June 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

Dear Administrator Oz:

Civitas Networks for Health ("Civitas") appreciates the opportunity to submit public comments on the Fiscal Year 2026 IPPS & LTCH Prospective Payment System and Policy Chanes Proposed Rule (CMS-1833-P), published in the *Federal Register* on April 30, 2025 (90 FR 18002). Civitas is a national nonprofit collaborative comprised of more than 175 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), quality improvement organizations (QIOs), All-Payer Claims Databases (APCDs), 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 guide the private sector and policymakers on matters of interoperability, quality, coordination, and cost-effectiveness within the health system.

Accordingly, Civitas members have a compelling interest in CMS' policies and initiatives that continue to drive the digital transition by enhancing connectivity and interoperability across the healthcare ecosystem. Few federal policies have been more important in doing so than the Medicare Promoting Interoperability Program, which for well over a decade has been a critical lever for expanding and modernizing health data infrastructure at over 4,500 acute and critical access hospitals. The Proposed Rule seeks several changes to the program, most of which the Civitas community supports: requiring a best-practice self-assessment using the 2025 updates to the SAFER Guides; adding a security risk management attestation under the current HIPAA Security Rule implementation specifications; and maintaining the EHR reporting period as any continuous 180-day period for calendar year 2026 and subsequent years are all welcome improvements.

The Program change that many Civitas members consider misplaced is the proposal to add an optional bonus measure for public health information exchange via TEFCA. Under the Proposed Rule, eligible hospitals and CAHs that transmit validated data to a state, local, tribal, or territorial PHA through a QHIN as a participant or subparticipant using CEHRT would be able to claim 5 bonus points under the Program's Public Health and Clinical Data Exchange object. The data in question can be electronic case reporting (eCR), electronic lab reporting (ELR) or information related to other public health purposes (including but not limited to immunization data, vital records, prescription drug monitoring, hospital capacity, and chronic disease per TEFCA's Public

Health Implementation SOP). Interoperability bonus points are already available for public health registry reporting and clinical data registry reporting; TEFCA PHA reporting would be the third and newest bonus option. In its rulemaking, CMS notes the following:

We further recognize that eligible hospitals and CAHs may connect to entities that connect directly or indirectly to a Qualified Health Information Network[f](QHIN) using certified health IT in a variety of ways. This includes the other ONC health IT certification criterion at 45 CFR 170.315(f) associated with the Public Health and Clinical Data Exchange objective measures, and we believe that we should allow for substantial flexibility in how eligible hospitals and CAHs use certified health IT to exchange health information under a TEFCA Framework Agreement

Statewide and regional HIEs (some of which are also called health data utilities, or HDUs, to reflect their range of primary and secondary use cases) were established as public and nonprofit systems to collect, standardize, and transmit data from various provider EHRs to PHAs long before TEFCA was created. As such, they occupy a unique and essential place in network infrastructure for their service areas, which CMS has recognized in the aforementioned Public Health and Clinical Data Exchange objective measures and to varying degrees in the three other scored requirement categories for Promoting Interoperability. Since 2023, the agency has moreover included "enabling exchange under TEFCA" as a 30-point option to fulfill the requirement under the scored Health Information Exchange category.

Civitas appreciates that the agency continues to acknowledge the value of the HIE role, and has designed its TEFCA bonus measure proposal with "substantial flexibility" for "direct or indirect" connectivity in mind. Yet given the existence of the 2023 scored option for TEFCA exchange under the HIE category and the content of the scored measures under the Public Health and Clinical Data Exchange category, establishing the separate bonus measure for PHA exchange via TEFCA becomes exclusionary and redundant. Exclusionary, because many smaller acute care systems and the vast majority of critical access hospitals in rural areas do not connect to a QHIN for lack of financial and human resources. Among the growing number of hospital systems that are joining QHIN exchange, many are being guided by proprietary, market-incumbent EHRs which are simultaneously QHINs themselves—and thus, a separate incentive bonus for PHA exchange via TEFCA is in effect favoring these larger, hospital systems over the smaller facilities with the greatest need.

The proposed change would also be redundant, because those HIEs which are connected to a QHIN are already transmitting public health data to PHAs through TEFCA. This occurs either under the TEFCA Public Health SOP explicitly, in purpose-built partnership with state agencies (as in Maryland, Alabama, Virginia, Alaska, and the District of Columbia), or as a function of HIEs "on-ramping" their existing participant networks to TEFCA under other SOPs, given that the networks include PHAs leveraging them to conduct activities aligned with the Promoting Interoperability Program's six Public Health and Clinical Data Exchange objective measures (syndromic surveillance, immunization registry, eCR, and ELR, reporting, plus AU and AR surveillance). Such complexity and overlapping practical activities suggest that a consolidation and simplification of the PIP scored and bonus categories is what is needed, rather than an additional TEFCA-specific bonus measure.

Beyond the Promoting Interoperability Program, Civitas members have noted CMS' proposal to remove two social drivers of health measures from the Hospital IQR Program starting in the FY20206 payment determination period. The Screening for Social Drivers of Health (SDOH-1) and Screen Positive Rate for Social Drivers of Health (SDOH-2) measures would be dropped on the grounds that their costs exceed their continued benefits, based on feedback from some hospitals that the burden of "screening patients via manual processes, manually storing such data, training hospital staff, and alternating workflows" is excessive.

Our HIE members exist to mitigate this burden by providing the secure technical and operational capabilities to digitize and standardize health information in a neutral, collaborative and (in many cases) officially state-designated framework that is responsive from the ground-up, not the top down. Their work is enhanced by that of our QIO, APCD, and RHIC members, who combine data with expertise and deep local partnerships to identify and implement solutions that lead to better outcomes and lower costs. The results are comprehensive ecosystems that can integrate standard and emerging data elements aligned with the five CMS SDOH domains (housing insecurity, food insecurity, transportation needs, and utility difficulties) to help realize the long-term cost benefits of SDOH-1 and SDOH-2 through reduced hospital utilization and administration on all levels. Interoperability across these ecosystems is the answer to what CMS describes as the problem of "repeated screenings across multiple healthcare facilities" that the Proposed Rule frames as a primary obstacle to keeping the measures in question. As our members work with providers and PHAs around the country—and as CMS and HHS as a whole works to modernize the health system with proven solutions— we strongly believe that the core components of SDOH-1 and SDOH-2 should remain in the IQR Program.

On behalf of Civitas and our members, thank you again for your consideration of our comments. The Civitas community is deeply engaged in multiple corners of the health data policy and regulation space, and we stand ready to collaborate to achieve our shared goal of creating a higher-value health system.

Please do not hesitate to reach out if you have any questions or comments for us.

Sincerely,

Jolie Ritzo
CEO, Civitas Networks for Health