



June 29, 2026

Centers for Medicare & Medicaid Services
Office of the National Coordinator for Health Information Technology
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

Sent via Email to Partnerships@cms.hhs.gov

RE: Section 6220 Provider Directory Meeting – Written Comment

To Whom it May Concern:

DataSpring, powered by CAQH, appreciates the opportunity to provide feedback to the Centers for Medicare & Medicaid Services (CMS) as the agency develops guidance to support implementation of the provider directory accuracy provisions of the REAL Health Providers Act (REAL Act).

For more than 25 years, we have united practitioners, health plans, and other entities to improve the accuracy and efficiency of the information that helps the healthcare system operate effectively. Today, we maintain the largest and most complete healthcare data foundation in the country, including more than 4.8 million provider data records sourced directly from providers across all 50 states and the District of Columbia. Our records span primary care, behavioral health practitioners, and other specialists from independent practices and large health systems alike.

Health plans, clinicians, and other healthcare organizations use our provider data platform for credentialing, directory management, primary source verification, sanctions monitoring, and related administrative functions. Because the platform allows clinicians and authorized practice administrators to enter, update, and attest to professional and practice details through a shared workflow, this experience is directly relevant to the core challenge CMS is addressing: improving provider directory accuracy so beneficiaries can access care in a timely manner.

We support CMS's goals of improving accuracy and transparency in Medicare Advantage provider directories. In our experience, sustainable progress requires more than new technology or new federal submission channels. It starts with focusing on the core data elements most meaningful to beneficiaries, clearly defining those fields, standardizing how they are exchanged, establishing appropriate update cadences and processes, and measuring and validating quality in a consistent, meaningful way.

To improve accuracy without adding unnecessary burden, directory information should be collected, refreshed, and shared through existing provider, plan, credentialing, contracting, roster, and delegated-partner workflows whenever possible.

It is also important to recognize the shared accountability required to maintain accurate directory data. Providers and authorized delegates are closest to key practice information; plans remain accountable for beneficiary-facing directories; and data partners can help support standardization, exchange, quality checks, and validation. Clear expectations for definitions, source attribution, verification status, refresh cadence, and machine-readable exchange would reduce variation allowing organizations to use the channels already embedded in day-to-day operations.

We recommend CMS focus on the following:

1. Set clear, core data expectations.

Passage of the REAL Act, No Surprises Act and recent OIG reports demonstrate the need to solve a vital public need first, developing reliable beneficiary-facing directories especially among Medicare Advantage programs. While technology can support improved directories, the implementation of the REAL Act affords CMS the opportunity to tackle the true underlying issues plaguing Medicare Advantage directories today, undefined, inconsistent and overly inclusive data capture. We recommend focusing on capturing, defining and standardizing the fields that matter most to beneficiaries at enrollment or when seeking in-network care.

At a minimum, the core data elements should be tracked to the REAL Act. Fields include provider name, specialty, contact information, primary office or facility address, whether the provider is accepting new beneficiaries, accessibility accommodations, cultural and linguistic capabilities, and telehealth capabilities.

Secondly, we recommend consistently defining these basic, yet critical data elements. Today the lack of definitional consistency in fields such as address, specialty, telehealth capabilities, and whether a provider is accepting new beneficiaries perpetuates directory inaccuracies. Consistent definitions enable plans, providers, and data intermediaries to ingest, exchange, and interpret data reliably. Address definitions and standardization will also allow locations to be validated, matched, and reused across systems.

Some fields such as provider name, license status, specialty, and practice address, can be verified and remain relatively stable, while more dynamic fields, such as whether a provider is accepting new beneficiaries, office hours, appointment availability, telehealth availability, and accessibility or language service may change. Dynamic fields should be prioritized when they are critical to helping beneficiaries access timely, quality care.

2. Shared verification responsibility harnessing flexible, scalable methods.

Directory accuracy is a shared responsibility. Providers and authorized practice administrators are best positioned to confirm practice locations, contact information, availability, and whether they are accepting new beneficiaries. Plans should remain accountable for their directories, while relying on provider-supplied data, augmented by other reliable sources, and appropriate quality controls.

As CMS implements the REAL Act, plans must maintain their ability to use available sources relevant to their directory obligations, such as credentialing records, attestations, network participation files, primary source verification, licensure, and other authoritative data, including sources that CMS could deem reliable for plan use.

We support the 90-day update cadence especially for core, dynamic directory information as envisioned by the REAL and No Surprises Acts, and many state directory requirements. This provides a familiar compliance interval for plans, providers, and data partners while ensuring timely beneficiary-facing updates.

A central limitation of any cadence-based framework is that plans can request, prompt, and facilitate verification at the defined interval, but providers and practices must actively confirm or update their information for the process to work. CMS should therefore make clear that provider and practice participation is an essential component of directory accuracy. Verification is only effective when built into familiar existing workflows and supported by prompts, outreach, and checks for stale, conflicting, incomplete, or high-risk records. This approach enables plans to rely first on existing data sources and target follow-up only when information is missing, inconsistent, outdated, or otherwise requires confirmation thus reducing redundant requests to provider offices.

3. Harness existing channels to maintain directory data.

Clinicians and authorized practice administrators play a critical role in maintaining accurate directories. Their participation is essential and is only made possible through established workflows. Plans should also be able to obtain and refresh those updates through existing credentialing, contracting, rostering, directory, and delegated vendor processes. We strongly caution CMS to avoid requirements that create separate plan-by-plan or program-by-program activities when existing plan operations can support the same objective.

4. Identify reliable, operationally feasible and meaningful measurement.

Accuracy should be rooted in reliable consistent measurement that is comprehensive, operationally feasible and meaningful to ensure directory accuracy. Today, there is no consistent measurement process. We firmly believe there are four critical components to an effective measurement framework – accuracy, completeness, timeliness and uniqueness.

Building off CMS's previous work, DataSpring has convened a Provider Data Collective which is an industry-led, consensus-based initiative to improve the quality, accuracy, and usability of provider data. The Collective brings together the nation's leading regional and national health plans, key professional associations, and major accreditation bodies to address the fragmentation and inconsistency that drive directory errors, create barriers to beneficiary access, and add unnecessary administrative costs across the system. The Provider Data Collective's first priority is establishing a shared standard for measuring provider data quality, the foundational step without which downstream improvements are difficult to define or verify.

DataSpring has a proven track record of convening multi-stakeholder efforts to solve industry-wide challenges, including development of operating rules now cited consistently in CMS rulemaking, and an Index Advisory Council whose research on administrative burden informs federal policy. The Provider Data Collective builds on that governance experience with an accelerated timeline toward industry consensus on provider data quality measurement.

Directory quality measurement methodology should give greater weight to the fields most directly tied to access, including whether a provider is listed at the correct location, participates in the network, accepts new beneficiaries, and has contact information that allows a beneficiary to schedule an appointment.

Timeliness, completeness and uniqueness of data should also be accounted for. A record that is complete, recently verified, source-attributed, and supported by attestation or another reliable source is most useful.

Harnessing the above robust quality measurement will reduce CMS' reliance on secret shopper reviews which provide a point-in-time check, add burden for provider offices, create administrative friction, and skew results based on individual call responses rather than the quality of the underlying data.

Finally, any approach to measuring provider directory accuracy should be reasonable, comparable, and auditable, without imposing overly prescriptive operational requirements on providers or plans. At a high level, CMS validation should confirm that scores are supported by reliable evidence and based on representative sampling that accounts for variation across provider types, specialties, geographies, and practice settings.

5. Reduce fragmentation within CMS authority while relying on interoperable private-sector systems.

We encourage CMS to use this implementation process to promote greater consistency across Medicare Advantage plans and its work in pursuing a National Provider Directory.

That alignment should not require CMS to build or mandate a new data collection system when clinicians, plans, and data intermediaries already use established channels for a range of administrative purposes including directories. Addressing core data fields, common definitions, and interoperable exchange formats will allow those existing channels to support implementation within CMS's scope.

These approaches can help clinicians, plans, and their partners apply reusable standards and practices across relevant programs instead of treating each requirement as a separate reporting exercise.

Conclusion

We appreciate CMS's work to improve directory accuracy and beneficiary access to care. As CMS implements the REAL Act, the agency can set practical expectations for Medicare Advantage plans and, where appropriate, promote consistency across related programs it administers or has oversight. CMS should continue to rely on private-sector channels already used by plans and providers, rather than creating new requirements that add burden without improving accuracy.

We welcome continued engagement with CMS and would be happy to provide additional information as the agency develops guidance, rulemaking, and related policy.

Sincerely,

A handwritten signature in blue ink, appearing to read "Alexander Ding", is written over a light gray rectangular background.

Alexander Ding, MD
Chief Medical & Public Affairs Officer