



December 6, 2022

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

Submitted electronically

Thank you for the opportunity to provide input on the idea of establishing a single National Directory of Health Care Providers and Services (NDH) that could serve as a “centralized data hub” for healthcare provider, facility and entity directory information nationwide. LeadingAge has previously expressed its support for such an effort to help reduce the administrative burden that our aging service providers incur related to the number of places they must report or update organizational data.

The mission of LeadingAge is to be the trusted voice for aging. We represent more than 5,000 nonprofit aging services providers and other mission-minded organizations that touch millions of lives every day. Alongside our members and 38 state partners, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging and disability services. We bring together the most inventive minds to lead and innovate solutions that support older adults wherever they call home.

Our comments reflect the perspective of providers of post-acute care, long-term services and supports, and home and community-based services who contract with Medicare Advantage and Special Needs Plans to provide services. In addition, we also have providers who lead the operations of their own Medicare Advantage plans, Special Needs Plans (SNP) and PACE programs.

As noted above, LeadingAge supports the establishment of an NDH to centralize data, reduce administrative burden and ensure accuracy and consistency of the available provider data across platforms. It appears the original intent of the RFI was to establish the NDH for physicians, but we would stress that the need is just as great for providers of post-acute care services, long-term care supports and services, home health agencies, and home and community-based services. Just like physicians, our aging services providers spend considerable time submitting the same data to CMS through multiple

systems as well as to multiple managed care plans in Medicare and Medicaid. This is not a good use of time or resources. When there is an administrator change or key contact change, hours must be spent updating numerous systems and it is not always clear which systems must be updated.

Aging service providers submit core organizational, licensure, certification, quality and other data into multiple systems (e.g., CMS payment, PECOS, CDCs- NHSN, MDS, HRSA Provider Relief Reports, Federal Government grant applications to FEMA. In addition, documentation of this information must also be copied and shared) with multiple managed care plans at least annually. Therefore, we would like to see CMS include these providers in a future NDH. With limited financial resources, these providers would also benefit from not needing to pay a private entity for this service.

Reducing administrative burden of data reporting and maintenance

An NDH that includes aging service providers could drastically reduce administrative burden, streamline processes and reduce the cost of resources to keep up with all the data requirements from the federal and state governments as well as Medicare and Medicaid managed care organizations (MCOs). It should be noted that providers are often paid less than Medicare Fee-For Service (FFS) by the MCOS but have more administrative costs to comply with these MCO contracts. Providers have gone from a single Medicare claim submission form, minimal prior authorization requirements, one auditor (their MAC) in FFS to needing to navigate multiple contracts each who have their own claims forms, online entry, credentialing process, audit approach, appeals and grievances, etc. Some plans like the data/information faxed, others emailed, and others submitted via a plan-specific portal. A single portal or NDH would allow all documents to be uploaded or accessed through a single platform by plans and providers eliminating the need to repeatedly upload “missing” documentation. As to the provider burden, one home health agency reports they hired a full-time person just to submit the eligibility and benefit checks for the MA plans. A Skilled Nursing Facility (SNF) member has 5 positions or 3 FTEs in their finance department to meet the demands these MCO contracts necessitate.

Credentialing and recredentialing is a process every MCO must undertake with each provider in its network. Much of this information is already available as providers must be a Medicare certified provider or supplier so this credentialing process seems redundant as providers are listed with CMS and licensed or registered with CMS. An NDH could eliminate the need for the provider to submit this data to the plan and with appropriate regulatory changes, could reduce or eliminate this requirement for the MCOs. Plans using NDH data for their provider directories could also reduce directory errors and be more efficient than re-collecting this same data. The reality is if there were common practices, then it would be easier for not only providers to submit the right information the first time and within the prescribed time, but it would also be easier for plans to update their systems for these standardized systems. By standardizing these data and corresponding processes, IT companies would likely be incentivized to upgrade systems for health plans due to the standardized processes, which in turn could create economies of scale for these system investments. The NDH has the potential to fix the challenges of the current system in which plans’ struggle to correctly process claims, find prior authorization documentation that is submitted, and pay according to contract or accommodate value-based arrangements due to their system and data issues.

We would encourage CMS to consider how data entered into the NDH could pre-populate other databases and forms both within the federal government and be used by managed care plans and other payers. For example, if this were possible, a provider could enter their organizational data, key contacts, phone numbers, license number, etc. into one entry point and when they login to other systems, the forms in those systems would be prepopulated with the NDH data ensuring consistency and reducing the time it takes to complete the form. This could include claims forms, quality reporting, assessment submissions (e.g., MDS, OASIS), managed care plan prior authorization forms and claims, etc. This could reduce errors. An NDH with this capability would also minimize the time it would take providers to update their information when there is a change in key contacts, organizational address or emails. Providers would also know the one place they needed to update the information. By submitting data once, CMS and others who use the data could ensure data accuracy, eliminate concerns about reconciling conflicting information between systems because one has been updated and the other hasn't or because the data was inconsistently entered between systems. Also, a single NDH that prepopulates other forms could be used for managed care plan claims forms and prior authorization requests so both can be processed more quickly.

Of note, Ohio is in the process of testing a credentialing portal for Medicaid managed care that might provide some insights about how to streamline this process across plans reducing the time commitment by plans and providers.

In addition to administrative burden reduction for providers, and possibly plans, a centralized data hub such as an NDH may provide CMS a better view into care delivery patterns in Medicare Advantage (MA) plans, across geographies, identify best practices and produce reports to help guide improvement and ensure health equity between MA enrollees and their Original Medicare counterparts.

As CMS evaluates establishing an NDH, it should consider future, potential applications such as the ability to use this to simplify other processes such as claims submissions to Medicare, Medicaid and MCOs and MCO prior authorization requests.

We have selected the following questions from the RFI to respond to more specifically:

What benefits or challenges might arise while integrating CMS data into an NSH?

One challenge that has arisen as aging service providers have applied for and reported on Provider Relief Funds is that often these organizations provide an array of services and as such, do not fit neatly into a single provider category. Therefore, providers should be able to select multiple service lines under a single organization and their related licenses. Perhaps this could be set up as a check box item, "pick all that apply." Consumers might appreciate seeing all the service lines a provider organization offers, too. There may be a parent organization with one address and subsidiaries at the same or different addresses. Sometimes aging service provider organizations are set up under a single tax identification number (TIN) and other times the parent and each subsidiary have their own TIN. Provider organizations may have a name on their tax forms, a second name that they do business as (DBA). These can lead to challenges connecting the appropriate CMS data to the state data and the IRS tax forms. There were cases where providers were denied Provider Relief Funds because these data didn't match up exactly. CMS might also want to consider using drop down selections for commonly used information to ensure consistent data. For example, using Street vs. St. and all states be listed as their two-letter code. Sometimes a direction is used in an address, but

it could be written “West 33rd Street” or “33rd St. W.” if matching software was used the two entries wouldn’t match. Efforts to standardize these entries could be beneficial and create needed efficiencies.

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

In addition to PECOS, Care Compare for Medicare, Medicare and Medicaid managed care organizations, aging service providers currently must report organizational data and tax identification numbers to the Health Resources & Services Administrations (HRSA) for Provider Relief Fund, which includes updating organizational data and key contact information. Nursing homes and home health agencies must submit assessment data (e.g., Minimum Data Set and OASIS), which is used for determining payment rates by CMS and managed care plans, and sometimes state Medicaid programs. Nursing Homes are also required to report data on COVID-19 vaccination rates, cases and deaths, as well as testing availability into CDC’s National Healthcare Safety Network (NHSN). Therefore, we hope CMS will consider their inclusion in the NDH.

What state or local level systems would be beneficial for an NDH to interact with, such as licensing, credentialing, Medicaid provider enrollment, emergency response or public health?

The data nursing homes report to NHSN on COVID-19 is often also reported to state and local governments for public health purposes. If the states and local governments could access this data, it may eliminate the need for providers to report the same data to multiple places and could lead to more standardized public health data across states. MCO access to state licensing, credentialing and provider enrollment data could eliminate the need for providers to copy and submit this data to each MCO with which they contract. MCOs often ask providers to document their license number, and/or a copy of their license or certification as part of the credentialing process but it would be so much easier for MCOs and providers if the MCO could find all this information in a single NDH and providers wouldn’t need to waste time submitting the data.

What data should be publicly available?

While we have not been able to consider the breadth of data collected currently and which items should be publicly reported. We are not aware of any currently available public data that should no longer be public. We hope to have an opportunity to provide future input into the process as the NDH is developed and specific data elements are identified for inclusion.

How could NDH use be incentivized by health care industry?

CMS might consider incentivizing MCOs to use the NDH by eliminating all or most of the credentialing requirements if the MCO confirms provider data via the NDH. In this way, MCOs could add to the provider data file by noting which providers are in-network with their plans.

Providers might be more incentivized to use the NDH data and update it if their ability to get paid were tied to it. Perhaps CMS requires providers to annually update their NDH information or attest annually to its accuracy. It could also require key data such as contact information and key leadership changes within a designated period. Providers will want to use and maintain their data within the NDH if by using it, it reduces their need to report or update the data to multiple payer sources and if it makes submitting claims and quality data easier by pre-populating some elements.

How to evaluate if the NDH meets the targeted outcomes for end users?

We would encourage CMS to consider the following goals of an NDH:

- Provider time to complete forms, etc. is reduced
- MCOs use the NDH data to replace or reduce the credentialing requests, and to speed prior authorizations and claims processing
- Fewer provider directory errors are observed
- CMS spends less time trying to reconcile provider data or link provider data

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)?

The following data would be useful to support patient access and consumer choice:

- **Provider Availability:** Information on whether a provider is accepting new patients or new admissions for urgent care, hospitals, nursing homes, etc. Ideally, if the NDH could link to Electronic Health Record data or other data that shows a provider's real-time availability - beds, rooms, etc., --this would be the most helpful for consumers/families to make provider choices/selections but also useful for provider referrals depending upon how up to date the information is.
- **Geography served:** The data should show not only where a provider/organization is located (physical address) but also the geographies served by the provider. An ability for consumers to look at providers within a given radius to their home or their family could be helpful.
- **Quality:** Many providers have Star Ratings that offer some information about a provider's quality. Consumers should be able to see a providers current quality information including star rating, where applicable. Third-party verified consumer satisfaction data.
- **Plan Network Status:** As consumers make their annual health plan selection, they need information on what health plan networks providers are in. This data also assists consumers in selecting in-network providers for their care to ensure that the service is covered.
- **Provider Expertise/Specialties:** Another element that might be beneficial to include about providers is if they have any specialties (e.g. cardiac care rehabilitation, dementia care, chemical dependency) or serve certain populations (e.g., memory care unit, older adults vs. children)
- **Special Attributes:** This might include target populations served, languages spoken other than English, special equipment such as open-sided vs. closed Magnetic Resonating Imaging

equipment, cultural competencies and building accessibility. For nursing homes, we would suggest also noting whether a nursing home accommodate certain cultural or dietary preferences, such as Kosher meals, gluten-free or vegan options, etc. and whether they have a faith-based affiliation, which can be important when a consumer is selecting a long-stay residential-based care.

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

We certainly would encourage CMS to set up this central data hub so it could be used for standardizing prior authorization requests, claims payment submissions to MCOs, public health reporting (e.g., COVID-19 cases/deaths reporting to local, state and national). CMS should consider whether it is possible to connect provider Electronic Health Record (EHR) data with the system to assist with ensuring appropriate documentation for prior authorizations, acuity determinations, claims submissions, and identification and sharing of patient assessments including patient information on social determinants. If providers could access current patient data on SDOH instead of all providers asking the same questions, it could facilitate better care coordination and addressing of needs with less time. Providers could confirm information in the record vs. starting from scratch.

How can data be collected, updated, verified and maintained without creating or increasing burden?

Ultimately, there should be a single data entry point with standard information that is collected. Providers could attest to the data accuracy and annually update or confirm it is still current, much like doctor's office ask patients to confirm their address, etc. Data entry requirements could establish an organizational login and unique identifier for the organization that could be used across payers and providers using the system. Rules could require that when key information (e.g., new leadership, organizational name change, contact info – email or phone) changes that the data must be updated by the provider within a specified timeframe. If the NDH was used as the single source of truth and was the only place providers needed to update the information, it could eliminate many of the current challenges of knowing where certain information about a provider is located within CMS' systems so that it can be updated. Nursing homes have encountered challenges in updating data that is listed on Care Compare because it is not clear which system it is pulling the information from such as number of beds.

Delegation of authority to submit data on a provider's behalf

We encourage CMS to permit this option to allow a third party to make updates. Many of our providers are part of provider networks and this is one of the functions they offer is assistance with credentialing and data updates. In other cases, we use outside parties to submit assessment data or claims data on behalf of the provider through an aggregated process. In all cases, however, the original provider entity must give permission and there must be a simple

process for revoking or amending this authority (e.g., changing the third party or individual permitted to enter data).

We are highly supportive of this effort to establish and NDH and recognize the breadth of work that will be required to bring it to fruition. However, we believe it is an effort worth undertaking because it will reduce administrative burden and associated costs, as well as create efficiencies in data sharing. We look forward to the opportunity to provide further feedback as the NDH development work happens. Please contact me if you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Nicole O. Fallon". The signature is written in a cursive, flowing style.

Nicole O. Fallon

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