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November 18, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) Request for Information; National Directory of Healthcare Providers & Services, as published in the October 7, 2022 Federal Register (CMS-0058-NC).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. The AHIMA mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

The following are our responses to selected requests for information.

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

C. Comment Solicitation

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

AHIMA continues to support the development and implementation of FHIR as a potential solution to health and healthcare data exchange related issues. While FHIR continues to be one piece of the interoperability puzzle, it is important for CMS and other federal government agencies to ensure multiple different technologies and technical standards are being cultivated and pursued to solve data exchange and interoperability issues. By ensuring multiple technological solutions and standards are pursued, HHS and CMS will safeguard that the success or failure of an initiative is not solely dependent

on the ability for one technology and/or standard to be developed and achieve near universal implementation.

As CMS pursues an NDH and looks for solutions to achieve those goals, it is important to remember that FHIR is not universally used and there are providers who did not receive EHR incentive program funds and lack certified EHR technology. By pursuing a FHIR only solution to implement the NDH program, CMS could limit those who are able to take advantage of the NDH to only those providers who possess certified health IT systems. This in turn, could have continuity of care implications for individuals in communities whose providers lack access to certified health IT systems.

Despite the challenges FHIR presents, integrating all provider digital end point data into one system does present several benefits as it reduces the administration burden required to ensure data is kept in multiple CMS and federal government systems. AHIMA supports all efforts from CMS to simplify the regulatory space to allow providers an easier pathway to exchange data and locate their respective provider digital endpoints. Making one seamless API, as opposed to multiple systems, gives providers and developers the ability to pursue one technology solution to attain relief from both the cost and time compliance burdens.

The data elements contained on and within the APIs, and that are accessible by the providers who utilize the discussed NDH API, should be included in a forthcoming proposed rule that outlines API requirements in detail. Clearly defining the data that should be included in the APIs allows providers and technology developers to have a clear set of requirements to build towards. CMS should also survey those utilizing the existing CMS systems to discover digital end points to determine which data they find valuable, what data is missing, and what data contained within the systems are duplicative. By doing so, CMS will have a clear understanding of the NDH data requirements.

Are there other CMS, HHS, or federal systems with which an NDH could or should interface to exchange directory data?

It is important for the NDH to interface with all other systems within the federal government sphere of influence that involves the exchange and use of patient health data. For instance, the VA and DoD medical systems utilize EHRs for the exchange and use of patient health data. It is important for providers who may provide care to patients either coming from or moving to a VA or DoD facility to be able to locate DoD and VA provider endpoints to request and send that patient's health data. Additionally, other federal government managed providers that are not already participating in the NDH should be required to place their digital endpoints in the system.

CMS should also ensure it is collaborating with ONC and the Sequoia Project, acting in their role as the Recognized Coordinating Entity (RCE) of the Trusted Exchange Framework and Common Agreement (TEFCA). The case for the TEFCA can be made stronger and can serve as a potential solution for the NDH, as it is expected to be a widely used solution for enabling health data exchange. By allowing the NDH to interface with the TEFCA, providers and patients who utilize the network could better locate where patient data is being stored and contact those parties to send and receive consent to exchange that data.

Are there systems at the state or local level that would be beneficial for an NDH to interact with, such as those for licensing, credentialing, Medicaid provider enrollment, emergency response or public health?

Public health authorities continue to struggle with state-to-state data exchange and with data exchange that lacks specificity. Fully understanding the scope of the data exchange problems at the state level that an NDH may be able to rectify requires further investigation by CMS. The COVID-19 pandemic demonstrated that state public health agencies struggle to exchange public health data – such as vaccination information – throughout the health system. Those struggles may include difficulties in matching patients, or problems querying up-to-date patient information. By undertaking a full survey of state public health needs related to data exchange and provider digital end point identification, CMS can understand how the NDH can help close data exchange gaps in states nationwide.

Are there beneficial ways an NDH could interface with a list of health information networks that have adopted the common agreement and are capable of trusted exchange pursuant to the common agreement or provide additional information that may be useful, such as directory service?

As stated above, AHIMA recommends CMS work with both ONC and the Sequoia Project, acting as the RCE, to determine opportunities for the NDH to either enhance or participate in the common agreement. The TEFCA, and its constituent members, networks, and services, provides a unique and powerful opportunity for the healthcare continuum to be better connected. An NDH providing location services to provider organizations is one way it can be useful to the TEFCA as it looks to connect providers. It is important for CMS to engage ONC and the Sequoia Project in these conversations to fully understand the scope and capability of an NDH and TEFCA partnership.

What listed entities, data elements, or NDH functionalities would help underserved populations receive healthcare services?

Providing an easy way for patients to locate and access community-based services is one of the main ways an NDH can help close equity gaps. Additionally, any information an NDH can provide to patients on the types of community services a provider interfaces with will be important. As it stands today, the underserved population is unable to access information on accessibility to a provider organization, but there is also no clear information available to patients on whether their provider interfaces with community-based services and what those services are that are available to them in their area. If the NDH were able to fully catalogue and make available the community-based services and how providers – as well as patients – can locate those and connect with them, it would allow the health system to fully utilize the social determinants of health data (SDOH) it may have been collecting and direct patients to the care services that they need.

How could NDH use within the healthcare industry be incentivized? How could CMS incentivize other organizations, such as payers, health systems, and public health entities to engage in the NDH?

CMS currently possesses multiple mechanisms to incentivize the use of an NDH within the healthcare regulatory continuum. AHIMA continues to advocate for CMS to pursue pathways that prioritize administrative and regulatory simplification, and this includes making new technology innovations required. CMS should continue to pursue pathways that prioritize making it easier for providers to understand and comply with the complex yearly payment rulemakings, such as the Inpatient Prospective Payment System (IPPS) and Physician Fee Schedule (PFS) rules. If CMS wanted to incentivize the use of the NDH, those two rulemakings would serve as two pathways with the least number of new requirements for providers. AHIMA participates in the comment process for those two rules – as well as other payment rules when relevant – and urges CMS to include the NDH in the Promoting Interoperability Program as a voluntary measure if the agency is looking to incentivize NDH usage. One

limitation to this pathway, however, is that not all provider types are included in the Promoting Interoperability Program.

As it relates to other groups such as payers and public health entities, AHIMA urges CMS to survey and seek input from those organizations on where and how it could best incentivize NDH usage. This will allow CMS to better understand those organization's needs and how CMS can assist them with other incentive-based activities.

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

A centralized source of information for digital contact information will benefit the whole healthcare continuum as it allows providers working on behalf of patients to more easily locate, request, and receive health data. At this time, the current CMS systems used to locate a provider's information on how to request data for exchange remains incomplete or out of date. This causes providers to struggle to find where to request a patient's data with regularity. Having one true source for this information allows providers to know where to request patient data in an easy to use and reliable way. An NDH has the potential to expand interoperability nationwide by removing roadblocks limiting providers from exchanging information.

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, suppliers, pharmacies, public health entities, community organizations, nursing facilities, suppliers of durable medical equipment or health information networks?

AHIMA supports making a potential NDH as accessible as possible to as many provider types as have an interest in participating in digital endpoint access. As stated above however, it is crucial for CMS to remember that not all provider types were given incentives to purchase certified health IT products with technology or API connections that would make their participation in an NDH as seamless as those currently involved in CMS programs, such as providers subject to the Promoting Interoperability Program. If CMS were to expand the types of entities able to participate in an NDH enabled through FHIR APIs, they must ensure that positive incentives are in place to encourage those entities to participate in the NDH. Without certified products, participation in the NDH will be difficult if not impossible for entities. It is crucial for CMS to survey the needs of these entities prior to mandating their participation in an NDH.

Are there NDH use cases to address social drivers and/or determinants of health?

An NDH could address some social drivers and/or determinants of health, specifically as it relates to access to telehealth services, ability to identify connected community services, and understanding what equity related services or social determinants of health services are available from a provider. For instance, a patient looking for a specialist that is available for tele-visits due to their proximity to care, could use an NDH to locate such a specialist provider. It is important for CMS to work with health equity focused organizations and patient advocacy groups to understand gaps in available data and patient needs. Without grasping the scope of the problem, it may be difficult for CMS to fully understand the issue and potential solutions. Working with those groups will help CMS understand the needs of patients and the challenges presented to providers.

What provider or entity data elements would be helpful to include in an NDH for use cases relating to patient access and consumer choice (for example, finding providers or comparing networks)

It is important for CMS to ensure the NDH comprises full details of services offered by a provider along with care modalities available to patients and how best to access their health data to initiate patient directed data transfer. Ensuring that provider health information network (HIN) participation information is included, as well as any ePrior Authorization information, allows patients the increased ability to control their data and find realistic up front cost comparisons when shopping for their care. Providing clear overviews of virtual care options, and ensuring those are present in an NDH, will also help patients who may be unable to attend a medical visit in person or understand if they can still access care. Crucially any identification or contact information that a patient can use to direct provider-to-provider exchange must be included at a minimum in the publicly available portion of the NDH.

What provider entity data elements would be helpful to include in an NDH for use cases relating to care coordination and essential business transactions?

The examples provided by CMS in the RFI of prior authorization requests and responses, referrals, and public health reporting are several of the needed care coordination use cases that an NDH can provide. Other NDH information that should be included to enable patient care involves information related to the HINs the provider participates in and information on EHR data exchange capabilities. Care coordination also requires patients and other providers to understand the standards language that is being used to code and exchange a patient's health data. By knowing the EHR system and HIN a provider belongs to, other providers can quickly and easily identify how best to exchange patient data.

Would there be benefits to including public health entities in an NDH?

As stated above, there are several use cases for including public health in a potential NDH. Prior to mandating inclusion of public health entities, it is crucial for CMS to understand the needs of public health and how those needs can be addressed in a potential NDH.

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

AHIMA urges CMS to work with both private and public payer communities to understand how they currently facilitate patient transitions of care between coverage modalities. Private and public payers will be able to provide CMS with further understanding of the challenges that are presented by patients who change coverage modalities and help CMS implement features into the NDH to help overcome those challenges. CMS should also work with State Medicaid Agencies to ensure those challenges are captured.

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

An NDH has the potential to limit privacy breaches and insecure data transfer by giving health data exchange entities verified connection points and known true data exchange addresses. Additionally, an NDH can help limit privacy breaches and improper data handling by labeling known bad actors who misuse patient data or utilize non-verified digital end points to help providers discuss with patients

where it is and isn't safe to exchange their health data. While providers under information blocking are not able to stop or prevent patients from exchanging data with certain entities, arming providers with as much information as possible can ensure patients make informed decisions related to exchanging their data.

In order for the NDH to be successful in this goal of preventing fraud, waste, abuse, improper payments, and privacy breaches, CMS must undertake extensive efforts to audit and ensure information in the NDH is current and accurate. Previous attempts by HHS to create directories similar to the NDH have been laudable, but ultimately fell short of their intended goals due to incomplete or incorrect information. If CMS were to pursue requirements for an NDH it is crucial they account for the need for the NDH to remain complete, accurate, and up to date to remain useful. Providers will be unable to rely on and potentially will not utilize an NDH if they are not able to trust the data that is within the NDH itself. Similarly, inaccurate information increases the likelihood of information being sent to the wrong provider, jeopardizing patient privacy and allowing for bad actors to infiltrate the NDH for purposes of perpetrating fraud or participating in waste and abuse activities.

What types of entities should be encouraged to use data from an NDH?

All entities involved in interoperable health data exchange should be encouraged to use data from an NDH. By ensuring all exchange entities are utilizing an NDH, the landscape for data exchange can be made more seamless and secure. An NDH will also help lower the number of inadvertent data disclosures when patient data is directed and sent to the wrong or incorrect entity or endpoint. CMS must ensure it has talked to all impacted parties prior to mandating or encouraging any NDH use to ensure as many provider types as possible may participate.

What concerns might listed entities have about submitting data to an NDH?

Some providers may have concerns about contact information being listed publicly in the NDH, especially in cases where providers are working with patients suffering from behavioral health, mental health, or sensitive healthcare issues. As CMS continues to explore utilizing an NDH, it should ensure that no patient can identify an individual provider and ultimately physically locate them in cases where a patient was intending to do harm. Instead, all information should be maintained at an organizational level within the NDH.

Are there entities that currently exist that would be helpful to serve as intermediaries for bulk data verification and upload or submitting to an NDH?

As previously stated, AHIMA encourages CMS to work with ONC and the Sequoia Project to explore opportunities for the TEFCA to either participate as part of the NDH or manage some NDH activities. There are multiple use cases in which the TEFCA could handle verification or transmission of NDH data to providers participating and other services connecting to the TEFCA.

Use cases for providers accessing the NDH through their EHR and patients through a third-party app.

Providers and patients both will benefit from being able to access an NDH through their respective technology tools. Both outcomes are similar as EHR and patient app access to an NDH will allow providers and patients to better understand the cost of care and services available to treat certain

patient specific conditions in advance. Additionally, accessing an NDH regularly will help patients remain aware of the changing care landscape available to them both in person and virtually.

What security standards should be used to support an NDH?

AHIMA urges CMS to use widely recognized security standards and to require the developer of APIs that enable NDH access to utilize those widely recognized security standards and frameworks. Those providing access to an NDH API should be held to the same security standards, if not stricter ones, as those HIPAA providers and technology developers subject to ONC technology and EHR certification standards. Ensuring the healthcare continuum is speaking the same security language helps simplify the security threat protection landscape and allows the healthcare system to be nimbler in its responses to security threats.

AHIMA and its membership remain committed to developing and implementing standards based FHIR APIs and exchanging new data to help patients better engage with and understand their care. At this time, we continue to recommend federal agencies fully survey impacted parties prior to implementing new requirements to ensure alignment with other federal and state requirements. Fully engaging with the health IT community ahead of proposing new regulations also ensures the healthcare community is prepared when those new requirements are proposed. If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please contact Andrew Tomlinson, Director of Regulatory Affairs, at 443-676-7106 or andrew.tomlinson@ahima.org.

Sincerely,

A handwritten signature in cursive script that reads "Wylecia Wiggs Harris".

Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer