

September 13, 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

**Re: CMS 1772-P: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating**

Dear Administrator Brooks-LaSure:

[Civitas Networks for Health](#) (“Civitas”), appreciates the opportunity to provide input on the CMS 1772-P; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating (the “Proposed Rule”). Civitas is a national collaborative of regional and statewide Health Information Exchanges (“HIEs”) and Regional Health Improvement Collaboratives (“RHICs”). We are significant stakeholders in the health data interoperability landscape, helping providers, other key stakeholders and facilities achieve many of the policy goals presented in this Proposed Rule. Representing more than 95 percent 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, 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 provide comment on the sections discussed below.

**1. Overarching Principles for Measuring Healthcare Quality Disparities Across CMS Quality Programs**

In the Proposed Rule, the Centers for Medicare & Medicaid Services (“CMS”) requests information on key considerations CMS should take into account across all CMS quality programs when advancing health equity. We commend CMS for its continued focus on health equity; as the vehicles for state and regional health information exchange and health improvement, Civitas’ members are acutely aware of the inequities presented across the population.

As is well documented in the public health space, both race and ethnicity are strongly associated with prevalence and treatment patterns of numerous medical conditions. Furthermore, race and ethnicity data are important for public health entities who may begin to consider how to best allocate resources in order to support communities who may be at a higher risk for conditions. Regional health data organizations such as HIEs and RHICs can be valuable in this space because they not only serve as a centralized hub for health information sharing, allowing them to impose uniform requirements on data fields for race and ethnicity to the participant organizations who may be

connected to them, but they are also able to work with state and public health entities to facilitate a dialogue on how to improve on the collection of these metrics.

In addition, it is challenging to gather accurate and complete race and ethnicity data by using a single data source for information. HIEs and RHICs can remedy this concern by combining and aggregating data from multiple sources to help increase health equity measures. Many of our stakeholders have already begun using HIEs/ RHICs in this manner. For example:

- Vermont utilized their HIE to address race and ethnicity relative to the COVID-19 pandemic. Early in the pandemic, Vermont Information Technology Leaders (“VITL”) worked with the Vermont Department of Health to provide access to its web-based provider portal to the state’s infectious disease epidemiology team. This access allowed the epidemiology team to perform case investigation and reporting, removed the burden of manual data collection from providers, and allowed the epidemiology team to cross-reference medical records to gain more robust race information about COVID-19 cases in Vermont. At the end of March, prior to using the portal, race was unknown in 73 percent of cases. Through their joint work they were able to bring that number down to just 8 percent. Looking forward, the epidemiology team intends to use the portal to perform case investigation on all of its reportable diseases.
- MN Community Measurement (“MNCM”) has been working for over a decade to collect and validate patient-level data on race, ethnicity, language, and country of origin (“RELC”) to measure and publicly report on health care disparities. MNCM has complete and validated patient-level data on RELC for about 95 percent of the patients included in its statewide quality measure reporting. MNCM’s approach was highlighted in a 2021 RAND Health Care report to the Assistant Secretary for Policy and Evaluation for its “thoughtfully chosen group of measures, incorporation of multiple important social risk factors..., ability to reliably distinguish performance among providers, clear focus on incentivizing achievement for at-risk beneficiaries, and choice to anchor disparities to the overall state average rather than the performance of a predetermined group.”

**Civitas strongly encourages the use of HIEs/ RHICs in collecting and evaluating health equity data, as they are uniquely situated to fill gaps relative to race, ethnicity, and other demographic information.**

## **2. Supporting Comment Letters**

A number of our HIE and RHIC members, listed below, wish to add their individual support for the items raised in this comment letter. We would also like to draw your attention to the comment letters from other Civitas members which have been separately submitted in response to this proposed rule. As you will see, the Civitas community is deeply engaged in health information exchange and interoperability across the country, and we stand ready to collaborate to achieve the goals of this proposed rule.

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 make a more interoperable health care system.

Sincerely,



Lisa Bari  
CEO, Civitas Networks for Health  
[lbari@civitasforhealth.org](mailto:lbari@civitasforhealth.org)  
(415) 680-6921

700 12th St N.W Suite 700 PMB 95712  
Washington, DC 2000

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Sign-on Organizations:

Comagine Health  
CRISP, Inc.  
CRISP Shared Services  
HEALTHeLINK  
Indiana Health Information Exchange  
Louisiana Health Care Quality Forum  
NC Health Information Exchange Authority  
SYNCRONYS

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