CMS RFI: Make Your Voice Heard
Comments submitted online by Civitas Networks for Health on Nov. 4, 2022

Questions from CMS (in bold): Accessing Healthcare and Related Challenges

CMS wants to empower all individuals to efficiently navigate the healthcare system and access comprehensive healthcare. We are interested in receiving public comment on personal perspectives and experiences, including narrative anecdotes, describing challenges individuals currently face in understanding, choosing, accessing, paying for, or utilizing healthcare services (including medication) across CMS programs.

Response from Civitas:

Creating New Models: The Center for Medicare and Medicaid Innovation (CMMI) should explore creating new models to improve patients' access to quality care which incorporate the use of health information exchange, health data, and multi-stakeholder, cross-sector approaches. Dispersion across the health system and the artificial segregation of human services and social care data leads to huge gaps in care coordination and health equity. Additionally, we believe there is an opportunity to test new models that improve access to social care and that address social care. Key stakeholders, states, and community-based organizations need support with capacity building to better utilize flexibilities and allowances.

Addressing Health Literacy: CMS should address challenges related to the overall low health literacy of the U.S. population. One clear way to address health literacy is through increased use of community health workers (CHWs). For example, Health Impact Ohio, which manages the Central Ohio Pathways HUB, a Regional Health Improvement Collaborative (RHIC) and a Civitas Networks for Health member, is a care coordination program that provides connections to care and services for Central Ohio's most at-risk populations. CHWs engage with at-risk individuals in the community who they meet through canvassing, referrals from MCOs and community partners. The team of CHWs at the Central Ohio Pathways HUB collectively speak 16 different languages. CHWs enroll clients in the Pathways Community HUB based on assessment, opening standardized pathways to care and services. CHW's check in with clients on a regular basis, provide continued support and education, and help maintain connections to care and resources. Since March of 2019, CHWs in the Central Ohio Pathways HUB have provided care coordination to 2,527 clients, completing over 12,200 connections to care and services. Overall, 192 CHWs from Ohio HUBs served 4,036 clients in those programs in 2020.

Understanding Provider Experiences

CMS wants to better understand the factors impacting provider well-being and learn more about the distribution of the healthcare workforce. We are particularly interested in understanding the greatest challenges for healthcare workers in meeting the needs of their patients, and the impact of CMS policies, documentation and reporting requirements, operations, or communications on provider well-being and retention.

Examples may include, but are not limited to:

- **Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, retention, maldistribution);**
- **The increasing use of digital health technology on provider well-being and attrition;**
- **Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made;**
- **Impact of CMS policies on patient panel selection, and on providers' ability to serve various populations; and**
- **Factors that influence providers' willingness or ability to serve certain populations, particularly those that are underserved and individuals dually eligible for Medicare and Medicaid.**
- **Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.**

Response from Civitas:

Bolster Reporting Infrastructure: We strongly recommend that CMS support existing reporting infrastructure to reduce burden on hospitals and providers 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. Reducing burden and automating these types of reporting requirements is greatly needed, especially during a natural disaster or public health emergency when hospitals and providers are already under extreme pressure. We believe that some of this burden can be reduced by allowing hospitals 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.

Increase Use of Standards: CMS should encourage standards for screening, making sure providers do not have to ask patients sensitive questions multiple times. Additionally, CMS should highlight the importance of interoperability while recognizing it is not just a technology issue, but also requires technical assistance and community capacity building for providers and community-based organizations (CBOs). Finally, CMS should recognize the need to reimburse CBOs for services as they are addressing critical needs of patients.

Improve Data Flow and Use of Digital Quality Measures: We believe in the utilization of FHIR to access expanded data sets in support of digital quality measures, as this continued shift will enable greater interoperability at a 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 RHICs can be utilized for data flow options and digital measure data collection, further reducing provider burden.

Advancing Health Equity

CMS wants to further advance health equity across our programs by identifying and promoting policies, programs, and practices that may help eliminate health disparities. We want to better understand individual and community-level burdens, health-related social needs (such as food insecurity and inadequate or unstable housing), and recommended strategies to address health inequities, including opportunities to address social determinants of health and burdens impairing access to comprehensive quality care.

Examples may include, but are not limited to:

- **Identifying CMS policies that can be used to advance health equity:**
    - **Recommendations for CMS focus areas to address health disparities and advance health equity, particularly policy and program requirements that may impose challenges to the individuals CMS serves and those who assist with delivering healthcare services;**
    - **Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences;**
    - **Input on how CMS might encourage mitigating potential bias in technologies or clinical tools that rely on algorithms, and how to determine that the necessary steps have been taken to mitigate bias. For example, input on how we might mitigate potential bias with clinical tools that have included race and ethnicity, sex/gender, or other relevant factors. Further, input on potential policies to prevent and/or mitigate potential bias in technology, treatments or clinical tools that rely on clinical algorithms.**
    - **Input on how CMS coverage and payment policies impact providers, suppliers, and patients, especially in the treatment of chronic conditions and the delivery of substance use disorder and mental healthcare, including individuals who are dually eligible for Medicare and Medicaid; and**
    - **Feedback on enrollment and eligibility processes, including experiences with enrollment and opportunities to communicate with eligible but unenrolled populations.**

Response from Civitas:

Emphasize Patient Identity and Matching: Patient identity, identity matching, and match rates remain a complex and evolving area of success for Health Information Exchanges (HIEs) and Regional Health Improvement Collaboratives (RHICs). With patient right of access and patient-directed queries, HIEs and Health Information Networks (HINs) must comply with Cures Act requirements while providing assurance that data is not inadvertently disclosed improperly. To complicate matters further, patient identity and matching has been recognized as an equity issue in care delivery – more stringent specifications for matching invariably impact populations without adequate demographic information. Health Data Utilities present a unique and

achievable opportunity to combine, enhance, and exchange health data for health equity and improvement.

At a high level, there are three categorizations of HIE/HIN efforts to address patient identity and matching:

1. The Trust Exchange Framework and Common Agreement (TEFCA) specifies that Qualified Health Information Networks (QHINs) must apply a patient matching process and align to industry best practices for patient matching as part of QHIN certification.
2. The HL7/ONC Patient Identity Work Group is working on a patient identity and matching FHIR implementation guide (IG) to help standardize matching and match rates to improve standardization of identity management.
3. Consortiums such as Carequality and Commonwell are leveraging the NIST Special Publication 800-63 specifications for Identity assurance level (IAL) 2 threshold of identity matching for all patients and providers as part of data exchange.

Recognize Community-Based Organizations as Key Stakeholders: Both RHICs and HIEs actively have participated in engagement strategies with Community Based Organizations (CBOs) to address health equity in a data driven ways. CBOs are often experts of the communities and populations they serve, observing and combating the inequities that mitigate the ability for data on the healthcare experiences to be free of biases. Community focused discussion of risk mitigation and correction should be at the forefront of dialogue in this space.

Increase Reimbursement for Community Health Workers: CMS coverage and payment policies impact providers; CMS should consider reimbursement for Community Health Worker (CHW) services on a national scale, beginning with Medicare. CHWs are individuals with strong ties to the communities they serve and who provide a range of services addressing the health and social needs of their clients.

- **Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs**

Response from Civitas:

Support Collection of Race, Ethnicity, and Language Data Collection (REAL): It is well documented within public health that both race and ethnicity are strongly associated with prevalence and treatment patterns of numerous medical conditions. REAL data are important for public health entities who may begin to consider how to best allocate resources to support communities who may be at a higher risk for certain 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, ethnicity, and language 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. Specifically,

it is challenging to gather accurate and complete race, ethnicity, and language 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. Key stakeholders have already begun using HIEs/ RHICs in this manner. We encourage CMS to work with HIEs and RHICs to ensure access to care for minority populations and advance health equity.

- **Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.**

Use of Patient Matching for Improved Efficiency: These steps should be considered as best practices for considering patient matching and match rates:

- Establishing rules that automatically queue a record out for manual review and decisioning. For example, first name does not match.
- Using referential matching to match patient records against a reference database vs comparing it to a "Golden Record". Referential matching allows matches to be made against out-of-date or older records.
- Providing patient identifier cross-referencing capabilities to record and manage all known identifiers for a patient.
- Conforming to IHE Patient Data Management Protocols - PIX, PDQ, etc.
- Maintaining collections of blacklisted values or patterns for specific fields - 0000 for SSN 4, email@email.com for email, etc.
- Using several matching techniques including exact matches, synonym matches, phonetic matches, single character match, single digit mismatch, day-month transposition, day only mismatch, etc.
- Using probabilistic machine learning matching algorithms - cosine similarity, etc.
- Processing patient demographic updates from source systems to manage currency of identity records.

Ensure Use of Z Codes: Additionally, in the IPPS proposed rule, the Centers for Medicare & Medicaid Services ("CMS") sought 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. 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.

Many of our HIE members 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 RHICs can be utilized for data flow options and digital measure data collection.

Impact of the COVID-19 Public Health Emergency (PHE) Waivers and Flexibilities

CMS wants to understand the impact of waivers and flexibilities issued during the COVID-19 PHE, such as eligibility and enrollment flexibilities, to identify what was helpful as well as any areas for improvement, including opportunities to further decrease burden and address any health disparities that may have been exacerbated by the PHE.

Examples may include, but are not limited to:

- **Impact of COVID-19 PHE waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on providers, suppliers, patients, and other stakeholders.**

- **Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.**

Response from Civitas:

Maintain Flexibilities Afforded during the Public Health Emergency (PHE): There are specific waivers and flexibilities that were utilized during the PHE that addressed health disparities and increased access to care. For example, HHS waivers during the PHE made telehealth more accessible by allowing providers to deliver telehealth services across state lines, made it easier for providers to use telehealth services for Medicare and Medicaid patients, and gave providers more flexibility in the technology used to provide virtual visits. Although Congress is already considering extending these flexibilities for the short-term, the administration should encourage Congress to put these flexibilities in place permanently. These flexibilities, combined with other solutions such as value-based payment and increased broadband infrastructure, have the potential to drastically reduce health disparities and increase healthcare access nationally.

Support Adoption of Health Data Utilities within States: Additionally, state to state the Health Data Utility (HDU) model for shared health data infrastructure has moved from theory into practice, and likely precipitated by the urgency of the COVID-19 pandemic and disparate and siloed data systems. Statewide entities combine, enhance, and exchange electronic health data

across care and services settings for treatment, care coordination, quality improvement, and public and community health purposes. HDUs enable specific, defined use cases, with extra protections to ensure patient privacy and appropriate data use.

HDUs represent both the evolution of community health information exchange as well as a new paradigm—a multistakeholder, cross-sector data resource for multiple use cases and services. Whole-person and public health today is reflected in clinical and non-clinical data across multiple settings and sources. HDUs emphasize multistakeholder organizational and use case-specific data governance with an emphasis on public health. Most organizations at the center of an HDU will be designated non-profit organizations or independent state agencies. In all cases, state and multistakeholder governance, oversight, and accountability is paramount. HDUs are flexible and uniquely capable of meeting state-specific health data needs. These interventions could have been more targeted during the public health emergency if there had been access to real time data that HDUs can provide.

States have existing infrastructure in place for clinical data exchange, including regional and statewide HIEs. However, this existing technical and relationship infrastructure needs to be strengthened and developed further, especially where services and organizations are not capable of meeting HDU requirements. There needs to be a pathway and a funding stream to support both the planning and development needed to build capacity. HDUs leverage existing infrastructure, displaying the critical application and responsible use of federal funds. Telehealth flexibilities, combined with the use of HDUs, can address health disparities and increase access to care and quality of care.