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Center for Medicare & Medicaid Services

Office of the National Coordnator for Health Information Technology

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Sent electronically to partnership@cms.hhs.gov

Subject: Section 6220 – Provider Directory Meeting – written comments

Thank you for hosting the June 15 stakeholder call on implementation of the Requiring Enhanced an Accurate Lists (REAL) of Health Providers Act. We appreciate the opportunity to share additional, more detailed thoughts on the topics raised during the call, particularly because the discussion to date has focused largely on physicians, specialists, and hospitals, with little attention to the potential burden these verification requirements could place on post-acute care providers or how the requirements would apply in those settings.

LeadingAge is a national organization representing more than 5,300 nonprofit and mission-driven aging services providers that serve older adults and touch millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership spans the full continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.

Some LeadingAge members also operate and/or own Medicare Advantage (MA) and Special Needs Plans (SNPs), and they are concerned about additional reporting requirements, particularly given their smaller enrollment. Our comments reflect the perspectives of both our post-acute care provider members,

including skilled nursing facilities (SNFs) and home health agencies (HHAs), and our provider members that operate MA/SNP plans.

LeadingAge supports the intent of the REAL Health Providers Act to ensure beneficiaries have access to accurate provider directory information. However, absent a streamlined approach, the operational burden of repeated verification across multiple MA plans will be significant. We are also concerned not only with statutory requirements, but with how MA organizations may operationalize them in ways that increase provider burden or disrupt network participation.

Data standards and "source of truth" for directory information

Providers, including SNFs and HHAs, may contract with and participate in multiple plan networks. It would be inefficient and time-consuming to expect providers to verify the same core information with each MA plan every 90 days, especially when much of the required data is already reported to CMS. In addition to updating information for managed care plans, providers are also required under licensing and certification rules to update information for CMS, state Medicaid agencies, and other payers.

This information is the same, or should be standardized, across all payers. Using a single data entry point with one set of expectations for updates would increase the likelihood that information is updated timely because providers would have only one place to complete this task.

Recommendation: CMS should use existing systems that roll up to a single provider database. To maintain accurate provider directories with minimal administrative burden on both plans and providers, we encourage CMS to use existing provider data from the CMS Provider Enrollment, Chain and Ownership System (PECOS)—data that is already collected from providers and required to be updated—as the single-entry point and source of truth. CMS could also use technology solutions, such as application programming interfaces (APIs), to make updated data available to plans for quarterly or more frequent provider directory updates.

SNFs and HHAs are already required to update organizational information in PECOS, including practice location, physical and billing addresses, ownership and organizational structure, key management and leadership contacts, Tax ID, legal business name, licensure and certification documentation, banking/EFT information, and related ownership information. This information is processed and validated by Medicare Administrative Contractors. Providers are obligated to update these records or risk noncompliance. Correspondingly, National Provider Identifier (NPI) and profile data are reported in the National Plan and Provider Enumeration System (NPPES), although these systems regrettably do not automatically sync with one another.

SNFs and HHAs are required to revalidate their enrollment information every five years, and CMS may require revalidation at any time if there are program integrity concerns or data discrepancies. When changes occur, SNFs must report certain changes within 30 days, including a change of ownership, adverse legal action, or a change in practice location or physical site. Other enrollment changes must be

reported within 90 days, including ownership details and managing control information, legal business name changes or DBAs, billing agency information, authorized or delegated officials, and other enrollment updates. SNFs may lose billing privileges or the ability to participate in Medicare if they fail to revalidate on time. For these reasons, it would make the most sense to use the data providers submit through these systems as the single source of truth. CMS could produce a weekly or monthly provider change report and push this information to plans through an API or otherwise allow plans to receive or access these data.

Much of the information required for MA plan provider directories under the REAL Health Providers Act and for MA plan credentialing processes can be found in PECOS, NPPES, or other CMS databases. CMS data systems contain data points beyond what plans need for provider directories but that may be useful for other purposes, such as credentialing, including billing address versus service location address, survey data, licensing and certification information, and Medicare standing. CMS could pull this provider information together, synchronize it in a single database, and make it available to plans through an API. Standardized fields would allow plans to create provider directory templates that could be updated in real time through available technology.

Although not addressed by the REAL Health Providers Act, we urge CMS to also consider updating MA regulations to eliminate duplicative MA plan credentialing requirements and instead provide plans access to PECOS and NPPES data for these purposes. This could reduce burden on plans and providers while improving the consistency and accuracy of provider data. Plans would no longer need to request the same information quarterly to reverify providers, and providers would enter the data once for all payers, eliminating duplicate reporting and the burden of navigating different plan processes, portals, and forms.

Verification approaches, updated cadence, and removal of non-participating providers

Recommendation: SNFs should only be required to reverify provider directory information annually. As facility-based providers**,** SNFs, like hospitals, have fixed physical locations and do not frequently move residents or services to different structures or locations. While some SNFs have closed or changed ownership in recent years, those changes represent a small fraction of the roughly 14,400 SNFs in operation and SNFs are already subject to reporting requirements, such as change-of-ownership, sale, closure, or certification updates. As stated above, CMS could use these existing reporting channels to provide plans with regular updates on provider information, rather than requiring all SNFs to reverify the same information with every contracted plan every 90 days.

Additionally, we ask CMS to consider whether quarterly reverification is necessary for HHAs. Smaller HHAs may face significant administrative burden if they must respond to frequent, duplicative revalidation requests from multiple MA plans. CMS should clarify whether annual verification, combined with already-required updates when key information changes, would be sufficient for HHAs as well. For

example, when an HHA changes office locations, it must submit a new Form 855A to its Medicare Administrative Contractor (MAC) within 30 days of the effective date. That submission triggers site validation, during which a MAC subcontractor confirms that the provider is operating at the reported physical address. This existing process provides stronger fraud protection than MA plan reverification because it includes physical location validation, which plan reverification does not require.

Recommendation: CMS should standardize and clarify which address is being requested, such as the facility or site-of-service address, billing address, corporate office address, or other contact address. This may be where some of the inconsistencies in provider directories originate.

Recommendation: There should be a single verification process for a provider. By using PECOS as the source of truth, providers would update or verify their information in a single system. Plans, in turn, could pull down all the needed provider data in a standardized format to populate their provider directories and to meet current credentialing requirements. Because the data originate from a single source of truth, beneficiaries can compare plans' provider networks and see that their providers are included because each provider's information would be identical in each plan's provider directory.

It is also inefficient to require every MA plan to verify the same provider data (available through CMS databases) quarterly. For every plan with which a provider contracts or is in-network, the provider may need to reverify its information every 90 days. For example, a provider that is in-network with eight MA plans could be required to complete 32 submissions per year across multiple formats, portals, and processes. This increases costs in the health care system and diverts resources from direct care to administrative spend.

Further, we've already seen that MA plans collecting provider information to populate their provider directories has been ineffective at achieving accuracy. It might be time for a new approach to achieve the goal.

Concerns about "unverified" designations.

Our SNF and HHA members report that MA plans do not always send provider directory communications to the most current email address or contact within the provider organization, even after the provider has updated that information through the plan's required process or portal. As a result, providers may never receive a reverification request and could be inaccurately marked as "unverified" or erroneously removed from a provider directory. This is a key reason CMS should rely on existing CMS databases as the single source of truth for provider directory updates. Doing so would eliminate the need for duplicative reverification requests from each plan and reduce the risk that critical communications are sent to the wrong contact.

A single source of truth would also reduce the number of legitimate providers incorrectly tagged as "unverified" while helping identify entities that are not legitimate Medicare providers.

If CMS does not use a single source of truth, such as PECOS, across plans, provider directories may become less accurate rather than more accurate. Under the REAL Health Providers Act, MA plans may flag providers for failure to verify even when the provider never received the request. As we recommended in our comments on the National Provider Directory Request for Information in 2022, CMS should require provider data to be updated through a single portal and give plans access to those data, potentially through an API. CMS could then push updated provider data to plans on a regular cadence, allowing plans to update their online directories without requiring each provider to respond separately to multiple plan-specific reverification requests.

Concerns about removal of providers from the directory and maintenance of network adequacy

We encourage CMS to define "no longer participating in the network" to ensure that it does not include providers that have not submitted a claim for a certain period of time. The term should apply only when either the plan or provider has terminated the contractual relationship. There are a number of reasons why a provider might not submit a claim over a period of time and being reinstated into a plan's provider directory could take time. In the meantime, beneficiaries are unaware that they are able to access this provider.

Also, depending upon how CMS calculates the MA plan accuracy scores, plans may be incentivized to remove providers they cannot verify because retaining them could reduce their accuracy score.

Recommendation: We ask that CMS carefully consider how it weights or factors in providers that are unverified in the plan directory accuracy score to prevent such removal actions by the plans. Another potential strategy to incentivize plans not to unnecessarily remove providers, would be for CMS to re-examine plan network adequacy compliance quarterly following a directory update to ensure that beneficiaries still have access to required services and providers. This would also be important to ensure beneficiaries still have adequate access to medically necessary services throughout the plan year as required.

Core vs. optional metrics

The REAL Health Providers Act requires certain metrics or data elements to be collected on providers for inclusion in provider directories. During the June 15 call, ONC/CMS staff asked whether some of these data points should be considered "core" items required of all providers and whether any should be treated as optional.

For Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs), we would recommend the following:

- **Do not require SNFs and HHAs to report whether they are accepting patients.** This data will never be accurate in a provider directory because it changes daily or even throughout a day.

Whether a SNF or HHA is accepting patients depends on several factors, including the number of patients currently being served, an ability to meet the patient's particular needs, staffing capacity, and, for SNFs, availability of beds. A provider may generally be accepting patients from a plan but be unable to accept a specific patient at a particular moment. For this reason, this metric is unlikely to be useful to beneficiaries and should not be required.

- **Cultural and linguistic capabilities should be optional for SNFs and HHAs.** SNFs are required, as a condition of participation, to meet the cultural and linguistic needs of the residents they serve. This does not always mean having specific language capabilities on staff; it may involve using telephone interpreter services or other supports to meet a resident's needs. HHAs are also required to provide information in a patient's preferred language (e.g. via an interpreter). At a minimum, this information should be optional on the provider directory verification form for those providers who have particular staff capabilities.

- **Telehealth capabilities should be optional for SNFs.** SNFs are limited in the circumstances in which they may use telehealth, so this is not an appropriate distinction for inclusion in a provider directory. Typically, telehealth is permitted only in limited circumstances, such as assessing a change in condition that may require changes to a resident's care plan.

LeadingAge strongly supports improving the accuracy of provider directories; however, without a centralized, CMS-driven data infrastructure, the REAL Health Providers Act could unintentionally:

- Increase administrative burden for providers and plans
- Create duplicative and inconsistent data processes
- Lead to inaccurate provider removals or confusion over "unverifiable" provider designations
- Divert resources from patient care.

Therefore, in summary, we recommend CMS:

- Establish PECOS as the single source of truth of provider data
- Enable API-based data sharing between CMS and plans
- Limit verification frequency (annual for SNFs)
- Standardize data elements and definitions
- Protect providers from erroneous removal or penalization
- Limit required data fields to stable, meaningful indicators.

We appreciate your consideration of these recommendations and welcome further collaboration to ensure implementation supports both accurate information for beneficiaries and operational feasibility for providers and plans.

Sincerely,

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