STATE OF WASHINGTON

DEPARTMENT OF HEALTH

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Dr. Mehmet Oz, MD
Centers for Medicare & Medicaid Services (CMS),
Department of Health and Human Services (HHS),
Attention: CMS-9115-P,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Re: Comments on Proposed Rule: CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

The Washington State Department of Health (DOH) appreciates the opportunity to comment on the proposed rule, "CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program," printed in the Federal Register on July 16, 2025 (FR Vol 90, No. 134). Public health activities play a vital role in the health of all Americans, including those receiving healthcare coverage from the Centers for Medicare & Medicaid Services (CMS). DOH has many programs that receive and send data to clinical data partners through their health IT systems. DOH also works with local, state, tribal and federal partners to protect and improve the health of all people in Washington state through broad program areas such as prevention and community health, healthcare licensing, environmental health, disease control, health statistics and emergency preparedness. We appreciate the Promoting Interoperability Program, what it has done and is doing to incentivize data exchange and we also appreciate the opportunity to comment on other proposed rules that impact our population health programming.

DOH has the following comments on the proposed regulations:

- Request for Information regarding Support Management for Prevention and Management of Chronic Disease (Page 32503). The department encourages CMS to consider a variety of policy changes to support management and prevention of chronic disease. We encourage the consideration of "upstream drivers" as a comprehensive approach for the consideration of factors like smoking, poor nutrition, low physical activity, substance misuse, and other environmental factors.

- *How could we better support prevention and management, including self-management, of chronic disease?* The Department recommends the following policies and service changes to improve care for chronic illness and behavioral health needs:

  Community-Based Workforce
  The Department supports recognizing the community-based workforce, including Community Health Workers (CHWs), promotores de salud, and peer navigators—as essential partners in chronic disease prevention and management. These frontline workers extend the reach of clinical teams by providing culturally and linguistically appropriate support for lifestyle change and self-management. We encourage CMS to ensure that new codes and payment models explicitly recognize the role of CHWs and the broader community-based workforce.

  CMS could strengthen prevention and management of chronic disease by:
  - **Expanding Coding and Reimbursement Pathways**: Create or adapt codes that reimburse for CHW-delivered services related to intensive lifestyle management, health coaching, and motivational interviewing. These services are often not adequately captured under current physician fee schedule codes, despite evidence of improved outcomes in weight management, diabetes prevention, hypertension control, and adherence to care plans.
  - **Addressing Loneliness and Social Isolation**: CHWs and peers can provide ongoing relational support, facilitate connections to community resources, and reduce social isolation among aging adults and persons with disabilities. Evidence shows that addressing loneliness reduces risk for cardiovascular disease, depression, and early mortality.
  - **Supporting Caregivers**: Family and informal caregivers are at high risk of stress, fatigue, and development of their own chronic conditions. Community-based workforce interventions can provide caregiver education, navigation, and peer support to reduce strain and promote caregiver well-being—thereby protecting the health of both caregivers and care recipients.
  - **Community- Based Organizations:** There are references throughout the rule to having the billing provider refer the provision of the service to a community-based organization (CBO), under the supervision of that provider. We are very supportive of this direction since it is likely that CBOs will employ CHWs to serve this role and would be effective for the reasons listed above. Having the ability to deliver preventive services outside of clinics and in communities will make uptake more likely. Additionally, there should be consideration of allowing billing providers to make referrals to Community Care Hubs. These organizations can work with providers to connect patients to CBOs in their networks that are the best fit for the patients, ensure standardization of service delivery across a network of CBOs, and provide the referral loops needed to report that service delivery has occurred. Services could be billed concurrently with other care management services.
  - **Bi-Directional Referral System**: Providers struggle to get information about patients when referred to support resources outside their health system. Using

the data modernization platform, CMS should assist and support health systems to integrate a bi-directional referral platform to help providers and patients self-manage their chronic diseases.

- **Provide Resources and Incentives**: Patients struggle with managing their chronic diseases due to a lack of education, resources, access to health-promoting environments, and motivation. Invest in a Medicare model that provides incentives for those who make progress in managing their disease. Examples of this include: health prescriptions for CMS covered gym memberships; fruit and vegetables at the grocery store; blood pressure cuffs for those with hypertension.

Life-course approach to addressing chronic diseases

- **Include Dementia in chronic disease programming**: Dementia is often left out of programming for chronic diseases which limits the attention to this critical condition. Nearly half of all dementia cases worldwide could be prevented or delayed by addressing 14 modifiable risk factors throughout the life course (2024 Lancet article: Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission). Outside of the Building Our Strongest Dementia (BOLD) Infrastructure grant, most state health departments, including Washington, do not have the same kinds of funding as other chronic disease prevention programs, even though there are clear ways to reduce risks of dementia.
- **Increase training for whole geriatric care:** There is often a lack of knowledge amongst providers on how aging and the associated conditions that may impact older adults. This includes increasing awareness by case managers and providers of dementia being classified as a chronic disease.
- **Programming for Dementia Navigators or Care Coordinators:** most individuals living with dementia have one or more other chronic diseases. The presence of cognitive impairment can severely complicate the management of these conditions. Source: https://share.google/J54LFlXmuSwAKRRUe

Rural Telehealth Availability

The extension of telehealth flexibilities for FQHCs and RHCs through 2026 is critical, but CMS should make these provisions permanent to ensure stability in rural care delivery.

- **Permanent telehealth:** The department supports ensuring that for rural populations, CMS makes telehealth reimbursement (both in-home and facility-based) permanent, as rural residents often face long travel distances, lack of public transportation, and limited local providers. Stable telehealth payment is particularly critical for rural Medicare beneficiaries who depend on these services for chronic disease management.
- **Audio-only telehealth:** CMS should also maintain reimbursement for audio-only telehealth, since broadband connectivity and access to video-capable devices remain significant barriers in rural and tribal areas.

- **Behavioral health and lifestyle coaching:** Consider encouraging integration of behavioral health and lifestyle coaching into telehealth models to help patients manage chronic diseases more effectively from home. Consider reimbursement mechanisms for connection to spaces supporting physical activity (e.g., YMCA or senior center membership).

Medical Nutrition Therapy
Medical Nutrition Therapy (MNT) provided by a Registered Dietitian Nutritionist (RDN) is an evidence-based method of nutrition intervention which supports both the prevention and self-management of chronic disease. Medicare currently only pays for appointments with an RDN after a person has already developed diabetes, kidney disease, or had a kidney transplant.

- **Expansion of coverage:** We recommend expansion of MNT to all CMS patients with a nutrition related diagnosis for prevention of chronic disease. MNT should also be available as treatment for at least the following diagnoses: cancer, cardiovascular disease including dyslipidemia and hypertension, celiac disease, eating disorders, HIV/AIDS, malnutrition, and prediabetes. The Academy of Nutrition and Dietetics has compiled evidence for medical nutrition therapy for these conditions here: mnteffectivenessleavebehind.pdf.

- *Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.*
  Connection to community-based health and social care services can support prevention of chronic disease, including fitness center membership and linkage to community services.

  - **Fruit and Vegetable Prescriptions:** Washington State is piloting a Fruit and Vegetable Prescription Program for patients who struggle to get healthier food into their diet. The health care provider assesses the patient's health condition and diet. If their health condition would benefit from having more fruits and vegetables in their diet, the health provider writes a prescription (voucher worth $10 - $50 per month) that they take to the participating grocery store to purchase produce.
  - **Physical Activity Prescriptions**: This is the same concept as the fruit and vegetable prescription. The participating gym or fitness facility would manage and coach the patient with appropriate balance, mobility, and fitness routines.

- *Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail?*

- **Social prescribing:** Much like physical activity and food prescriptions, social prescribing is supportive for chronic conditions (The National Academy of Social Prescribing in the United Kingdom(. Types of social prescribing include: advice and information; arts and culture; heritage; green; physical activity.
- **Simplified Billing:** CMS should consider that small rural practices, RHCs, and CAHs may not have dedicated billing or administrative staff to manage multiple fragmented codes. Any new codes created for services such as loneliness interventions or wearable device monitoring should be accompanied by simplified billing pathways or bundled options that rural providers can realistically use. Without this, rural patients' risk being excluded from innovative care models.
- CMS has an opportunity to test the connection to community-based resources, such as reimbursement of fitness center membership which can address both social isolation and physical fitness to reduce incidence of chronic disease, promote management of chronic disease and foster social cohesion.
- CMS should consider a new code to support telehealth-based intervention that addresses loneliness as a health risk, especially in older adults. Services such as outreach by care teams, virtual peer support, or telephonic/video-based social engagement interventions.

- *What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?*
  - **National Diabetes Prevention Program**: This program has been championed by CMS since its inception. However, current reimbursement policy does not sufficiently support program sustainability. Additional mechanisms for engagement and enrollment could be built, for example, facilitating access to fitness center membership as an initial precursor that can lead to engagement in chronic disease prevention and management programs.

- *Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?*
  - **Physical Activity Counseling**: General physical activity counseling to address mobility, balance, and fitness is not covered in the fee schedule. There is an opportunity to facilitate membership reimbursement for fitness or community centers that promote physical activity which often have trained coaches who can foster engagement and connection to a tailored physical activity plan. Costs for membership are low in comparison to upstream financial impact of chronic disease management.

- *How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?*
  - **Physical Activity Prescriptions:** Health providers would do a physical activity, mobility, and fitness assessment and, if the results are deficient, provide a physical activity prescription. The patient would take the prescription to a participating gym or fitness facility for coaching to achieve appropriate balance, mobility, and fitness

levels. The physical activity prescription would cover a pre-determined rate that the facility would bill the state Medicaid/Medicare agency. A physical activity assessment would then be sent back to the health care provider. As an incentive to the patient, Medicare would help sustain a discounted membership fee to the facility to sustain the patient's achievements for a pre-determined length of time.

- **Expand coverage to exercise physiologists:** These professionals could conduct assessment evaluations to determine challenges related to exercise such as a functional fitness assessment (Fitness Services) Having a provider who specializes in physical activity could provide increase confidence for Medicare users in their training program, and the program could be tailored for individual or group approaches. This may improve understanding for how to use exercise equipment, proper form, build confidence in establishing exercise habits, and minimize injury.
- **Wearable Devices:** While wearable devices and remote monitoring can improve activity levels, CMS must recognize that rural patients face higher barriers to adoption due to device cost and poor broadband availability. CMS should consider parallel reimbursement for non-digital, community-based physical activity supports in rural areas to avoid exacerbating inequities.
  - Use of wearable devices can foster increase physical activity, but it is only one tool that includes barriers to access. CMS should explore various technologies to promote physical activity.
  - CMS should recognize clinician time spent assessing data from wearable devices and prescribing or supervising exercise programs. New codes may be needed to capture this value.

- *Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under general supervision of a billing practitioner? If so, what would be the appropriate description of such a service, and under what patient circumstances (that is, after discharge from a hospital)?*
  - **Fruit and Vegetable or Food Prescriptions**: The health care provider assesses the patient's health condition and diet. If their health condition would benefit from increased fruits and vegetables and/or foods appropriate for their medical condition, the health provider writes a prescription (voucher) that they use to purchase foods at a participating grocery store. If the patient is home-bound or lacks transportation, food may be delivered to the patient by a community-based organization or grocery store service.
  - Medically tailored meals (MTM) can be meals developed as part of a care plan by a Registered Dietitian Nutritionist to meet the specific nutritional needs of individuals with severe, complex, or chronic diseases, for those with certain mental health diagnoses, or for those who are pre- and post-surgery. https://healthbegins.org/wp-content/uploads/2024/10/Medically-Tailored-Meals-Evidence-Assessment.pdf
  - Patients with a diagnosis of a severe, complex, or chronic disease (for example HIV, kidney disease, diabetes, and heart failure), certain mental health diagnoses (for example, depression, eating disorders), or who are pre- or post-surgery with increased nutrition demands should have access to MTM.

- In rural areas, access to organizations equipped to deliver MTM is limited. CMS should allow flexible delivery mechanisms, including mail-order services, regional meal hubs, partnerships with tribal food sovereignty initiatives, and farm-to-table cooperatives. CMS should also ensure that programs led by Registered Dietitians are fully recognized and not hindered by requirements for co-located physicians, which are often unavailable in rural communities.

- *Do community-based organizations providing medically tailored meals currently employ a physician, nurse practitioner, physician assistant, or other practitioner who could both bill Medicare and supervise a medically-tailored meal service (Page 32508)?*
  Yes, this appears to be the case. Registered Dietitians are the primary medical providers doing this work.

- *Should CMS consider allowing billing providers to refer to community-based organizations to deliver and ensure quality of medically-tailored meals while under general supervision of the referring billing provider(Page 32508)?*
  Yes. This would increase awareness of and access to these services.

- *If CMS were to create separate coding and payment for medically-tailored meals, how should CMS ensure integrity of the service being delivered (Page 32508)?*
  Provide funding to the state health agency to implement a monitoring program for the community-based organizations, similar to how hospital meals are monitored for quality. The supervising provider would be responsible for ensuring compliance with dietary guidance for the referring conditions and safe food handling techniques are used in the preparation, storage, and transportation of meals. CMS could fund the state health agency to monitor these programs.

- Proposal To Suppress the Electronic Case Reporting Measure by Excluding the Measure From Scoring for the MIPS Promoting Interoperability Performance Category for the CY 2025 Performance Period/2027 MIPS Payment Year and the Medicare Promoting Interoperability Program for the EHR Reporting Period in CY 2025 (Page 32735)
  WA DOH supports CMS's proposal to adopt a suppression policy to allow flexibility when circumstances outside of a provider's control prevent them from meeting a measure. With the recent CDC pause on onboarding for eCR coupled with reduced resources at WA DOH and other public health agencies it will be challenging to onboard all providers within the timeframes provided. A suppression option to allow CMS to not penalize a provider still provides incentive and priority to public health reporting via eCR while being realistic about the current circumstances impacting that process. However, DOH strongly urges that this remains only a temporary pause as we do not want to lose any of the great forward progress that has been occurring.

- Toward Digital Quality Measurement in CMS Quality Programs—Request for Information (Page 32712)
  We applaud the collaboration between CMS and CDC in the digital quality measures space. There are often overlapping needs that can put duplicative requirements on our healthcare partners between what CMS needs from a quality perspective and what CDC

needs from a surveillance perspective. WA DOH has been working on an initiative to reuse the quality measure definitions for hypertension and diabetes to provide chronic disease prevalence surveillance for public health. For this RFI here are our responses to the questions asked:

- *Are there specific eCQMs or components of existing eCQMs that you anticipate presenting particular challenges in specifying in FHIR?*
  - There are new measures being developed for public health reporting that might not have the required stratifications available. For example – stratification by age groups for reporting aggregate data for respiratory conditions.
- *What supplementary activities would encourage additional engagement in FHIR testing activities (such as Connectathons) that support the development of current and future IGs to advance adoption and use of FHIR based eCQMs?*
  - WA DOH regularly participates in HL7's FHIR-related events including Connect-a-thons, Dev Days, and working group meetings, as well as the HIMSS Interoperability Showcase. We believe these activities would be great places to gain additional engagement and support development. It would be great to see CMS and CDC partner on these events to show how measures can be shared for both payer quality and public health use cases.
- *Can you share any experiences or challenges reviewing, implementing, or testing the QI-Core, DEQM, or Bulk FHIR standards, including any experiences or challenges unique to Bulk FHIR Import versus Bulk FHIR Export?*
  - Access to test servers and relevant test data are often a challenge, especially if you want more than one or two test patients/cases. Ideally, a test server should allow users to select both FHIR version (e.g., R4, R5, 7.0.0, etc) and relevant implementation guides (e.g., Bulk Data Access 2.0.0).
  - Use of Bulk FHIR standards for 'data gathering' and using the data sets for evaluating specific measures is not a practice that has been widely adopted yet. This process, when developed, is expected to improve efficiency for periodic reporting of measure reports that specifically pertain to eCQMs. However, when it comes to real-time or near-real-time reporting, the combination of bulk data and aggregate reporting (mostly pertaining to dQM for situational awareness) proves challenging and extremely resource intensive in terms of bulk export and measures computation.
- *What, if any, additional concerns should CMS take into consideration when developing FHIR-based reporting requirements for systems receiving quality data?*
  - Traditionally CMS has used/requested claims data to evaluate Medicaid/Medicare quality improvement or treatment impact. Yet, claims data does not measure the impact of provider treatments or public health approaches on patient health indicators. In order to extract these indicators, there needs to be a standard way in which providers, clinics,

and hospitals gather patient data through baseline assessment and/or new patient intake questionnaires. Data gathered from regular visits to clinics/providers is essential to measure the treatment's effectiveness and it is also necessary to gather information from different health care systems as many Medicaid recipients are very mobile or migratory.

- CMS's strategy to advance digital quality measures (dQMs) should take Medicaid into consideration to ensure consistency and scalability across all federal programs. Specifically, CMS should align Medicaid with Medicare and Marketplace efforts in areas such as measure definitions, data standards (e.g., FHIR-based reporting), and infrastructure investments to reduce burden on providers serving dual-eligible and low-income populations. Including Medicaid in the eCQM roadmap will help address health disparities and support states in building interoperable systems that serve all beneficiaries.

- Proposed Scoring Methodology for the CY 2006 Performance Period/2028 MIPS Payment year (Page 32743)

  WA DOH encourages CMS to consider providing 5 bonus points for each of the Public Health Optional Measures verses only providing 5 points total for any of them that are met. We believe that providing more incentives for exchange of data between providers and public health benefits our efforts to protect and improve population health.

- Proposal To Adopt the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an Optional Bonus Measure (Page 32730)

  WA DOH was an early public health adopter of TEFCA last year. We were successfully able to leverage it to receive electronic case reports from a provider that has a footprint in both WA and OR. Using TEFCA allows this provider to make just one connection to submit eCRs for both states. We are still using this connection in production today. We think it is valuable to incentivize providers to further leverage TEFCA for public health data exchange. We are working on a few projects now to leverage it further for this purpose. One concern is that the proposed rule offers 5 bonus points for any of the bonus measures met, but a provider is not allowed to do multiple bonuses. We feel this could dilute the bonus measures section and make it hard for public health to encourage providers to extend beyond the 6 required public health measures to other important public health registries. We encourage CMS to consider allowing each bonus measure to provide 5 points vs. only being allowed to get points for one. We also encourage CMS and ASTP/ONC to add additional use cases to the Public Health Exchange Purpose beyond lab and case reporting to help further realize its potential.

- Request for Information (RFI) Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure (Page 32747)
  - *Should CMS propose to adopt a performance-based (numerator/denominator) reporting requirement for the Query of PDMP measure? If so, how should the numerator and denominator be defined?*
    - There is a potential barrier for providers if performance-based reporting on PDMP queries is adopted. Currently there are three mechanisms for

WA State providers to query the PDMP; through the PDMP portal (manual query) or through the integration options, Bamboo Gateway and Washington's Health Information Exchange (HIE). Currently, the HIE is configured in a way that a facility credential, rather than a provider credential, is reported when a provider queries the PDMP. While we are not sure if providers would pull the numerator and denominator from their EHR, or if they would pull that data from the HIE. If the numerator and denominator would come from the HIE, then hospitals and CAHs would not have sufficient data to report performance-based measures.

- *What are potential barriers for eligible MIPS eligible clinicians meeting the Query of PDMP measure as a performance-based measure?*
  - In addition to the above potential issue, the other primary barrier we are aware of is not having integration into the EHR workflow. Also, the degree of integration. If an EHR automatically queries for a provider and presents the information vs. requiring the provider to click a button in the interface to query. Also, whether a state allows a delegate (such as nurse or medical assistant) to query on the prescriber's behalf.
- *Would adoption and use of Health IT Modules certified to the ''Prescription Drug Monitoring Program (PDMP) Databases—Query, receive, validate, parse, and filter'' certification criterion proposed by ONC in the HTI–2 proposed rule (89 FR 63547), if this criterion were to be finalized, help to mitigate previously identified burden associated with implementing and reporting on a performance-based ''Query of PDMP'' measure?*
  - No, the certification criterion proposed by ONC in the HTI–2 proposed rule (89 FR 63547) would not alleviate any identified barriers that adopting PDMP query performance-based measures. The potential barriers identified with adopting performance-based measures do not relate to how the data is queried, received, validated, parsed, and filtered.
- *How would the adoption and use of Health IT Modules certified to the proposed ''Prescription Drug Monitoring Program (PDMP) Databases—Query, receive, validate, parse, and filter'' certification criterion, if it were finalized, impact the numerator and denominator of a potential performance-based PDMP measure?*
  - If both rules were passed it could impact the implementation of performance-based measures as both would likely require changes to technical systems which would further burden/strain both state, vendors, and hospital resources.
- *What are other measure concepts we should consider that would allow us to focus on outcomes related to overdose prevention?*
  - There is data that shows patients with chronic pain who are on high dose opioids long term, are at higher risk of overdose in the months after no longer receiving opioid prescriptions. CMS could consider measures that incentivize providers to follow up with patients in this situation to help protect against overdose.
- *Should we explore measures related to monitoring data from PDMPs that could assess multiple opioid prescriptions, opioid prescriptions from multiple*

prescribers, combined opioid and benzodiazepine prescriptions, or very high standardized dosage of opioids prescribed?

- If CMS considers these measures, it should be cautious new measures related to these instances could negatively impact pain patients, cancer patients, and patients in rural areas, as these groups may frequently require more than one opioid prescription and/or multiple providers. Anecdotally we have heard that the more onerous the requirements are to meet, the more likely the provider may stop treating patients with *medications.*

- *What measure concepts related to the use of PDMPs are likely to involve the lowest effort and provide the highest value to the health care community?*
  - Further incentivizing health care organizations to integrate with PDMPs would provide high value as we see queries of the PDMP rise significantly when facilities integrate EHRs with the PDMP. Cost and time/resources as the most common reasons given for delaying PDMP integration.
- *What challenges exist, if any, around expanding the Query of PDMP measure to include all Schedule II drugs?*
  - Given that all PDMPs collect all Schedule II drugs WA DOH does not feel this expansion would impose any real challenges. By including the entire schedule instead of picking certain drugs from in it, it could make the analytics easier to pull.
- *What are the potential benefits versus risks of expanding the Query of PDMP measure to include all Schedule II drugs?*
  - The key benefit is ensuring non-opioid Schedule II drugs are also be reviewed as part of treatment decisions. WA DOH has seen other Schedule II drugs being misused such as stimulants. If providers have automated their query of the PDMP the risks (burden to providers) should not be an issue.
- *Would expanding the Query of PDMP measure to Schedule II nonopioid drugs create barriers for patients appropriately prescribed Schedule II non-opioid drugs (for example, central nervous stimulants appropriately prescribed for ADHD)?*
  - WA DOH feels there is always that risk as it is difficult to know how all providers will respond. Some may find it easier to stop prescribing these medications and refer to specialists (that are hard to get scheduled with) if they see potential issues rather than trying to help the patient with complex medical diagnosis.
- *How should CMS account for varying levels of readiness and capacity for MIPS eligible clinicians to meet an expanded scope of the measure, particularly for small and rural providers?*
  - WA DOH feels that CMS should account for smaller facilities through use of exclusions, such as, their CEHRT does not have PDMP query capabilities in place. To put the burden of an expanded scope on lesser resources facilities would only make it harder for them to provide care and operate successfully financially.

- *What exclusions should be considered, if any?*
  - Please reference our proposal above.

- RFI Regarding Performance-Based Measures (Page 32751)
  - *What aspects of data quality and usability are most appropriate and valuable to measure in the context of the Public Health and Clinical Data Exchange objective of the Medicare Promoting Interoperability Program (for example, timeliness and completeness of reporting)?*
    - For public health where we need to move quickly to stop the spread of disease, timeliness, accuracy and completeness are all very critical. In order to make good, informed policy decisions we need data quickly that properly covers the entire population, that has the necessary fields properly populated and does not contain errors. In particular, demographic fields are very critical to our work (address, date of birth, etc…) along with NPI for identifying the provider, and we still run into issues with labs results being submitted with no LOINC or SNOMED codes (this has delayed onboarding of many organizations by up to a year or more).
    - In relation to the above three attributes of the data, the laboratory confirmation of the disease being done promptly and reported without delay is the desired action which also affects the timeliness, completeness of reporting. A composite measure that captures the three attributes above would be helpful to track the surveillance system performance.

  - *How could data completeness be defined? For instance, how should we define ''complete data''? Should we consider a threshold approach, under which eligible hospitals and CAHs would attest that they are successfully sending complete data for a minimum set of data elements to a PHA?*
    - WA DOH believes that the American Immunization Registry Association (AIRA) has a very robust data quality program. They define "completeness" as: "The degree to which full information about a data set, record, or individual data element is captured in the IIS (i.e., the proportion of stored data with complete information measured against the potential of "100%")." As a member of AIRA who uses their data quality tools we have found this to work very well. CMS can learn more about the AIRA data quality program at - https://www.immregistries.org/data-at-rest. Other data quality metrics from AIRA we support CMS considering are Validity and Timeliness. Also CSTE and APHL have partnered with CDC to establish similar data quality requirements for eCR that should be considered.
  - *Are there other metrics available that we should consider in the Medicare Promoting Interoperability Program that more directly relate to actions and outcomes that public health reporting is intended to enable (for example, overdose prevention)?*
    - CMS could consider adding death reporting. CDC has funded PHAs to report death data via FHIR to the National Center for Health Statistics. Death records are a large part of monitoring the overdose crisis. By having providers report death records via FHIR also, this would make the surveillance activities much timelier. Given this would be a new measure, perhaps adding it as a bonus

measure would be a good place to start. PHAs still need federal funding to support not just sending death records via FHIR, but to receive them via FHIR.

- *Of the current types of public health data exchange reflected in the Public Health and Clinical Data Exchange objective measures, what use cases should we prioritize for a focus on data quality that would provide the highest value to the health care community while resulting in the least burden?*
  - Given the amazing work that AIRA has done in this space already, immunizations would likely be the least burdensome as a lot of data quality has already been standardized in this space. The value for providers is that with immunization it is not just sending data to public health but providing back critical immunization history and forecast information to inform provider treatment decisions. Also prioritizing eCR given the national hub used for data quality and routing could be a good use case to start with. The value to providers is the desire to end manual reporting of case reports to Public Health. A data quality focus in this area would help move providers and PHAs closer to that reality.
- *Under a revised scoring approach, should we specify that MIPS eligible clinicians could earn 10 points for each required measure and five points for each bonus measure, with a maximum of 10 bonus points for a total of 30 points for the objective? Are there other scoring approaches for the Public Health and Clinical Data Exchange objective we should consider?*
  - Any moves that further incentivize critical public health reporting would be welcome and appreciated. WA DOH would suggest 15 points for each required measure and 5 points for each bonus measure for a total possible of 50 points for the Public Health and Clinical Data Exchange objective.
- *Should we score all public health measures for which we finalize a numerator and denominator based on performance? Or should we only score a subset of measures based on performance?*
  - To help drive data quality and ensure public health transactions are providing good data both to PHAs and Providers, WA DOH recommends scoring all public health measures where a numerator and denominator are finalized.
- *What are the most promising uses of FHIR approaches to the public health reporting requirements under the Medicare Promoting Interoperability Program?*
  - FHIR is most promising for eCR where a FHIR IG is available. Most of the other measures so far have not had a FHIR IG available. We would encourage the creation of such IGs, perhaps using the FHIR Accelerator for Public Health – Helios.
  - The Public Health Reporting Measures IG would be great with the creation and addition of the measures libraries specific to public health system performance.
- *What approaches have the most potential to reduce the burden of reporting on MIPS eligible clinicians and increase the quality and timeliness of data submitted to PHAs?*
  - Continued development of FHIR. This will require the creation of FHIR IGs for the PH measures currently listed and adding new measures (birth and death reporting for example). This will also require investment in Public Health Infrastructure as very few PHAs have FHIR capabilities at this time. FHIR has

shown it can be a much more efficient and effective method in reducing reporting burden (easier to implement) and has the potential to increase data quality and timeliness (APIs and Bulk FHIR).

- Continued adoption of eCR. The automated exchange of case report information between healthcare facilities and public health agencies reduces the required reporting burden on providers. It also does not disrupt their clinical workflow. Data on notifiable conditions are integrated into DOH surveillance systems at a fraction of the time manual reporting does, allowing for a reduction in response time in a public health emergency as well as for timelier and more complete data to support outbreak management, case investigation, and the monitoring of disease trends.
- We highly stress the importance of engaging public health leadership across federal, state, territorial, tribal and local health departments when developing any of these new metrics or measures.

- *Approaches to public health reporting using FHIR have focused on greater automation of the interactions between health care providers and PHAs in order to reduce burden on providers, including eligible hospitals and CAHs, and increase PHAs' ability to obtain the information they need. How might FHIR approaches to the exchange of public health data impact measurement of MIPS eligible physicians performance?*
  - See the answer above.
- *Use of FHIR APIs could ultimately result in consolidation of disparate functions in EHRs that are currently being used to support different types of public health data exchange, for instance, through availability of an API that makes data available for a range of public health use cases. If these approaches are implemented in certified health IT in the future, should we consider streamlining or reduce the number of measures required in the Promoting Interoperability performance category?*
  - The ability to have a single API support multiple PHA measures would likely reduce the burden of exchange on our clinical partners. WA DOH would support streamlining measures in a future state where this is possible if the rules still required all the important public health data transactions (ELR, eCR, IIS, etc…) within that API and that the overall points for Public Health Exchange does not decrease. WA DOH would not want to see the importance of public health exchange diminished by lowering the points gained via the public health measure(s).

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Page 32547)

  Administrative burden: The proposal to require RHCs and FQHCs to break out individual component codes for services currently bundled under G0512 and G0071 may create significant reporting and workflow challenges, especially for small rural clinics with limited administrative staff. We recommend CMS provide technical assistance, simplified reporting pathways, or continued options for bundled billing to prevent undue strain.

- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Page 32386)

The removal of steps 4 and 5 may reduce administrative barriers that delay the availability of necessary telehealth services by expanding service availability based on needs rather than peer-reviewed evidence or academic publications. However, removal of Step 5 may create inconsistencies in telehealth and coincidently have a negative impact on care quality and patient safety. Lack of proper guardrails could disproportionately affect vulnerable populations.

There could also be a risk of digital health disparities for populations who are not able to engage effectively via telehealth. CMS should clarify what kind of real-world evidence or data is acceptable to justify ongoing inclusion of services to allow for some data and tracking to show efficacy of services and catch any safety issues (e.g., patient outcomes, utilization trends, or satisfaction data). With the removal of steps 4 and 5, CMS should issue clinical decision tools or guidance documents to aid practitioner judgement.

To avoid health disparities, it's recommended that CMS collect and publish data on demographic characteristics of telehealth users. CMS should prioritize inclusion of telehealth services that address preventive care, chronic disease management, mental health, and care coordination, as these services are vital to improvement of population health outcomes, and should remain reimbursable under telehealth. Services should only be removed when clear evidence demonstrates negative outcomes or inequitable access.

We encourage coordinated participation with our HHS partners and with public health agencies to continue to advance chronic disease prevention, telehealth and interoperability between public health and healthcare. If you have any questions, please contact Mike Ellsworth at Michael.Ellsworth@doh.wa.gov or the Director, Federal and Inter-State Affairs for Governor Ferguson's Washington, D.C. office Rose Minor at Rose.Minor@gov.wa.gov Thank you.

Sincerely,

Tao Sheng Kwan-Gett, MD, MPH
State Health Officer
Washington State Department of Health