

October 5, 2023

Representative Jason Smith (MO-08)
Chairman
House Ways & Means Committee
1139 Longworth House Office Building
Washington, DC 20510

RE: Request for Information from Stakeholders on Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Smith:

[Civitas Networks for Health \(Civitas\)](#) appreciates the opportunity to provide feedback on the September 7, 2023, request for information (RFI) from stakeholders on improving access to health care for Americans in rural and underserved areas issued in your capacity as Chairman of the House Ways & Means Committee. Civitas is a national nonprofit collaborative comprised of more than 165 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), and providers of services to meet their needs—working to use data frameworks, information infrastructure, and multi-stakeholder, cross-sector approaches to improve health for individuals and communities. We educate, promote, and influence both the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system, while also supporting multi-site, grant-funded programs and projects around the country.

Civitas is proud to be an essential voice for our members and the communities they serve at a critical time in the development of America's health data frameworks, when rapid advances in the availability and use of medical information are colliding with systemic challenges and the imperatives to improve health system efficiency, security, and accountable governance. In the course of navigating these dynamic and sometimes conflicting circumstances, Civitas members have become leaders in the development of a new and innovative paradigm known as the Health Data Utility Model (HDU) that holds great promise for effectively managing the demands of this new landscape. The HDUs emerging around the country represent an evolution rather than a revolution in the structure of health information networks and value-added capabilities, combining the multi-directional data transmission infrastructure of incumbent statewide and regional HIEs with a wider array of quality improvement, analytics, community health and social service functions that in many areas have been advanced by RHICs and related quality improvement organizations of varying sizes.

The resulting nonprofit organizations—or partnerships of nonprofit organizations—which comprise an HDU can take advantage of scaling efficiencies across well-defined geographies to better serve their communities as information networks, secure data stewards, platforms for the integration of new technologies, and public health assets. HDUs' nonprofit status, local stakeholder governance (typically overseen by boards with representatives of different providers, patient advocates, and community organizations) and official recognition by public authorities (in state laws, regulations, or contracts) have positioned them as neutral system arbiters vis-à-vis

corporate electronic health record platforms (EHRs) and other technology vendors, whose products are “plugged in” to the HIE architecture to perform specific functions at different sites, but who do not own or control the HDU at large. The service territory structure of HDUs also enables the participating organizations to achieve greater levels of financial self-sufficiency through payer and provider fee schedules, as well as through the use of public formula funds (e.g., Medicaid, block grants) and larger contracts. Analogies from outside the health space are long-established models of nonprofit, public-serving utilities like electric cooperatives and water authorities that are thoroughly connected to wider infrastructure networks while maintaining sufficient autonomy to respond to their customers’ needs, or the role of state and local roads in the national surface transportation network.

Examples of Civitas member organizations that can be characterized as emerging HDUs based on their current capabilities and various aspects of their operations include the Tiger Institute/Lewis & Clark Health Information Exchange partnership in Missouri; CyncHealth in Nebraska; MyHealth Access Network in Oklahoma; Contexture in Arizona; and West Virginia Health Information Exchange (WVHIN), all of which have substantial rural populations as part of their service areas and devote significant attention to rural use-case operations. These operations are described below with associated Civitas policy recommendations, as an innovative care model under Ways & Means Committee jurisdiction that leverages technology and existing federal investments to benefit the country’s most underserved providers and patients.

Multi-directional, synchronous exchange of patient medical records between primary, specialty outpatient, and hospital clinicians. This is the modernized version of the original point-to-point legacy model for health information exchange, and on a basic level it remains especially important in rural service areas to negate distance barriers and bring disparate patients and providers together. As the number of rural providers keeps shrinking and more rural residents are forced to travel long distances for specialized care—or make use of telehealth applications—the necessity of a secure, interoperable third-party pipeline between a local nurse practitioner at a rural clinic and a neurologist at a hospital 50 miles away is clear. The most illustrative and compelling use cases are often exercises in leveraging records from large numbers of patients and providers that would otherwise be impossible to assemble on a practical timescale, such as the statewide organ donor matching and coordination activities performed by the emerging HDUs in Missouri (Tiger Institute/ Lewis & Clark HIE and Midwest Health Connection/Velatura), Colorado, California, and elsewhere.

Connectivity between different types of healthcare providers. A hallmark of the emerging HDU model is the integration of technology, technical supports, and value-added applications across a broad and expanding range of provider facility types within the same serve area. In recent years, hospitals of different sizes (from critical access hospitals to academic medical centers) and independent primary care practitioners have been joined by—and in some cases, outnumbered within the HDUs own networks by—skilled nursing and long-term care facilities, urgent care clinics, ambulatory surgical centers, federally-qualified health centers (FQHCs) and look-alikes, rural health centers (RHCs), hospital outpatient departments, independent clinical laboratories, and psychiatric residential treatment facilities. The proliferation of these “new” provider types is particularly evident in rural areas where the number of hospitals and physicians is categorically low and trending lower. To use one example, Missouri’s Tiger Institute/LACIE partnership alone

has enrolled more skilled nursing facilities (59) and federally qualified health centers (58) statewide than there are hospitals in the state's rural counties (67). These sites have in turn been joined by non-physician practitioners including physical and occupational therapists, psychologists, and licensed clinical social workers. The leading edge of provider recruitment into HDU functionality in most states is pharmacies, many of which already share limited prescribing information with HIEs per state prescription drug monitoring programs (PDMPs) as an opioid abuse countermeasure, but most of which are only beginning to unlock the full potential of incorporating all prescriptions into HDU datasets as a result of new state laws and regulations.

Technical protocols and standardization to promote an open health data landscape and inclusive advancement. Emerging HDUs, HIEs and RHIC organizations have been leaders by necessity in the adoption of platform-agnostic data standards and processes (such as HL7 FHIR and API-based specifications more generally) that ensure as many stakeholders within their service areas as possible can participate in information exchange for their own benefit, and for purposes of securely contributing valuable datasets to further quality improvement and public health applications. Because Civitas members tend to have statewide or comprehensive regional service areas that typically include a mix of urban, suburban, and rural health ecosystems, they act as levelers for rural participants who might otherwise be forced to play catch-up (more so than they already do). Moreover, many Civitas members have prioritized direct and ongoing technical assistance to rural healthcare facilities within their service areas, providing education for system onboarding, project-specific support, and training that integrates data management into the routines of community health workers and other key personnel (notable examples exist in Ohio and Vermont).

As a matter of policy, the Ways & Means Committee can help HDUs continue expanding the capabilities of locally-governed, nonprofit, and structurally neutral health information exchange networks for rural and underserved providers by supporting efforts to make better use of existing federal resources, notably Medicaid formula funding. Emerging HDUs are defined by a growing suite of operational and technical services offered to a wider set of clinical and non-clinical provider types than ever before, which is key for rural areas with fewer hospitals, higher physician-to-patient ratios, and distance barriers that make providers harder to reach for patients. These services rely on in-house and contracted digital infrastructure including continuously updated patient indices; ADT (Admission-Discharge-Transfer) messaging, document query pathways, authentication protocols, and cybersecurity tools, all of which must be kept fully-functional for all HDU participants on a 24/7 basis. Even more important is the human capital behind the moving parts—the relatively small but dedicated staffs of system engineers, provider liaisons, administrators, and others who support entities connected to HDU systems and are especially valuable for onboarding new providers.

The digital and human components of the system require funds to maintain. As noted previously, most Civitas member HIEs and HDUs have achieved high degrees of sustainability by developing revenue models that mix fee schedules for participating providers and commercial payers with existing funds from federal and state sources (as opposed to new funding or annual public appropriations). Revenue from participant fees alone covers 100% of the regular operations budget for more than a third of Civitas' 69 HIE and emerging HDU members around the country, which is a remarkable statistic given that virtually all of these organizations were major

beneficiaries of HHS HITECH Act funding for over a decade until the program expired in the fall of 2021. HDUs are not seeking and do not require new multibillion-dollar funding commitments from the federal government to replace HITECH dollars. Instead, Civitas HIE and HDU members would benefit from more flexibility in the structures of existing funding programs, especially the Medicaid Management Information Systems (MMIS) and Medicaid Enterprise Systems (MES) programs that finance their partnerships with State Medicaid Agencies (SMAs) for Medicaid beneficiaries' health record transmission in most states.

During much of the HITECH period, OMB waived pre-existing requirements that MMIS/MES funds allocated by SMAs for HIE services be based strictly on the percentage of Medicaid beneficiaries who are directly served by the HIEs. This waiver period allowed SMAs to move away from this constrained and outdated “beneficiary-based” formula and approve more effective “provider-based” cost allocation methodologies for HIEs using the percentage of Medicaid-enrolled providers in the state who are networked into the HIE system. Because HIE systems serve all patients equally at equal operational cost—the doctor's office computers transmit Medicaid and non-Medicaid patients' records the same way—the provider-based methodologies are more conducive to HDU development, and to making the wider health system function more efficiently consistent with the rationale for these systems and taxpayer return on investment. Unfortunately, OMB has reverted back to its “beneficiary-based” framework since the end of HITECH, and as a result SMAs around the country (and CMS) are disallowing provider-based funding for HIE activities that would support updating technologies, training staff, and onboarding new clinical and non-clinical providers. While at present the cost-allocation methodology discussion is ongoing between HIEs/HDUs, SMAs and CMS, the Committee is nonetheless in a position to have a significant impact on the outcome by demonstrating interest in the more flexible provider-based approaches.

Resources and tools to enable effective and systematic quality improvement. Building on the work of state and regional RHICs around the country, HDU partnerships have increasingly made quality improvement a major part of their portfolios as they recruit a wider array of providers and leverage expanding volumes of health data—and the federal health enterprise has been a key partner to this end. Eleven Civitas members have active contracts under Medicare's longstanding Quality Improvement Organization (QIO) Program through 2024: seven of them (Telligen, Alliant Health Solutions, Mountain-Pacific Quality Health, Quality Insights, Comagine and Metastar/Stratis Health within the Superior Health Quality Alliance) are among the 14 Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) nationwide tasked with implementing Program activities in their assigned multi-state respective regions, while four others (Iowa Healthcare Collaborative, New Jersey Innovation Institute, New York e-Health Collaborative, and Rhode Island Quality institute) serve as Network of Quality Improvement and Innovation Contractors (NQIICs) within state borders. In rural areas specifically, Civitas members Mountain Pacific Quality Health and Comagine were also two of the three QIOs contracted to carry out the Medicare Quality Payment Program's Small Practice, Underserved, and Rural Support initiative (QPP-SURS) that focused on delivering technical assistance necessary for independent clinicians serving some of the nation's most medically underserved communities to participate in QPP—until QPP-SURS expired without authorization in February 2022.

Quality improvement can vary significantly by provider and project type, with activities ranging from assessment of patient outcomes for specific medical procedures and large-scale evaluations of clinical best practices to the development of performance measures, workforce training, and community engagement. The common emphasis is better outcomes and lower costs, driving efficiency and bending the cost curve away from entrenched bureaucratic inertia and toward the promise of value-based care. This transition is particularly important for both rural and urban underserved areas, which account for markedly disproportionate shares of the nation's highest-risk and most expensive patients. In rural areas, the problem is compounded by more small practitioners with fewer resources and less administrative bandwidth to handle the reporting requirements associated with Medicare's flagship quality improvement programs (Shared Savings Program, QPP) and CMS innovation pilots despite being among the providers who stand to gain the most from them.

As a matter of policy, the Committee should support the reauthorization of the Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) initiative to restore much-needed technical assistance for rural primary care providers, enabling them to maximize the benefits of Medicare quality improvement efforts for rural health systems. Between 2017 and its expiration in 2022, QPP-SURS provided free technical assistance to over 100,000 clinicians annually in HHS-designated medically underserved and health professional shortage areas across eight states (MO, TX, OK, MS, LA, KS, CO, AR) and Puerto Rico, helping to extend the reach of value-based mechanisms into communities where patient-centered care practices would otherwise be scarce or absent. Program activities focused on transitioning from CMS' legacy payment reporting systems to the current Merit-Based Incentive Payment System (MIPS), which among other criteria includes standardized health data reporting and use requirements ("promoting interoperability") that facilitate HIE adoption and serve to tie quality improvement more closely to the HDU model. Medicare practitioners participating in QPP-SURS could avail themselves of live webinars, data analytics, and real-time workflow reviews to ensure consistency with MIPS standards and help position these practices for high-scoring reimbursement. These interventions are still very much needed in the original QPP-SURS service area and beyond, and the Committee is well-positioned to meet this need by backing bipartisan legislative proposals for a revival of this program in the near future.

Localized social service referral networks and systemic integration of social determinants of health. HHS has defined "social determinants of health" (SDOH) as "economic and social conditions which influence the health of people and communities." These conditions include housing, food, and utility insecurity; transportation needs, education and health literacy, household income, geographic distance to care, justice system involvement, and toxic environmental exposure (among many others). Their relative prevalence or absence in different communities is largely responsible for a broad array of socioeconomic indicators, impacting not only access to care, but the ability of individuals to sustain the benefits of medical interventions when they do receive them—and therefore lower utilization rates, particularly for expensive acute and inpatient hospital services. Everyday SDOH effects on healthcare provision in rural America are hard to overstate, as every mobile clinic nurse trying to explain drug interactions or critical access hospital with patients stranded in the ED for lack of a ride home can attest.

Addressing patients' social needs can be a complex and protracted process, but in all cases the process begins by finding appropriate modes of care and staying in contact with those providers. This is where emerging HDUs around the country have demonstrated their value, by incorporating public and private social care providers into health information exchange and data-integrated technical assistance networks alongside clinical providers. The HDU model refers primary care patients who are food-insecure to local food banks (and to local charity transit services to get to the food banks) in the same way it refers them to cardiologists or substance abuse clinics, and is able to gather similarly useful (de-identified) data points for quality improvement and public health analytics purposes. On the patient level, this makes records more comprehensive and practical for both clinicians and social service organizations, while compounding efficiencies on the level of the local and regional systems. As partners within the HDU framework, Civitas' RHICs have taken integrated SDOH activities several steps further by creating multi-pronged care coordination efforts organized around specific needs in their geographies, such as maternal mortality in Ohio and pediatric care in Kansas.

As a matter of policy, the Committee should advance SDOH clinical integration and emerging HDU models that make such integration possible by supporting ongoing CMS efforts to institutionalize these activities in Medicare, such as those contained in the 2024 Physician Fee Schedule (PFS) Proposed Rule. The 2024 PFS, released in July, breaks new and welcome ground with proposals for three new billable services—SDOH Risk Assessment, Community Health Integration (CHI), and Principal Illness Navigation (PIN)—that would compensate physicians for time spent conducting social needs integration activities. SDOH Risk Assessments would be delivered as an optional part of Annual Wellness Visits (AWVs) or as part of a standard Evaluation & Management (E&M) visit at six-month intervals, using any “validated” methodology of the practitioner’s choice. The CHI and PIN coverage proposals are more comprehensive, with emphasis on patient-centered connections to social needs and care transitions for patients with severe chronic illness, respectively. Both also allow auxiliary personnel working under contract with third-party CBOs (like Civitas RHIC members) to take charge of the necessary care coordination activities after the physician’s medical initiating visit. These proposals are currently back under review at CMS with the rest of the PFS in advance of a final rulemaking (expected in November).

Thank you again 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 achieve a community-governed, interoperable health data system to improve public health and health care outcomes.

Sincerely,



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