is only accepting new patients via telehealth or is on short term disability or parental leave. Even within a health plan, a provider may be accepting new patients under one product (e.g., employer PPO coverage), while not accepting new patients under another (e.g., an ACA HMO plan). For each provider, this may result in hundreds of combinations that may change frequently.

There is value in the NDH collecting information from providers on whether they are collecting new patients but in the initial phase of work should only focus on broad information on provider availability. While we recognize this information would be very general, it could be useful for payers to understand which healthcare providers are not accepting new patients at all (e.g., the provider may be preparing to retire, or the practice is full). The NDH should include whether the provider is accepting new patients, but for any initial version should be a binary (yes/no) or trinary (accepting patients for all products, not accepting patients for any products, accepting patients depending on the product) as selected by the provider. Payers or third-party application developers could build upon that information and build tools that direct consumers a digital endpoint where they could determine if that provider is accepting their specific insurance.

Information Not to Collect through the NDH

CMS should not mandate the collection information on payers' networks or insurance acceptance through the NDH. While we see the potential value in allowing organizations to note relationships through the NDH (e.g., to request updated information or to receive notification when information is updated), this information should not be used as a proxy for information on networks from payers. We define networks as what insurance networks a particular provider participates in. Instead, CMS should build the NDH so that payers can pull information and supplement it with their information on network status to ensure accurate and consistent information is provided to members of a health plan. However, CMS could build the NDH with extensionality in mind so that payers could collect additional information from providers using the same user interface that is unique to the plan and would assist with connecting the information to network specific information at the same time. These data added via extensions would only be stored with the payer requesting it, not with the NDH.

Summary Recommendations:

- Build the NDH in a phased approach. The initial phase should focus on collecting digital endpoints then expanding to collect the contact and demographic information from providers currently required by federal regulations. Subsequent phases could expand to include additional provider types and data elements.
- We recommend the NDH not mandate the collection information on payers' networks or insurance acceptance.

III. Policy Dependencies

CMS seeks comment on the policy dependencies to building an NDH.

Health insurance providers have demonstrated their commitment to provide meaningful information to consumers to support their choice of a provider. Payers invest significant resources to verify and correct inaccurate data from providers and to outreach to providers who do not update current directories. Payers have also been working diligently to implement the requirements of the CMS Interoperability Rule, the No Surprises Act, and the Transparency in Coverage final rule. Payers are also expecting potential additional requirements in the Interoperability and Prior Authorization proposed rule. While certain provisions of the NSA and these rules are intended to achieve similar objectives, together these policies create a complex web of overlapping requirements that heighten burden. We encourage CMS and other government agencies to consider the need for new, thoughtful solutions as payers and health care providers navigate new requirements. Working together, we can provider consumers better information to support their health care decisions without creating significant administrative burden and increases in health spending. Above all, regulatory action must:

- Prioritize empowering consumers.
- Improve their ability to make informed decisions about where to seek healthcare.
- Drive affordability.
- Ensure that the consumer experience is meaningful and as seamless as possible.
- Strengthen consumer trust by ensuring the accessibility of comprehensive and accurate information.

We appreciate CMS's considerations of the policy dependencies and potential changes necessary to ensure adoption of the NDH. During the prior administration and Congress, new legislative provisions were enacted, and multiple regulatory requirements were finalized—all aiming to promote data sharing and price transparency. However, the result was a series of fragmented and, in some cases, conflicting provisions. Certain requirements in the Transparency in Coverage final rule and the Interoperability and Patient Access final rule will not provide consumers with information that is meaningful or actionable and would likely increase health care costs and jeopardize patient privacy. Further, the No Surprises Act creates statutory requirements that overlap with requirements in the Transparency in Coverage rule. While certain components of the interoperability and transparency final rules offer a good start, other requirements are ill-conceived and should be reconsidered to improve accuracy, reduce operational inefficiencies and discordant rules across markets, and increase the health care system's readiness for successful implementation.

As noted in our May 2021 letter to Secretary Becerra, payers believe, consumers and patients deserve easy access to the actionable information they need to make informed decisions about their health and health care for themselves and their families. Sharing clinical data across hospitals, physicians, payers, and consumers while making accurate information on costs more accessible should empower Americans and their families as they make choices about their health and finances. However, complex and overlapping polices can strain resources and prevent successful implementation of these tools. We recommend CMS implement the NDH in the context of other regulations payers and health care providers are currently implementing, while exploring ways to streamline the regulatory environment to facilitate implementation.

Roadmap for Implementing Transparency and Interoperability Requirements

AHIP recommends a phased-in approach to the NDH that puts the consumer first, while also minimizing administrative burden and additional costs to the health care system. In partnership with the private sector, the Departments should develop a roadmap for building the necessary infrastructure that is put into the context of the other NSA and Interoperability Rules to create a cohesive, staged approach to achieve success. AHIP believes this approach will best position the industry to strengthen consumer trust, reduce burden and duplication for stakeholders, and improve health care quality and efficiency.

Streamline and Harmonize Directory Requirements

First, for the NDH to successfully reduce burden and achieve wide scale use, it must include all the information necessary for payers to meet compliance with federal provider directory requirements across product lines. Health plans are subject to multiple federal and state requirements to keep provider directories up to date in the commercial, Medicare, and Medicaid markets. In addition, since 2016, for over three-quarters of states in the federally-facilitated Exchanges, qualified health plans (QHPs) are required to maintain machine-readable provider directories. Moreover, CMS has implemented requirements for Medicare, Medicaid, and CHIP plans to make directory information available over a FHIR-enabled API. However, each of these regulations requires the collection of different data elements. The NDH must be able to collect all the required elements for federal regulations as well as for accreditation bodies.

Reconciling and streamlining these varying requirements could prevent situations where the NDH does not allow a payer to meet a requirement, necessitating additional data collection from providers. **To facilitate this, CMS should work with the tri-agencies (Department of Labor and Treasury) and Medicaid state agencies as well as accreditation bodies to reconcile and align requirements across federal, state, and accreditation programs.**

Summary Recommendations:

- Work with other federal and state agencies as well as accreditation bodies to reconcile and harmonize regulations regarding provider directories to ensure payers can use information in the NDH to fulfill these requirements without additional asks of providers.

Ensure Equal Payers and Provider Accountability

Another challenge are the unequal incentives on payers and providers to maintain directory information. While payers are subject to enforcement action if provider directories are found to be inaccurate, compliance is also dependent on provider responses as acknowledged in the RFI. We do not believe burden reduction alone will be sufficient to motivate providers to maintain accurate information in the NDH. Numerous previous efforts have aimed to improve accuracy of provider directory data, including an AHIP pilot with a dozen health plans conducted in 2016. Covering three states and over 400,000 providers, the pilot program faced significant challenges with provider response rates, managing multiple data formats and regulatory requirements, resolving data conflicts, and conducting outreach through multiple channels. Of the three states included in the pilot project, one state (California) included strong accountability measures that incentivized providers to respond to requests to update their information. This demonstrated that when regulatory requirements or contractual requirements such as payment delays are used, providers are more likely to respond.[3]

Provider directory accuracy depends on plans receiving timely responses to update requests. While we appreciate the FAQs[4] related to implementation of the No Surprises Act that emphasized the importance of providers responding to plan requests, we believe additional actions will be necessary to promote compliance and participation in the NDH. Thus, we encourage CMS to align incentives to ensure this information is entered and maintained on a regular basis. We believe that both "carrots" and "sticks" are needed to ensure timely, accurate updates. CMS should establish a mechanism that holds providers accountable for updating data and this should apply to both facilities and non-facility providers.

CMS should also work with stakeholders to ensure understanding of the potential limitations of the NDH. For example, CMS could remind providers in any rulemaking related to the database that they must still reply to payer requests for information to ensure the NDH does not inadvertently increase the non-response rate.

Summary Recommendations:

- Work with states to align federal and state requirements on the frequency of updates to avoid payers needing to ask providers for additional updates to meet state regulations.

[3] https://www.ahip.org/resources/provider-directory-initiative-key-findings
[4] FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (dol.gov)

- Require providers to verify the information in the NDH at intervals that will meet all state and federal requirements on private plans.

Hold Payers Harmless if Data from the NDH is Used

Such a broad rethinking of how provider data is captured, managed, and updated will have significant downstream implications. Health insurance providers and other entities will depend on the accuracy of this information and share information directly to beneficiaries and enrollees. The NDH must be reliable source of truth if broad adoption is to be achieved. We urge CMS to use its existing regulatory authority across the programs it manages to ensure that health insurance providers are not held accountable for incorrect information pulled from the NDH.

To garner use and trust, CMS and states must offer a "safe harbor" to any health plan or intermediary that relies on the NDH. For example, the Section 116 of Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act (CAA), 2021 requires validation of provider directory information every 90 days and updates to payer databases within two business days of receiving new or revised information from a provider that affects the directory, along with new patient protections for consumers who were provided inaccurate information. The two-day timeframe is difficult to payers to meet and the requirements to proactively confirm information every 90 days overwhelms providers with outreach from payers and can lead to low response rates in some cases. We appreciate CMS exploring the NDH as a potential solution to the burden of provider directories, including the particular challenges imposed by the CAA. As CMS develops and builds the NDH, we ask that CMS exercise enforcement discretion or continue to apply good faith compliance until the NDH is operational, so that stakeholders are not building in the wrong direction in the meantime.

Summary Recommendations:

- Hold harmless plans that rely on the NDH to populate their provider directories and later find the information to be inaccurate upon audited.
- Consider plans in compliance with the CAA if they rely on the NDH and exercise enforcement discretion until the NDH is built.

Use the CEHRT Program to Incentivize Connections to the NDH

As noted above, solutions vendors could facilitate the implementation of an NDH and provide alternative ways for organizations to upload and receive information to and from the NDH. CMS should work with ONC to update the requirements of the ONC Health IT Certification Program to support use of the NDH and ensure the NDH can interact with tools providers currently use such as EHRs and practice management systems. **ONC should leverage the Certification Program to ensure Certified Electronic Health Record (CEHRT) vendors build the necessary connections to the NDH to allow data entry to be as easy as possible for providers to facilitate updates.**

Summary Recommendations:

- Establish accountability measures to ensure broad provider participation in the NDH.

- Work with ONC to update the Certification Program to require HIT vendors to build necessary connections to the NDH.

IV. Impact on Health Equity

CMS seeks comments on how the NDH could be used to advance health equity and health equity considerations that could impact the design of the NDH.

AHIP applauds CMS's consideration of health equity in the design of the NDH and considers health equity a priority of its own. For far too long, discrimination and systemic racism have served as barriers to health equity for minority and underserved communities. Payers agree that mitigating these barriers to care is key to an equitable health care system and are actively promoting health equity by taking concrete steps to reduce disparities. Improving access to care and ensuring consumers have information to support their healthcare decisions are critical to addressing disparities in care. **However, CMS should work with stakeholders to carefully consider how best to operationalize the NDH to promote health equity.**

On one hand, it is important to collect and publish the information consumers need to support their choice of a healthcare provider. The NDH could play an important role in sharing better information about a provider's identity, cultural and linguistic capabilities, skills and training providing care for diverse populations, and commitment and experience to serving different populations. This information could help consumers either find providers who share their identity or find providers who have the experience, training, and commitment to delivering culturally competent and respectful care. AHIP notes that underscoring current health disparities is the cultural competency and humility of our health care institutions. Cultural competency is a reflection of how clinicians, payers, and other organizations are delivering health care services to meet the social, cultural, and linguistic needs of their patients. Research shows that racial and ethnic minorities are often disproportionately burdened by chronic illness and disease. Payers understand that every patient has different needs, and our member companies continue to invest in strategies to improve health outcomes for all the people they serve. The ability to provide more detailed information on a provider's capabilities could allow payers to work with members to help them find care that best meets their needs.

However, it may be difficult to verify information such as cultural and linguistic capabilities. We realize that some of this information will be self-attested by the provider themselves and cannot be readily verified. Additionally, there are few or no accredited trainings for providing respectful care to various diverse populations and intersectional identities, so it will also be difficult to verify the quality of trainings listed. For these reasons, **we believe the NDH should include a parameter for each data source that indicates whether the information is externally verified or obtained from a provider self-attestation.** This will ensure that users can appropriately assess the possible limitations of the data while also having access to information they may not otherwise be able to obtain.

There is also increasing interest in collecting and reporting information on provider race and ethnicity to support consumer choice in finding a provider who shares a similar identity. To improve the collection of this important information, CMS should add data elements on provider

race, ethnicity, and language. However, there should be a response option that allows providers to select "I choose not to respond" to ensure they have agency whether to disclose personal information on their identity or not given concerns voiced by providers. Some providers are not comfortable providing this information due to concerns about racism and discrimination. Other providers have expressed concerns that they would be expected to serve certain populations based on their identity. To ensure as frictionless of an experience as possible to encourage broad adoption, CMS, other agencies, and accreditation bodies should not place any type of requirement for provider race or ethnicity information to be included in payer directories until the data has been collected at scale and is verified to be accurate.

Finally, CMS should consider how to include organizations and clinicians who may be less resourced. Not all providers have adopted EHRs or other health information technology (HIT). While providers are now required to maintain FHIR-based APIs, it would still require substantial infrastructure investments to build out the technology for this purpose, especially for safety-net, small, and rural providers. Similarly, some providers may not have staff to manage data reporting or financial resources to contract with vendors who can provide these services. CMS should ensure there are easy to access, no-cost ways for organizations to participate in the NDH. For example, CMS could maintain a simple, user-friendly web-interface to allow updates. CMS should also consider ways to include less technologically savvy providers when determining which data elements to include. While many across the system would like to move away from the use of legacy technologies like fax machines, many smaller or less resourced providers are still dependent on them and may not have the ability to adopt new solutions.

An NDH will not solve the challenges of provider directories if only a subset of providers can use it. Moreover, imposing technological barriers to use of the NDH risks perpetuating disparities. CMS could also consider incentives to support providers with IT upgrades and infrastructure or alternative mechanisms for updating their data.

Summary Recommendations:

- Work with stakeholders to carefully consider how best to operationalize the NDH to promote health equity.
- Collect data on fields such as a provider's race, ethnicity, and language well as cultural and linguistic capabilities.
- Consider how to best include organizations and clinicians who may be less resourced.

V. Data Submission and Maintenance

CMS seeks feedback on considerations for data submission. CMS asks for input on how data can be collected, updated, verified, and maintained without creating or increasing burden on providers and others who could contribute data to an NDH, especially for under-resourced or understaffed facilities.

For the NDH to successfully reduce burden, it must have accurate information and reduce effort required to update information. A national, standardized, interoperable data infrastructure could play an important role in improving the accuracy of provider directory information while reducing the effort required to maintain this information. Improving accuracy and completeness

of provider directories requires solutions where health plans, providers, vendors, and other stakeholders work together to coordinate updates in a timely manner. CMS should develop a public-private partnership to provide oversight and input to the content and technical standards as well as the data submission and maintenance processes for the NDH.

CMS should leverage existing resources and initiatives to improve the current data and submission and maintenance process. Building on and coordinating existing industry initiatives to reduce provider burden could standardize and streamline the processes to submit, verify, and share data. Continuing to allow authorized representatives such as approved vendors to submit data on behalf of providers will minimize the burden of transitioning to the NDH. However, we caution any solutions must be vendor agnostic.

To ensure consistent data collection, government agencies, including CMS, should harmonize current regulations on provider directories across multiple programs. CMS should resolve the discrepancies in required data and timeline updates for different product lines, so payers are able to utilize the common information in the NDH and avoid asking providers for additional updates and data elements. Consistent requirements would increase use of the NDH and its value to all stakeholders. For example, implementing turnaround times consistent with Medicare Advantage for all product lines could strike a balance between ensuring timely updates and allowing the necessary time for verification.

As CMS builds a data submission and maintenance process, CMS should consider how frequently a piece of information is likely to change and will need to be updated. Some information is more static and less likely to change such as a clinician's specialty or the location of a hospital; other information such as a clinician's location or ability to accept new patients is dynamic and will change frequently.

How data is structured and how questions on the data entry form are worded will be essential to improving accuracy. **CMS should consider how to ask for information and how questions will be interpreted.** For example, asking if a clinician is accepting new patients at a given location will give different information than asking if that clinician practices at a given location. Again, a public-private partnership could provide guidance and standards on how to structure and ask for data. **Moreover, CMS could ensure that NDH design processes includes cognitive testing of the NDH data collection form and questions.**

CMS should also consider ways to allow for the collection of additional data that payers may need to meet state regulations or their specific business needs. Allowing for flexibility and extensionality could avoid payers asking providers for additional information or updates outside of the NDH.

We agree there is value in verification of the data in the NDH but caution there is currently no "gold standard" to verify data against. The information currently shared to populate provider directories can be incomplete, incorrect, inconsistent, provided by different staff members of an organization, or require updates to provider contracts, practice areas, or specialties. For example, even simple data points like the name of the practice or phone number can be difficult to verify. Practices may have multiple names due to location, legal name, licensing requirements, or

particular providers. Phone numbers can refer to the main office line, specific offices or divisions, or individual providers. In addition, the person providing the information can range from office staff to financial managers to the providers themselves.

Payers have found that data from NPPES can also have errors when building the machine-readable files required for QHP issuers. **To ensure acceptance and use of the NDH, CMS and other federal agencies should hold payers harmless if they use data from the NDH in their provider directories.** Otherwise, payers will continue to verify data independently and ask providers for additional updates.

Finally, when developing a process for data submission and maintenance, CMS should consider provider capabilities and technology savviness. Updates need to be easy to make and the NDH should allow solutions that enable provider buy-in. We suggest CMS explore a role for vendors to continue to make directory updates on provider's behalf while also creating a way that providers can update independently without vendors such as an easy to access web portal, and building connections to systems providers are already using. CMS could also explore solutions based on AI to flag potential errors for providers and ways for other parties to flag potentially incorrect data. For example, a payer could flag that they have been receiving feedback from members that a provider's address is out of date.

Summary Recommendations:

- Work across government agencies to harmonize current regulations on provider directories across multiple programs to ensure consistent data collection.
- Work with the public-private partnership overseeing the NDH to develop data submission and maintenance processes. Key considerations include how frequently a data element is likely to change and how data entry questions are likely to be interpreted by users.
- Consider ways to allow for the collection of additional data that payers may need to meet state regulations or their specific business needs.
- Hold payers harmless if they use data from the NDH in their provider directories, together with the Departments of Treasury and Labor.
- Consider provider capabilities when developing a data submission and maintenance process.

VI. Delegation of Authority to Submit Data on a Provider's Behalf

CMS notes it would be critical to allow listed entities, particularly providers, to delegate or authorize other individuals, either in their organization or intermediary organizations, to submit directory data on their behalf to reduce burden and ensure that data submission is feasible, timely, and accurate. CMS is using the term "listed entities" to refer to individuals and groups whose data could be available in an NDH. CMS requests comments on current industry best practices for delegating authority and aspects of this functionality that could be used with an NDH.

Success of the NDH depends on its comprehensiveness. A centralized data hub will only be valuable if it contains accurate and complete information. Achieving the provider buy-in to ensure the NDH reduces burden will require that the new system simplifies data submission and

streamlines current processes. We recommend that CMS continue to allow providers to delegate authority for data submission on their behalf. **Continuing to allow approved vendors to update the information for providers will avoid creating new burden. However, any solutions or delegation should be vendor agnostic.**

Summary Recommendations:

- Continue to allow approved vendors to update information on the behalf of other entities.
- Ensure the NDH is vendor agnostic and entities have options when choosing a vendor.

VII. Technical Considerations for an NDH

CMS notes that the technical approach to establishing an NDH could leverage work the federal government has already done, in collaboration with industry stakeholders and standards development organizations, to develop healthcare directory information exchange standards. CMS could build on existing work to develop FHIR-based standards for healthcare directories. For years, ONC has collaborated with HL7, an ANSI-accredited standards development organization, to support the scalability and industry adoption of FHIR standards for use in a healthcare directory.

In 2016, HL7, in cooperation with the ONC and FHA Healthcare Directory initiative, developed and published the Validated Healthcare Directory (VHDir) IG. The VHDir IG was developed to describe the technical design considerations for collecting, validating, verifying, and exchanging data from a healthcare directory. The IG also provides technical guidance for a FHIR API for accessing data from a validated healthcare directory. Building on this initial work, FAST has collaborated with HL7's Patient Administration Work Group to develop and maintain new FHIR IGs to further describe data attestation and verification processes. They have also collaborated on standard API for local directories to make verified data available to stakeholders: the National Directory Endpoint Query IG, the National Directory Exchange IG, and the National Directory Attestation and Validation IG.

CMS notes it could also build on work by FAST, which has identified numerous technical challenges associated with directories, particularly related to digital contact information, and conducted research, stakeholder engagement, and key technical development activities to establish the framework and capabilities needed for a scalable NDH. In their proposed directory technical solutions document, FAST also identified CMS as the appropriate potential maintainer of an NDH.

CMS states it could leverage this work to serve as the technical foundation on which to develop a FHIR API-enabled NDH. Additionally, using FHIR standards would help align an NDH with the technical standards at 45 CFR 170.215 finalized by ONC in the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program final rule (85 FR 25642).

AHIP appreciates the work CMS, ONC, HL7, and others have done to develop technological solutions to the challenges to provider directories.

Data Standards and Implementation Guides

We appreciate CMS seeking to leverage existing work where possible, but also urge it to be open to additional ideas. AS we noted above, we believe CMS should establish a TEP Panel to work through the advantages and disadvantages of different technological approaches. CMS should also include a broad group of organizations in its request for proposals to support the initiative to explore the role different technologies could play at each stage of the system. Finally, CMS should also be mindful that not all providers or payers will have the same level of capabilities and resources, so providing options for how to connect may be most workable.

We generally support the use of FHIR to create foundational exchange standards for nationwide interoperability in areas where standards do not already exist. The creation and adoption of an NDH that uses FHIR-enabled APIs could be a meaningful step forward in reducing the burden of creating and maintaining accurate provider directories at scale. The use of FHIR for the NDH offers several advantages. First, healthcare organizations can use FHIR as the foundational exchange standard and make data available via FHIR APIs. Next, organizations using FHIR implement standardized approaches to manage identity, endpoint discovery, security, and exchange. Exchange partners can dynamically identify and access FHIR servers maintained by or on behalf of healthcare organizations. Finally, the use of FHIR offers a consistent experience when interacting with other organizations.

As a first step to the creation of the NDH, CMS should look to the work of FAST. FAST is cross-industry collaborative that was launched in late 2017 in response to an industry-recognized need to address shared FHIR scalability challenges and is now an HL7 Accelerator. **The work of FAST could be leveraged to serve as a foundation and starting point for the NDH.**

Leveraging the work of FAST, CMS should support the creation of a validated, verified national directory with federated or distributed access. A federated rather than centralized approach could allow multiple stakeholders to contribute information, thus reducing burden and allowing the NDH to support additional use cases in the future.

In the FAST architecture, providers and other healthcare organizations contribute attested information and declare relationships. Next, information submitted to the central data hub is verified. Authenticated end users could then request data on other organizations from the central hub and use it to update their own applications (e.g., a network directory maintained by a specific health insurance provider or a consumer facing tool developed by a third-party application). The federated model developed by FAST would allow end users to contribute potential updates to the information contained in the centralized data hub while allowing the opportunity to verify such updates. This could allow the data in the centralized hub to remain accurate and up to date as multiple parties will have the opportunity to flag errors or outdated information.

We agree CMS should explore the use of the relevant DaVinci implementation guides. The Validated Healthcare Directory (VHDir) IG could serve as a starting point. However, policies have not been published regarding supporting different versions of the standards and IGs. Additional work is needed to ensure that users of this technology understand the baseline,

upgrade path, and maintenance requirements. Moreover, the IGs are limited to address the data transport and security, not to process around the subject or how the data is maintained at rest. CMS should also explore how best to leverage FAST's work to develop and maintain the National Directory Endpoint Query IG, the National Directory Exchange IG, and the National Directory Attestation and Validation IG. The IGs could serve as starting points in the development of the NDH.

CMS should make technical specifications for the NDH publicly available. This should include release of detailed specifications on how CMS will quality check the data. Transparent specifications and processes will ensure stakeholder buy-in and acceptance and allow stakeholders to build systems that align with the NDH.

Potential Future Work

We recognize that building an NDH will be a complex undertaking. As noted above, **AHIP supports the creation of a public-private partnership to oversee the design and implementation of the NDH. To support the NDH technically, CMS should further invest in the DaVinci Project's standards development and FAST to identify scalable solutions to speed adoption.** For example, more work is needed to fully flesh out the standards underpinning bulk data sharing.

CMS should also build the NDH to allow the system to grow and adapt to future use cases. We suggest that CMS solicit bids from an array of contractors to explore different technologies on which to base the NDH with future use cases in mind rather than simply consolidating its existing systems. Emerging technologies, such as blockchain, could offer advantages like greater privacy protections while allowing more users to contribute data to the NDH.

Regardless of the underpinning technology, accuracy of the information in the NDH will be essential to its success. **CMS could also explore how artificial intelligence (AI) and machine learning could facilitate the maintenance of accurate information in the NDH.** AI could be utilized to proactively identify information that could be inaccurate; especially regarding alternative sources of information that could be mined and compared to the NDH.

Interactions with Other Systems

Provider directories require numerous data points to be useful to consumers. Consumers need information on what services a provider offers, where they are located, what days they see patients at certain locations, and if they are accepting new patients. We believe a public-private partnership between the federal government, providers, payers and solutions vendors is needed to streamline collection of this information and improve its accuracy.

CMS should work with ONC to explore how the ONC Health Information Technology Certification Program could support interactions between the NDH and other HIT products such as EHRs and practice management systems. Ensuring that healthcare providers can use data generated by their EHRs to populate some of the required information in the NDH

could reduce data entry burden. Similarly, many providers already use practice management or scheduling solutions. Allowing these systems to interact and share data with the NDH could improve the accuracy of information on some of the most challenging data fields to collect in current provider directories: when and where providers are seeing patients and accepting new patients.

Functionality to Consider

The FAST work outlines the need for organization to delineate billing hierarchies. **We believe CMS will need to collect not just each provider's NPI, but also the Tax ID/NPI combinations under which they may bill for services.** In addition, it would be helpful to harness these disclosed relationships to facilitate the exchange of information. **For example, the NDH could allow organizations to "follow" each other as supported in various social media platforms.** This functionality could then be leveraged to allow organizations to receive alerts if another organization they have a relationship with submits updated information to the NDH, to request updates to meet federal or state requirements, and to flag potentially inaccurate information for corrections.

User Experience

The value of the NDH would be its comprehensiveness. If it can only be used or accessed by a subset of providers or does not include information need by private plans on the basic information, it would not alleviate the need for duplicative systems and processes and would be much less valuable. Ease of use will be essential to ensuring the broad adoption necessary to creating a useful NDH. **We recommend CMS work with stakeholders, including the public-private partnership that would provide oversight to the NDH, to facilitate a positive user experience for the NDH.** Data entry should be easy and frictionless. The design of the NDH should also consider the needs of providers who may be less technologically advanced or have fewer resources (e.g., may not have an EHR system or staff that can manage data entry).

As noted above, in addition to the design of any user interface, there are several technical strategies that could be developed to improve the user experience such as allowing the NDH to interact and interoperate with systems providers already use that may have important information such as EHRs and practice management systems. For example, the NDH could leverage EHR information to understand which providers are part of a group and what locations a provider sees patients at and scheduling systems to better understand which days a provider may be at a certain location.

CMS could also leverage technical standards to improve user experience. Allowing for bulk uploads and downloads would facilitate the transfer of information for all stakeholders. Large groups could more easily share updates about multiple providers while payers could download information for multiple providers in their networks. **CMS should work with HL7 to update the IGs to define a bulk data exchange.**

Summary Recommendations:

- Support the creation of a validated, verified national directory with federated or distributed access.
- Explore how to leverage the work of FAST as a basis for the NDH.
- Explore the use of the relevant DaVinci implementation guides.
- Build the NDH to allow the system to grow and adapt to future technologies. This could allow the NDH to collect additional data and support novel use cases.
- Work with ONC to explore how the ONC Health Information Technology Certification Program could support interactions between the NDH and other HIT products such as EHRs and practice management systems.
- Work with a public-private partnership to ensure ease of use for the NDH and a positive user experience.

VIII. Phased Approach to Implementation

CMS states that the primary goal of an NDH would be to serve as a "centralized data hub" for accurate directory information in the healthcare market. To achieve that goal, CMS is seeking comments on a potential phased approach to establishing an NDH, in alignment with IT industry best practices. CMS would assess the agency's statutory authorities to establish an NDH and take appropriate action. The initial phases of implementation would focus on consolidating and verifying existing data, building trust, and gaining industry buy-in. Subsequent phases would build on that foundation by incorporating additional data elements, listed entity types, and functionality while maintaining trust in the integrity of the system and data. CMS believes this phased approach would allow CMS to gather consumer and industry input while focusing on scalability, data validity and governance, ethics, and equity for needed agency action or NDH development.

AHIP supports a phased approach to establishing an NDH. Creating and implementing an NDH will require cooperation and input from numerous stakeholders. Moreover, an NDH will only be successful if it is adopted broadly. If the NDH does not meet the need of both payers and providers or does not have the flexibility to avoid one-off asks for information, it will not achieve its desired purpose.

To ensure the system meets stakeholder needs, AHIP recommends the creation of a public-private partnership to oversee the development and maintenance of the NDH. This partnership should be multistakeholder in nature to ensure feedback from a range of parities, while focusing on the core needs of the key stakeholders responsible for maintaining directory information: payers, providers, approved vendors, and government representatives. To build trust and avoid conflicts of interest, the NDH and any solutions to develop and implement it should be vendor agnostic.

We recommend CMS focus the first phase of implementation of the NDH on a use case addressing provider contact and demographic information. As a starting point, CMS could begin with a system to collect and share information on both payer and provider digital endpoints to support implementation of the CMS Interoperability rules and advanced explanations of benefits (AEOBs), then expand to a broader set of provider contact and demographic

information. This would allow CMS to build and test the system with a new set of data to obtain proof of concept.

Once tested with digital endpoints, the NDH could expand to include all the information that is necessary for compliance for federal provider directory requirements across product line (e.g., Medicare, commercial, Medicaid). Such an approach would minimize the frequency with which a provider would need to change or validate information and efficiently share the information across payers in an automated fashion, allowing the NDH to quickly begin to reduce the burden of creating and maintaining provider directories. Additional phases could bring in a large scope of stakeholders, such as a broader definition of providers, as well as support additional use cases such as licensing and credentialing.

As noted above, **we urge CMS to ensure that the NDH is designed with user experience mind.** The ability for providers to enter information needs to very easy. Providers will be more likely to update data if it is easy to do so and the experience is frictionless. As noted above, bulk uploads and interoperability with could be technological solutions to ensuring ease of use. Similarly, allowing payers and providers to work with approved vendors could allow for easier implementation of the NDH. Stakeholder input, including guidance from the overseeing public-private partnership, could provide iterative feedback into the design and implementation of the NDH to facilitate broad uptake.

Summary Recommendations:

- Use a phased approach to implementation of the NDH. The first phase of implementation of the NDH should focus on a use case addressing provider contact and demographic information.
- Create a public-private partnership to oversee the development and maintenance of the NDH.

IX. Risks, Challenges, and Prerequisites

CMS notes challenges associated with establishing an NDH include, but are not limited to, project planning and scoping, stakeholder and collaborator engagement, development risks, use of existing identifiers (for example, NPI or TIN), data publication, system maintenance, and stakeholder adoption.

As CMS considers the creation of an NDH, there are numerous issues to take into account. Ease of use will be key to implementation and avoiding the inadvertent creation of additional burden will be key to adoption**.** CMS should also consider the impact of COVID-19 on provider strain in exacerbating existing challenges with low provider response rates to directory update requests. While challenges with provider directory accuracy and timely updates existed prior to the COVID-19 pandemic, health care providers face increased demand at the same time as ongoing staff shortages, burnout, turnover, and other extreme challenges due to the ongoing public health emergency. These factors have made provider response rates and compliance with new provider directory requirements very challenging. While in the long-term, the NDH may reduce burden, implementation should be balanced with other solutions to reduce the short-term burden of a new solution. **CMS should continue to examine ways to minimize the administrative burden of**

provider directory requirements on providers and plans, such as an interoperable infrastructure, that will encourage efficient and correct information while also leveraging resources like vendors and data science in addition to traditional methods like phone, fax, and email.

Another potential issue is variation between federal policies governing provider directories, as well as variation between federal and state policies. Moreover, accreditation bodies such as the National Committee for Quality Assurance maintain requirements for provider directories. **CMS should work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines to ensure the NDH meets all relevant requirements or has the capability to allow organizations to collect additional data points that may be required to meet State requirements or business needs.**

CMS should also consider ways to align the NDH with state policies to minimize redundancy and burden. CMS should begin its effort by creating an asset map of what information is already available and how it is being collected to ensure it is leveraging best practices. Additionally, **the NDH and any state provider directories should be interoperable.**

Summary Recommendations:

- Examine ways to minimize the administrative burden of provider directory requirements on providers and payers.
- Work with federal, state, and private sector stakeholders to resolve the discrepancies in required data and timeline updates for different product lines.
- Work with States to ensure the NDH and any state provider directories are interoperable.

X. Conclusion

AHIP appreciates CMS exploring solutions to improve the accuracy of provider directories while reducing burden for all stakeholders. CMS should create an NDH using a federated model overseen by a public-private partnership to ensure the system meets the needs of both the public and private sectors. As a starting point, the NDH could collect and share the digital endpoint information necessary to implement the CMS Interoperability Rules, the ONC Information Blocking Rule, and the requirements of No Surprises Act. Once proof of concept is established, CMS could expand the NDH to collect the contact and demographic information payers are required to collect to meet current directory requirements. The NDH could then expand to support additional use cases.

CMS should also ensure there are incentives to use the NDH. CMS should streamline current directory requirements to ensure the NDH will allow payers to meet regulatory obligations and provide a safe harbor for payers using information from the NDH that is found to be incorrect. CMS should work with states to ensure they also offer similar protections. CMS should also implement concordant requirements on healthcare providers to ensure they update the NDH regularly.

The work of FAST provides a valuable starting point for building the infrastructure for the NDH. CMS should leverage this work while exploring how new technologies such as blockchain could allow for the collection of additional data while maintaining privacy.

AHIP agrees with a phased implementation of the NDH. The table below outlines our vision for how the NDH could be developed and implemented:

Table A: AHIP Framework for NDH Phasing

Phase	Entities	Data Collected
One	Payers, Providers currently included in payer directories or with whom payers contract	Contact information, information on services offered, demographic information (e.g., name, race/ethnicity, location, etc.)
Two	Payers, providers as defined by the Information Sharing Rules	Payer and provider digital endpoints
Three	Other organizations on a voluntary basis	Additional use cases such as credentials and licensing information