Civitas 2026 Annual Fly-In – Prep Document
Our members are a necessary component of the implementation layer for every federal health priority listed.

**While talking with policymakers, lead with what your organization does, connect it to the relevant federal initiative, and close with the ask.*

Who We Are

- Civitas is a national network of organizations advancing critical health infrastructure. In 2026, we are demonstrating how member capabilities improve cost, quality, safety, and upstream drivers of health in communities nationwide:
    - HIEs and HDUs are foundational public infrastructure for the portability and usability of health data. Most HIEs operate as non-profit entities and exchange data in a secure standardized manner (HL7 FHIR).
    - APCDs are foundational public infrastructure for health care cost transparency, market oversight, and value-based purchasing.
    - QIOs are foundational public infrastructure for clinical best-practice implementation, technical assistance, regulatory compliance, and measure development.
    - RHICs are foundational public infrastructure for multi-stakeholder health system improvement, advancing value-based care, delivery system transformation, and upstream drivers of health. RHICs can also incorporate data from non-traditional healthcare sources, such as housing, transportation, and education data.
- Civitas members share a commitment to data-driven, multi-stakeholder collaboration and public-private partnerships within regions. Our members' work shows how locally governed, interoperable infrastructure can deliver measurable progress on national priorities at every level.
- Civitas members are committed to responsible data use and serve as a trusted voice in federal efforts to strengthen health data privacy and cybersecurity. As Congress considers new legislation in both areas, Civitas brings direct operational experience with what works and what creates unintended barriers for health data exchange at the state and regional level.

Rural Health Transformation Program (RHTP)

- APCDS, HIEs, QIOs, HDUs, and RHICs have spent decades building the data infrastructure and stakeholder relationships that RHTP depends on for long-term success and sustainability.
- Civitas members are locally governed, already embedded in the communities RHTP is trying to reach, and are uniquely positioned as neutral conveners across providers, payers, and community partners.
- QIOs are positioned as technical assistance partners under the 13th Statement of Work and through other QI-focused initiatives; they can move immediately into RHTP implementation without a learning curve to provide on-the-ground support to rural providers.
- HIEs and HDUs provide the data connectivity that makes RHTP outcomes measurable and accountable to Congress by tracking whether care is actually improving, costs are being managed, and the program is delivering on its rural health promises.

HR1/OBBBA: Medicaid & SNAP Implementation

- We applaud the E&C Committee's decision to preserve enhanced match rates for key Medicaid administrative functions. Implementation funding should flow to states directly so they can build durable, accurate infrastructure vs. one-off verification systems. We encourage Congress to continue to preserve match rates in future reconciliation bills.
- Medicaid fiscal pressure trickles down to state health data infrastructure. State appropriations for HIEs and APCDs are often tied directly to Medicaid funding levels and provider revenues. Cuts to Medicaid to reduce federal spending may inadvertently defund the infrastructure HR1 needs to execute verification requirements accurately and efficiently.
- HR1's eligibility verification requirements are data-intensive: checks against Social Security, death files, address records, out-of-state enrollment, managed care data, and work or community engagement status. States with HIE and APCD infrastructure can execute them accurately, but states without will produce errors, which could result in loss of coverage, appeals, litigation, and political exposure.
- December 2025 guidance from CMCS requires states to use "reliable information" from payroll, education enrollment, job training, and community service records *before* requesting documentation from enrollees. Many of those sources are federally administered by multiple agencies, with no joint guidance establishing how HIEs can serve as intermediaries. That gap should be closed before the January 2027 deadline.

New CMMI Models

- Since December 2025, CMS has launched nine new CMMI models, four of which Civitas is tracking closely: ACCESS, LEAD, MAHA Elevate, and ASPIRE. All four share a common design assumption: interoperability exists, data flows, and the necessary infrastructure is in place. CMS designed these models as if that's already true everywhere, when in reality it is not.
- The ACCESS model is explicit: participants (i.e., providers) must integrate with an HIE or similar trusted network. HIEs and HDUs provide multi-source, real-time data infrastructure that makes outcomes-based payment possible. Without it, providers are unable to meet the thresholds that trigger payment.
- LEAD is designed specifically for smaller practices, rural providers, and safety-net organizations; these providers are least likely to have internal data capacity while also serving high-risk, high-need populations. Without shared HIE infrastructure, the model risks creating pockets of success in markets that are already well-resourced.
- MAHA ELEVATE requires longitudinal cross-program beneficiary tracking, cross-setting behavioral health visibility, multi-payer attribution, and connections to social services and community care hubs. States with mature HIE, HDU, and APCD infrastructure can operationalize faster.
- ASPIRE is distinct from the others because it focuses on children and youth on Medicaid. However, like the others, it assumes the kind of cross-program, longitudinal data infrastructure that HIEs and HDUs already operate but does not explicitly name them. That omission should be addressed before the NOFO is released later this year.

CMS Health Technology Ecosystem Initiative

- CMS envisions a federated “network of networks” to modernize the nation’s digital health ecosystem. Civitas members are those networks — already operational, locally governed, and accountable to multi-stakeholder boards. What is missing is formal recognition, clear participation pathways, and guidance that encourages states to partner with their HIE or HDU through existing mechanisms for funding.
- ONC’s organizational reset creates an opportunity to ensure HIEs and HDUs have formal roles in federal interoperability governance, something previous administrations never clearly defined.
- Near-term information blocking fixes are achievable without new legislation and would meaningfully improve data access: pharmacy and lab compliance, excessive EHR onboarding fees that price smaller HIEs out of data access, and state delegation for enforcement.

Public Health Infrastructure & Data Modernization

- States are increasingly carrying public health activities once held at the federal level: surveillance, analytics, and technical assistance. That is only viable if states have the data infrastructure to step in, and right now that infrastructure is uneven.
- Civitas has signed on to a coalition letter requesting $340 million for CDC Public Health Data Modernization, $55 million for RREDI (Response Ready Enterprise Data Integration), and $100 million for the CDC Center for Forecasting and Outbreak Analytics, directed to the FY27 LHHS Subcommittee. These are capacity investments, not new spending categories. Congress has already invested more than $1 billion to build the foundation; this funding sustains it.
- HIEs and HDUs serve as intermediaries between clinical data systems and public health agencies; they handle reporting, surveillance, and data sharing in ways that reduce provider burden and improve data quality. FY27 appropriations language already directs CDC to leverage data intermediaries, including HIEs and HDUs, to efficiently route data between healthcare providers, health departments, and CDC. That direction should be implemented through formal guidance to states.
- APCDs provide multi-payer, population-level data no other source replicates. Section 514 ERISA preemption leaves a structural gap in every state APCD: self-insured employer plans are exempt from state data reporting requirements. A targeted federal fix consistent with SAPDAC recommendations has broad bipartisan support and no direct federal cost.

Privacy and Cybersecurity

- Civitas members have a direct and operational interest in how federal privacy legislation interacts with HIPAA, state law, and existing health data exchange infrastructure. Additionally,
- HIEs and HDUs serve as a critical continuity resource when providers and health systems experience a cyberattack – maintaining access to patient records, ensuring data availability across the care continuum, and helping support clinical operations when individual systems go down.
- QIOs provide technical assistance and education to help providers, hospitals, and health systems – particularly rural and safety-net organizations – understand and implement cybersecurity best practices before a situation occurs.

- The Health Information Privacy Reform Act (S.3097) is an active Senate bill Civitas has already engaged on. Civitas comments helped shape key provisions, including alignment with existing HIPAA standards.
- The Health Care Cybersecurity and Resilience Act (S.3315) passed the HELP Committee. Civitas is tracking this bill closely, given its implications for member organizations

Summary of Asks

Close each conversation with the relevant ask. If the office covers multiple topic areas, prioritize the ask most connected to their committee assignments.

- **RHTP:** Ensure that APCDs, HIEs, QIOs, HDUs, and RHICs are named implementation partners in RHTP planning, not just late-stage stakeholders.
- **HR1:** Direct HR1 implementation funding to states for durable health data infrastructure. Issue joint CMS-FNS guidance establishing a standard framework for cross-program data sharing and an explicit role for HIEs as intermediaries. Ensure Medicaid data functions supported by HIEs and APCDs remain eligible for federal match.
- **CMMI:** Encourage CMMI to build HIE and HDU participation into model design and TA resources from the start. Direct CMMI to assess whether new model data requirements are achievable in states without mature HIE infrastructure and invest accordingly.
- **Health Tech Ecosystem:** Direct CMS and ONC to formalize HIEs and HDUs as Aligned Networks with clear participation pathways. Support targeted information blocking enforcement fixes.
- **Public Health:** Support $340M for CDC Public Health Data Modernization, $55M for RREDI, and $100M for CFA in the FY27 LHHS bill. Support a targeted ERISA fix for APCDs. Direct CMS, IHS, VA, and OPM to improve federal data access for state HIEs and APCDs. Encourage HHS to follow through on fiscal year 2027 report language directing the department to “leverage existing authorities, funds, and other resources to construct policy and regulations that strengthen existing HIE infrastructure to facilitate their transition to HDUs.”
- **Consponsor the LINC VA Act (S.3303):** Introduced, by Sen. Dan Sullivan (R-AK), the bill creates a pilot program to establish or enhance a “community integration platform” for services for veterans such as healthcare, housing, nutritional assistance, job training, referrals, etc.