

December 6, 2022

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

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

Dear Administrator Brooks-LaSure:

On behalf of our 162,000 members, the American Dental Association (ADA) is pleased to provide comments on the request for information (RFI) on a National Directory of Healthcare Providers & Services (NDH). These comments focus on the Interactions With Current CMS Data Systems and Impacts to Business Processes, as well as Phased Approach to Implementation.

The ADA believes in the importance of timely and accurate updating of provider directories as this has the potential to reduce confusion for beneficiaries and let them know where they can access dental care. We stand ready to work with CMS on the development of a national provider directory, and offer the below comments for consideration by CMS.

Interactions With Current CMS Data Systems and Impacts to Business Processes

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

We note that the statutory definition of physician under section 1861(r) of the Act is clear in its inclusion of a doctor of dental surgery or of dental medicine as a "physician". To conform to this definition we support including dentists in the NDH. Some dentists already participate in Medicaid and Medicare including Medicare Advantage plans, and should be included in any national directory.

As noted in the RFI background, the CMS Interoperability and Patient Access final rule required that Medicare Advantage organizations, Medicaid and Children's Health Insurance Program (CHIP) Fee For Service programs, Medicaid managed care plans, and CHIP managed care entities "make standardized information about their provider networks available through a Provider Directory API that is conformant with technical standards finalized by ONC." These directories include dentists, and we urge CMS to work with organizations and states where dentists are already included in provider directories to both avoid duplication and implement best practices for a potential NDH.

Beyond using FHIR APIs, what strategic approaches should be taken to ensure that directory data are interoperable?

The ADA strongly supports the efforts of the Department of Health and Human Services to integrate Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interfaces (APIs) into a national directory of healthcare providers and services.

FHIR APIs could be leveraged to make NDH information accessible directly in the provider's workflow via the practice management system/electronic health record (PMS/EHR). However, dental practice management and record systems have limited adoption of FHIR. Instead, the dental practice management and record system industry has experienced rapid development of proprietary APIs to meet data access and exchange

requirements. The ADA continues to work with several HL7 workgroups on developing the dental content in various FHIR standards including the CARIN EOB. We would support incentives and significant investment in dental-specific FHIR-based pilots and technology to move the dental industry towards FHIR-based APIs that could be used to make the directory data interoperable.

How should CMS work with states to align federal and state policies to allow all parties to effectively use an NDH?

States directly license dentists, physicians, and other healthcare providers, and many aspects of health and dental insurance are regulated at the state level. Therefore, many states have developed policies about the collection of demographic information from providers for the purpose of regulating certain procedures (such as the prescription of opioids in prescription monitoring programs), or to ensure that state-regulated insurance products maintain adequate, accessible, and accurate provider networks. However, many states protect information collected in directories used for the regulation of medical and dental practice, and insurance directories belong to private entities. CMS should work with states to understand their experience of regulating insurance network directories for accuracy, particularly states that require insurance companies to maintain these provider directories. CMS should also use national, state, and local dental and medical associations with experience navigating the state and federal regulation of provider information as resources to get a better understanding of the national landscape.

Further, many state Medicaid programs as well as commercial entities that manage Medicaid and CHIP programs already have the data infrastructure to collect provider data. In addition, commercial entities that manage networks for both private plans and Medicare Advantage plans have established data systems to collect provider data. For example, the ADA encourages dentists to participate in the Council for Affordable Quality Healthcare (CAQH) ProView system to help centralize provider data collection and reduce provider burden for initiatives that require the provider data. Over 96,000 dentists use this system. The ADA strongly encourages CMS to understand the existing data infrastructure and use APIs to integrate rather than creating a brand-new system.

What specific strategies, technical solutions, or policies could CMS implement to facilitate timely and accurate directory data updates? How could consistent and accurate NDH data submission be incentivized within the healthcare industry?

While there have been some shifts in the composition of practice ownership in the dental industry, small practices constitute a large group of dental businesses. CMS should minimize the burden on these small offices by providing them with financial incentives to share data with the NDH and update that data as needed.

It is also critical that dentists not be penalized for errors in the directory that are beyond their control or the fault of another party. As CMS notes in the introduction to the RFI, inaccuracy in provider directories is driven by a number of factors, among which are the different requirements for information included in different directories. Demographic information included in a directory may differ depending on the purpose of the directory, what entity is storing it, diligence in auditing directories, and resources available to solicit and audit information in directories. Furthermore, all data should have an identifying source so that providers can seek remediation in circumstances where data is incorrect. It will be important for the providers or delegated reporting agency to be the primary source of information submitted. Submitted data then can be verified by collaborating organizations such as insurance plans. The NDH should allow for the review/correction of information by data field as opposed to resubmission of all requested information.

We would encourage CMS to consider a collaborative review process that would identify a coreset of minimally viable data elements and focus on piloting data updates in varying intervals before implementing system wide. Any attested or verified data which exceeds this coreset could then be considered for an incentive program. Updates to data should be expected on a predictable schedule unless a pre-identified qualifying event (practice location transition, loss of license, etc.) should occur. The ADA would be glad to work with CMS on identifying specific instances that would trigger a qualifying event submission for dental providers.

Phased Approach to Implementation

What entities or stakeholders should participate in the development of an NDH, and what involvement should they have?

National, state, and local healthcare provider groups like the ADA and state and local dental societies should be consulted by CMS on the development of the NDH. These groups can advise CMS on how to address uptake of the NDH among the providers they represent, as well as what elements healthcare providers and their

patients may like to see in an NDH. Organized dentistry and organized medicine can also amplify CMS communications about the NDH.

Additionally, the ADA would advocate that CMS continue to work closely with CAQH, a nonprofit alliance of health plans and trade associations that specializes in healthcare technology solutions with nearly two decades of experience. CAQH brings an in-depth understanding of the specific provider directory requirements and constraints at the federal level and state level, the current technical landscape of APIs, and the coming impact of new technology like FHIR.

What stakeholders could have valuable feedback in the scoping and early implementation processes to ensure viability of an NDH and sufficient uptake across the healthcare industry?

Stakeholders that may have the most valuable feedback for CMS on the scoping and early implementation of the NDH, as well as those that could best help with sufficient uptake, include organized membership organizations like the ADA. The ADA and other healthcare provider groups have frequent contact with their members, who can provide the experience and expertise needed by CMS as they develop, implement, and scope the NDH. Outreach from groups like the ADA to its members can also facilitate uptake across the dental profession and industry, or whatever profession and industry a group represents. Organized healthcare membership organizations also frequently have experience with maintaining their own databases of member healthcare providers that may be useful to CMS.

Healthcare technology entities, such as CAQH, can also provide CMS with valuable feedback in the scoping and early implementation processes to ensure viability of an NDH. Examples of topics that they can speak to include how to best define what would be included in an NDH, the limitations of the National Plan and Provider Enumeration System (NPPES) database as a source of reliable data as a starting point (as outlined in the RFI), and how to address the underlying issue around churn and unreliable data.

What issues should CMS anticipate throughout an NDH system development life cycle?

Maintaining reliable data in the NDH is the biggest hurdle to developing and implementing an effective NDH. Experience with NPPES shows that directories that are held harmless for incorrect data in the directory will not be able to solve the problem of ensuring reliable data. On the other hand, CMS may find it necessary to commit significant resources to maintaining the data in the NDH to ensure reliability, since demographic data is constantly churning.

Additionally, the NDH as conceived in the RFI may differ in purpose and usage from the perceptions of consumers. Data elements required for public or population health usage, which is a focus of the RFI, go beyond the requirements of consumers who use directories to find information about healthcare providers that is current and accurate. In order to make the NDH more useful to consumers, CMS may want to consider tailoring the elements to the concerns of consumers.

Thank you again for the opportunity to comment on this RFI. The ADA looks forward to working with CMS on the development of the NDH. Should you have any questions, please do not hesitate to contact Ms. Roxanne Yaghoubi at yaghoubir@ada.org.

Sincerely,

George R. Shepley, D.D.S.
President

Raymond A. Cohlmiya, D.D.S.
Executive Director

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