

June 17, 2022

Administrator Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1771-P
PO Box 8013
Baltimore, MD 21224-1850

[Response delivered via Regulations.gov](#)

Re: CMS-1771-P; Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

[Civitas Networks for Health \(“Civitas”\)](#), appreciates the opportunity to provide input on the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation Proposed Rule (CMS-1771-P) (the “Proposed Rule”). Civitas is a national collaborative of regional and statewide Health Information Exchanges (“HIEs”) and Regional Healthcare Improvement Collaboratives (“RHICs”). We are significant stakeholders in the health data interoperability landscape, helping providers, facilities, and other key collaborators achieve many of the policy goals presented in this Proposed Rule. Representing more than 95% of the United States, Civitas is comprised of member organizations working to use health information exchange, health data, and multi-stakeholder, cross-sector approaches to improve health. We educate, promote and advocate to the private sector and policymakers on matters of interoperability, quality, coordination, health equity, access, and cost-effectiveness of healthcare. While there are many areas of this rule on which Civitas’ work and stakeholders’ expertise is applicable, we would specifically like to comment on the sections discussed below.

1. Social Determinants of Health Diagnosis Codes – Request for Information

In the Proposed Rule, the Centers for Medicare & Medicaid Services (“CMS”) is soliciting public comment on how the reporting of diagnosis codes in categories Z55-Z65 may improve its ability to recognize severity of illness and/or utilization of resources. Many of Civitas’ stakeholders are actively collecting these Z codes from clinicians and reporting them through their HIEs. Clinicians have commented that these codes are critical in making informed decisions about health care and in providing referrals to appropriate human service organizations. We also note two important and related considerations; some stakeholders are concerned that these Z codes may “follow” a patient for too many years and cause potential discrimination, bias, or other misunderstandings in the future. **Therefore, while we encourage CMS to require reporting of Z codes, we also encourage standardization**

around the amount of time these codes should remain in a patient’s health history. We also encourage CMS to consider how to operationally implement time-bound Z-codes. Secondly, we have heard from our stakeholders that clinicians may be apprehensive to ask questions in these areas if the appropriate referral sources are not available for a patient. Thus, while expanding reporting on Z codes offers important potential for improved care, we encourage CMS to also support the need for increased infrastructure and capacity building for human service organizations as well as the partnerships essential to creating available services and plans to address needs.

2. Proposed Changes to the Query of Prescription Drug Monitoring Program Measure

CMS is proposing to make its Electronic Prescribing Objective’s Query of Prescription Drug Monitoring Program (“PDMP”) a mandatory measure in its Promoting Interoperability Program for eligible hospitals and critical access hospitals (“CAHs”). We support this proposed change to make this measure mandatory and expanding it to include Schedule II, III, and IV Drugs. Many of our stakeholders manage the PDMPs in their states and/or integrate these data into a larger clinical profile of a patient through their HIEs. Understanding a patient’s medication history is critical to safe, effective, quality care, particularly when Schedule II, II, and IV drugs are prescribed and dispensed. We encourage CMS to continue the development of this measure in future years beyond a “yes/no” measure to ensure clinicians continue to identify potential opioid use disorders, inform the development of care plans, and develop effective interventions.

3. Advancing the Trusted Exchange Framework and Common Agreement (“TEFCA”) – Request for Information

CMS is proposing to add a new Enabling Exchange Under TEFCA measure to the Medicare Promoting Interoperability Program, which would allow eligible hospitals and CAHs to receive credit for the Health Information Exchange Objective in the Promoting Interoperability Program if they are a signatory to a “Framework Agreement” under TEFCA, enable secure, bi-directional exchange of information to occur for all unique patients discharged and all unique patient records stored or maintained in the electronic health records (“EHR”), and use the functions of certified EHR technology (“CEHRT”). In addition, CMS is requesting comment on other ways it can help advance information exchange under TEFCA. Although we strongly support a contractual framework, such as TEFCA, that would encourage more data sharing and interoperability among eligible hospitals and CAHs, we do not believe that TEFCA is mature enough to add such a measure at this time. Under current circumstances, eligible hospitals and CAHs may be encouraged to shift from more mature and interoperable networks, leading to an overall decrease in interoperability. For example, currently the regional coordinating entity (“RCE”) has not released any standard operating procedures (“SOPs”), which provide the operational “nuts and bolts” of TEFCA; thus, it is difficult for entities to fully assess whether they should participate. In addition, it is our experience that many potential health information networks (“HINs”) that may wish to become qualified HINs (“QHINs”) to support TEFCA are only structured to allow HIPAA-permitted treatment, payment, and limited health care operations, as well as some limited public health use cases. However, TEFCA envisions supporting HIPAA-authorization based use cases (such as Benefits Determinations) and Individual Access Services (“IAS”), which are not yet as tested in this space. In the future, we believe TEFCA will reach a maturity level at which CMS should re-consider such a measure.

In addition, *when CMS considers such a measure in the future, we encourage CMS to consider expanding the measure to include bi-directional exchange agreements like TEFCA.* Civitas’ stakeholders include many exchange collaboratives that are already functionally exchanging data through agreements which have previously been incentivized by the government, including HIEs and RHICs who are actively supporting community level aggregated data integration into the HIEs to promote a holistic view of a patient’s needs and experiences. Furthermore,

existing and mature national networks and frameworks such as Carequality and eHealthExchange have already been adopted by many entities. This bi-directional exchange would allow for the SDOH portions of work discussed in the Proposed Rule to be fluidly included in the patient information.

We encourage CMS to continue to build upon incentivizing these prior investments while also promoting similar functionality that can be achieved through TEFCA for eligible hospitals and CAHs not currently participating in similar arrangements.

4. Focus on Improving Maternal Health in the United States

We commend CMS for its focus throughout the Proposed Rule on maternal health and decreasing maternal mortality. Many RHICs have been at the front lines of the efforts to combat maternal mortality, focusing on health equity, health literacy, pre-conception care and postpartum efforts to ensure that patients' voices are heard in their health-related experiences. They have worked to improve patient safety and quality; have provided critical technical assistance; and have supported payment and care transformation models that focus on value and improved outcomes. **Civitas commends and supports CMS' efforts in the maternal health space as we recognize that the clinical quality measures proposed will give focus to improving outcomes and enrich understanding on gaps in care.**

5. Condition of Participation (CoP) Requirements for Hospitals and CAHs To Report Data Elements To Address Any Future Pandemics and Epidemics as Determined by the Secretary

We commend CMS for continuing its focus on addressing data and reporting gaps in addressing public health needs, in light of the COVID-19 pandemic and future pandemics and epidemics. **We strongly recommend that CMS support existing reporting infrastructure to reduce burden on hospitals and CAHs, and to avoid building and maintaining parallel or siloed data reporting structures and repositories.** We also support these data elements continuing to be reported to the CDC's National Health Safety Network (NHSN), to ensure consistency and the ability build on existing infrastructure. We encourage CMS to engage with collaborative efforts such as the [Situational Awareness for Novel Epidemic Response \(SANER\) Project](#), which leverages a standards-based approach using HL7® Fast Health Interoperability Resources (FHIR) to ensure exchange of situational awareness data during public health emergencies. The SANER Project was launched in 2020 and three Civitas Networks for Health members (Texas Health Services Authority, Healthcare Access San Antonio, and Audacious Inquiry) were awarded a cooperative agreement from the HHS Office of the National Coordinator for Health IT to pilot the solution.

Reducing burden and automating these types of reporting requirements is greatly needed, especially during a natural disaster or public health emergency when hospitals and CAHs are already under pressure. We believe that some of this burden can be reduced by allowing hospitals and CAHs to report via existing aggregators of health information at the local, state, territorial and tribal levels, such as regional and statewide health information exchanges and networks.

6. Continuing to Advance Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources ("FHIR") in Hospital Quality Programs – Request for Information

We commend CMS for moving to utilization of FHIR to access expanded data sets in support of digital quality measures, since this continued shift will enable greater interoperability at lower provider burden. Many of our

HIEs have experience collecting and exchanging data based on FHIR application program interfaces. **We encourage CMS to consider speaking with our stakeholders about how HIEs and RHCs can be utilized for data flow options and digital measure data collection, further reducing provider burden.**

Finally, we recommend that you review the additional comment letter submitted by our member organization, Velatura Health Information Exchange Corporation.

Thank you for the opportunity to comment. Please do not hesitate to reach out to Civitas if we can be a resource as we work together to create a more interoperable, community- and person-centric health care system.

Sincerely,



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