Sound Policy. Quality Care.

December 6, 2022

Ms. Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-0058-NC
P.O. Box 8013
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

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

Dear Administrator Brooks-LaSure,

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians across 15 specialty and subspecialty societies. The Alliance is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write in response to CMS's 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 and digital contact information nationwide.

CMS clarifies in this RFI that integrating an NDH with current CMS-maintained systems, such as the National Plan and Provider Enumeration System (NPPES), the Provider Enrollment, Chain, and Ownership System (PECOS), and Care Compare, could streamline data collection by acting as the single entry-point for listed entities to update their data across multiple CMS systems. However, CMS is not specifically requesting comment on replacing any of these or other CMS systems with an NDH. Rather, it believes that an NDH could be a tool that would feed data to these other systems to use within their intended functions, thereby creating efficiencies and minimizing inaccuracies.

Our comments below focus on specific questions included in this RFI. We highlight two areas that we believe could benefit from the adoption of a centralized provider directory, which are: 1) identifying and tracking physicians' specialty and payer contracts; and 2) prior authorization processes.

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

The Alliance has long voiced concern about payers, particularly Medicare Advantage and Health Insurance Exchange plans, that fail to maintain an adequate network of specialty and subspecialty physicians. In addition, our member societies have found the accuracy of health plan directory information, including the specialty of providers and the insurance accepted, to be an ongoing issue. We believe that an NDH could help improve directory accuracy and network transparency, which could ultimately improve network accuracy. As such, we believe it is imperative for CMS to include "clinician specialty," and "subspecialty" where applicable, as foundational data elements included in the NDH. To

accurately capture these data points, we recommend that CMS develop a drop-down list that includes the full healthcare provider taxonomy code set, developed by the National Uniform Claim Committee (NUCC), which reflects subspecialties and is already in use by CMS as part of the NPPES.

What specific health information exchange or use cases would be important for an NDH to support?

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

The Alliance believes that it is critical that an NDH support more streamlined prior authorization processes. Utilization management protocols, including prior authorization, create more angst and frustration for specialty physicians and their patients than any other administrative task associated with the practice of medicine. For prior authorization, in particular, the process for obtaining approval is lengthy and typically requires physicians or their staff to spend the equivalent of two or more days each week negotiating with insurance companies — time that would better be spent taking care of patients. These payor-driven cost-control tactics are a primary cause of significant delays in patient access to medically necessary items and services (e.g., diagnostic tests, procedures and medication therapies), diverting clinical staff away from patient care activities and creating multiple inefficiencies that result in increased costs (e.g., prior authorization requirements for items and services that are eventually routinely approved). The Alliance conducted a survey of more than 1,000 specialty physicians, which found the following:

- Nearly 90% of responding physicians have delayed or avoided prescribing a treatment due to the prior authorization process;
- 95% report that this increased administrative burden has influenced their ability to practice medicine;
- 82% state that prior authorization delays access to necessary care, with 37% reporting "always" and 45% reporting "often";
- Prior authorization causes patients to abandon treatment altogether, with 32% reporting that patients often abandon treatment and 50% reporting that patients sometimes abandon treatment;
- Nearly two-thirds of responding physicians report having staff who work exclusively on prior authorizations, with one-half estimating that staff spend 10-20 hours/week dedicated to fulfilling prior authorization requests and another 13% spending 21-40 hours/week; and
- Ultimately, the majority of services are approved (71%), with one-third of physicians getting approved 90% or more of the time.

The Alliance supports the *Improving Seniors Timely Access to Care Act* (H.R. 3173/S. 3018), which would:

- Establish an electronic prior authorization process that would streamline approvals and denials;
- Establish national standards for clinical documents that would reduce administrative burdens health care providers and Medicare Advantage plans;
- Create a process for real-time decisions for certain items and services that are routinely approved;
- Increase transparency that would improve communication channels and utilization between Medicare Advantage plans, health care providers, and patients;
- Ensure appropriate care by encouraging Medicare Advantage plans to adopt policies that adhere to evidence-based guidelines; and
- Require beneficiary protections that would ensure the electronic prior authorization serves seniors first.

We believe that an NDH could help to ensure that these goals become a reality by reinforcing the following processes[1]:

- Incorporating accurate formulary data and prior authorization requirements into electronic health records (EHRs) so that providers have requisite information at the point of care;
- Communicating utilization review decisions to providers in a more timely manner;
- Supporting utilization review entities in making statistics regarding prior authorization decisions available to the public in a readily accessible format, which can be used to improve efficiency and timely access to clinically appropriate care;

Through its recently established Office of Burden Reduction and Health Informatics and its MA and Part D rulemaking activities, CMS has gathered information on utilization management issues. Most recently, CMS's Center for Program Integrity held a Virtual Focus Group to hear from stakeholders as the agency works to "improve its processes and eliminate unnecessary requirements for medical review and prior authorization." We urge CMS's Health Informatics and Interoperability Group and others working on this NDH to coordinate with these other offices to ensure alignment of goals and targeted solutions.

Improving utilization management processes, including through the widespread adoption of electronic prior authorization processes, should be a top priority of both CMS and the Office of the National Coordinator (ONC) for Health Information Technology (HIT) and should apply to all federally authorized plans, including MA plans. We believe that an NDR would help to ensure the electronic exchange of more standardized data and would represent one more valuable step towards achieving a more streamlined system.

What issues should CMS anticipate throughout an NDH system development life cycle, including development, implementation, operations and maintenance? For example, CMS asks about a phased roll out, timelines, and obtaining buy-in.

If CMS ultimately moves forward with this project, the Alliance urges it to adhere to a phased approach in alignment with information technology (IT) industry best practices. We appreciate CMS's vision of starting with an initial implementation phase that would focus on consolidating and verifying existing data, building trust, and gaining industry buy-in, before moving on to incorporating additional data elements, listed entity types, and functionality. The Alliance agrees with CMS that this gradual approach will help to maintain trust in the integrity of the system and data.

CMS notes that a core requirement of an NDH would be the capability to validate and verify submitted information. For example, a digital endpoint could be verified by sending a secure message to that endpoint asking the provider to complete verification through some action. While we recognize the need for validation and support efforts to ensure the accuracy of the data, these processes will take dedicated time. The burden associated with data validation should be limited and should be monitored over time for impact.

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In conclusion, the Alliance supports CMS's goal of making available to the public more accurate and up-to-date directory information about providers in an easier to use format than is available today, which

[1] Note that these processes are reflected in the American Medical Association (AMA) Prior Authorization and Utilization Management Reform Principles. The Alliance strongly supports the 21 principles across five domains discussed in this report, which are essential to any prior authorization program.

could help patients find providers; facilitate interoperable provider data exchange, care coordination, and public health reporting; and help payers improve the accuracy of their own directories.

We appreciate the opportunity to provide feedback on this issue and look forward to continuing to work with CMS as this concept is fleshed out. Should you have any questions or wish to schedule a meeting, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society