The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Washington, DC 20201

Dear Administrator Brooks-LaSure:

On behalf of the Healthcare Information and Management Systems Society (HIMSS), I am pleased to provide written comments to the Notice of Proposed Rule Making (NPRM) regarding Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation (CMS-1771-P). HIMSS appreciates the opportunity to leverage our members' expertise to share feedback on the adoption of digital quality measures, changes to the Inpatient Quality Reporting Program (IQR), and use of the Trusted Exchange Framework and Common Agreement (TEFCA) at the agency, and we look forward to continued dialogue with the Centers for Medicare & Medicaid Services (CMS) on these topics.

HIMSS is a global advisor and thought leader supporting the transformation of the health ecosystem through information and technology. As a mission-driven non-profit, HIMSS offers a unique depth and breadth of expertise in health innovation, public policy, workforce development, research and analytics to advise global leaders, stakeholders and influencers on best practices in health information and technology. Through our innovation engine, HIMSS delivers key insights, education and engaging events to healthcare providers, governments and market suppliers, ensuring they have the right information at the point of decision. Headquartered in Chicago, Illinois, HIMSS serves the global health information and technology communities with focused operations across North America, Europe, the United Kingdom, the Middle East and Asia Pacific. Our members include more than 130,000 individuals, 480 provider organizations, 470 non-profit partners, and 650 health services organizations across 86 countries.

For our public comment, HIMSS offers the following thoughts and recommendations on this NPRM:

HIMSS Principles for the Implementation of New Quality Measures

Core to the HIMSS mission is promoting the use of health information and technology to improve the quality of healthcare delivery through effective performance measurement and decision support. HIMSS believes that the use of digital health information by any payer can be utilized to identify gaps in care, optimize clinical care delivery, and improve patient outcomes.

HIMSS supports the thoughtful transition to digital quality measures (dQMs). Properly implemented, dQMs will enable more holistic and meaningful assessment of the health of patients, which potentially can also reduce provider burden. At the same time, HIMSS members have expressed concerns that, while digital measurement represents an ideal future state, several critical barriers and challenges must be addressed to ensure that dQMs facilitate improved care and not add to the administrative burdens on providers.

Over the last decade, HIMSS has authored principles, featured in public comments and letters to CMS, which should be utilized when adding any new measure or reporting method to value-based payment programs. These principles state that any new quality measures should meet the following criteria before CMS (or any payer) mandate their use. dQMs (and new eCQMs being added to the IQR program) should meet the same criteria before being required for CMS reporting.

A. Meaningful measure of care quality: Any new quality measure should utilize data to present a meaningful and actionable assessment of patient care. Emphasis should be placed on the development of measures which are clinician-driven to support care delivery meeting the standard of care, not meeting the data collection needs of payers only.

B. Accurate measure of care quality: Any new quality measure should be lab/simulation tested, field tested, and validated to produce comparable and consistent results against the measure's intent.

C. Actionable measure of care quality: Whenever possible, clinical quality measure data should be available in as close to real-time as possible to drive needed changes in workflow to eliminate gaps in care. The latency of data for clinical quality measures should be driven by measure type. Performance data should be interoperable with data visualization tools that can easily identify gaps in care at the patient level.

D. Not overly burdensome to collect and report: Any new quality measures and associated policies should reduce the implementation and data collection burden on health systems, providers, and health information technology developers by using data already collected for care and without introduction of new inefficient workflows. We must ensure that data facilitates effective process change without overwhelming clinicians and resources.

Digital Quality Measurement Request for Information

HIMSS welcomes the opportunity provided by CMS's request for information (RFI) regarding the pending transition to digital quality measurement for the inpatient quality reporting program. The planned shift to dQMs represent an opportunity to expand the value and use of quality measures and associated structured and standardized data. Standardized digital data can support multiple use cases, including quality measurement, quality improvement efforts, clinical decision support, research, and public health. The expected payoff from such a dQM model would be richer data and

measures that could facilitate use of artificial intelligence and other tools to deliver near real-time modeling and analysis of treatment efficacy.
Accordingly:

- HIMSS strongly recommends that dQMs should be meaningful, clinician and specialty society- driven, endorsed by the National Quality Forum, and successfully tested and validated prior to being included in CMS quality measurement programs. dQMs should ensure that their data drive effective process change without overwhelming clinicians.

- HIMSS continues to support CMS efforts to create a common portfolio of clinical quality measures across private and public payers. HIMSS strongly recommends that decisions around measure alignment be driven by the needs of clinicians and specialty societies, not only payers.

- HIMSS strongly encourages CMS to continue engagement with stakeholders to address challenges with data validation, mapping, stewardship, and security prior to the next round of rulemaking.

HIMSS members have expressed concerns regarding potential avenues to adoption of dQMs outlined in the RFI. Those concerns, and HIMSS recommendations, are detailed below:

The Definition of dQMs

In the RFI, CMS proposes the definition of dQMs as "quality measures organized as self-contained measure specifications and code packages, which use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems." This definition is a change from the FY2022 CMS RFI, which suggested that dQMs would be singular applications, created by CMS and included in certified electronic health record (EHR) technology (CEHRT), designed to extract quality data to populate and calculate the measures.

If this changed language suggests that CMS will now approach dQMs as a "framework" of standards and specifications that can be implemented at the point of care by providers and their vendors, HIMSS supports the proposed language. HIMSS asks CMS to clarify this definition in future rulemaking.

The Standardization of Data

While the use of the underlying Health Level Seven International® (HL7) Fast Health Interoperability Resources (FHIR) standards, the United States Core Data for Interoperability (USCDI), and HL7 Quality Improvement Core (QI-Core) are strengths of a digital measurement driven health system, HIMSS members are concerned that there are unresolved barriers to digital measures producing accurate, comparable, and consistent results against the intent of the measure.

We note and approve of the centrality of FHIR and FHIR APIs to dQMs but also believe that these standards and standards-based APIs are not a panacea that will solve all the

data mapping and harmonization issues required for meaningful, accurate, and less burdensome quality measurement. FHIR API's do support dQMs in some use cases but the most common use case in dQM's implementation would be infeasible without some sort of scalable "Bulk FHIR" availability. There is significant variation in clinical documentation workflows from one EHR to another and from one healthcare organization to another. When data must be mapped from many diverse health IT applications and implementations, using customized mapping based on the needs of individual EHRs and organizations, measurement error is likely. Digital measures require adding more layers of data mapping challenges as result of a much larger ecosystem of data sources currently without harmonized standards or data models. Standards do not harmonize quality data and we cannot assume that data sources will use FHIR as their underlying data model. Additional data sources, mapping and collection methodologies, and the lack of context within the standards can result in measure scores that do not accurately reflect the quality of care being delivered. Inaccurate and non-comparable data also can drive decision-making and process changes that do not reflect the highest quality of care.

Also, clinical quality measures, particularly measures used in specialty practice, include layers of clinical context. The data needed to populate dQMs will require much more clinical context than can be supported by the capabilities of USCDI and QI Core for the foreseeable future. Additional layers of context are being added to USCDI+. However, it is unclear whether and when the quality-focused aspects of USCDI+ will become part of CEHRT. The implementation of USCDI+ standards outside of updates consistent with being CEHRT creates an additional burden for hospitals, providers, and their developer and vendor partners.

In addition, current clinical quality reporting processes feature health systems building relationships with vendor partners to validate data generated at the source before submission to CMS. HIMSS believes CMS has greatly underestimated the challenges with ensuring that clinical documentation can be supported by clinician workflows, especially when considering clinician burden and usability, and the work needed to ensure that data is appropriate for reporting.

Measures populated with data that is not an accurate reflection of the care being delivered is not actionable and does not drive action to improve care delivery. Unfortunately, the CMS proposal to adopt dQMs lacks detail on how data generated at the source will be validated without the lengthy and painstaking work of health system vendor partnerships to validate the data prior to submission to CMS. The proposal also lacks any kind of redress mechanism for hospitals and providers to challenge the calculation of a dQM.

Finally, the RFI does not detail if or how CMS plans to share insights derived from dQMs in a visual, timely, and actionable manner with the eligible hospitals (EHs) and clinicians. dQMs must be vehicles to learn and enable improvements in care delivery, made in as timely a manner as possible. HIMSS strongly recommends that CMS develop a strategy for providing a rapid feedback loop to EHs and providers on measure performance, and to share clinical insights based on the nation-wide data collection of dQMs (and all quality measures) to create more advanced standards of care based on the clinical effectiveness of interventions detailed in the measures.

Timeline for Implementation of dQMs

HIMSS members have significant concerns about a 2025 target date for starting the adoption of a digital measurement framework that was suggested in the FY2022 CMS dQM RFI. Our concerns arise from the current lack of a proof of concept or successfully validated model for collecting all the data elements necessary to ensure that proposed digital measures produce comparable and consistent results against the measure's intent. In addition, there are gaps in available information on the strategy for dQM adoption stated above, as well as the statement in the RFI that CMS has not created a CMS FHIR-based receiving system as of yet.

Once CMS resolves the aforementioned issues and develops, tests, and field tests eCQMs transitioned to dQM formats, the current timeline to get NQF-endorsed measures reviewed by CMS for inclusion in CMS Quality Programs is 18-24 months. While HIMSS encourages a nimble process for measure development, testing, and validation of digital quality measures, the current environment simply cannot ensure that the CMS go-live timeline can be met without cutting corners on ensuring measures produce meaningful, actionable, and consistent results. In order to meet a 2025 deadline, shortcuts would need to be employed and many of these issues will not be fully addressed.

HIMSS strongly encourages CMS to be flexible with the deadline for launching dQMs. Once dQMs have been fully tested, field-tested, and judged feasible against the intent of the measure, and CMS has identified the mechanisms to validate data at the source, HIMSS strongly recommends a minimum of two calendar years prior to requiring EHs to report using dQMs. This timeline allows EHs to implement dQMs and develop the supporting documentation tools and clinical decision support needed to facilitate any changes in their clinical workflow in a safe manner.

HIMSS also continues to encourage CMS to identify and apply or propose to Congress financial incentives to encourage a diverse and large cohort of EHs to participate in the testing and field-testing of these measures. Historically, creating voluntary reporting mechanisms to find process errors would not produce the volume of data required to identify potential major reporting barriers. Given the current burden placed on the American healthcare system caused by COVID, significant financial incentives would facilitate wide scale participation that would be unlikely with voluntary reporting.

Proposed Changes to the Inpatient Quality Reporting Program

HIMSS continues to support the goals of the Inpatient Quality Reporting (IQR) program. As HIMSS has observed through the Davies Award of Excellence Program, accountability for delivering the standard of care within a health system is a primary driver for improving care outcomes. HIMSS supports the commitment of the IQR Program to focus on issues of health equity and maternal health.

As stated above, before adding additional measures to the IQR program reporting requirements, HIMSS recommends that each measure should be:

- A meaningful measure of care quality where the measure can be used to identify gaps in care and pathways to improving patient outcomes
- Lab/simulation tested, field-tested, and validated to produce comparable and consistent results against the measure's intent
- Not overly burdensome to collect and report as part of a normal clinical care delivery workflow

HIMSS members have indicated that the following measures have been through a rigorous testing and field-testing process and work effectively as meaningful measures of care. HIMSS supports the inclusion of these measures to the IQR Program using the timeline proposed by CMS.

1. PC-02 Cesarean Birth
2. PC-07 Severe Obstetric Complications
3. HH-ORAE Hospital Harm: Opioid-Related Adverse Event

As stated above, HIMSS notes that voluntary reporting historically has not generated enough data to effectively identify potential barriers to successful data collection, and reporting before mandating reporting for all EHs financially to participate in the voluntary reporting period for these measures would increase the volume of data collected, should CMS choose to maintain a voluntary reporting period.

HIMSS also notes that our hospital and vendor members have indicated that it takes 18 months to successfully implement the data collection processes for a new electronic clinical quality measure (eCQM). If financial incentives were not connected with a voluntary reporting period, HIMSS would recommend that CMS finalize mandated reporting of these measures in calendar year 2024. However, performance on these measures should not impact hospital payment until the calendar year 2025/FY 2027 payment determination.

With regards to the proposed Global Malnutrition Composite Score (GMSC), HIMSS is not aware that the GMSC has completed the same rigorous testing and field-testing process. If the GMSC has not been field tested and vetted with a wide variety of EHs, HIMSS requests that CMS complete these steps before requiring GMSC as part of the IQR Program.

Health-Related Social Needs Measurement for the IQR Program

HIMSS supports CMS for taking the initial steps to create measures focused on screening patients to identify health-related social needs (HRSNs) to improve care access and quality for all people. The collection of social determinants of health (SDOH) data, and incorporation of that data into risk stratification of patients and care decision-making, should be a best practice adopted by all health systems. Furthermore, SDOH data can identify critical community needs that impact the health and well-being of vulnerable patient populations. HIMSS strongly supports the adoption of actionable, meaningful, and not overly burdensome measures which enable action to reduce the impact of health insecurities on patients.

HIMSS encourages CMS to take a methodical approach to implementing SDOH measures. While many healthcare organizations are starting to collect and utilize SDOH data to provide a more nuanced level of care to patients, health systems are still building the infrastructure to provide community services to address those health insecurities. Many suffer from a lack of sufficient numbers of social workers, care coordinators, and nurses. CMS should explore Medicare and Medicaid reimbursement models of care that embrace community-based solutions to address outcomes exacerbated by health insecurities that pay at levels to sustain the needed capital investment and staffing to provide those services effectively.

With regards to the specific proposed measures (Screening for Social Drivers of Health Measure and Screen Positive Rate for Social Drivers of Health Measure), HIMSS applauds CMS taking action to encourage hospitals and providers to collect and utilize HRSN data to support improving clinical care and care access for underserved communities. The adoption of these first ever SDOH measures for CMS programs potentially lays a foundation to scale adoption of quality activities that drive structural equity. SDOH measures, used thoughtfully, will improve health outcomes for patients by giving providers a better understanding of factors beyond the clinical sphere that can negatively impact patient health. By using actionable data to address health insecurities, hospitals can face lower-cost burden and improve the clinical outcomes for patients.

According to members in the HIMSS SDOH Committee, the HRSN Screening and Screening Positivity measures have been rigorously tested, with over one million Medicare beneficiaries screened at sites utilizing the Accountable Health Communities (AHC) Model, as reliable and valid. As a first step towards collecting SDOH data that can enable nationwide use for improving care, HIMSS recommends CMS take action to make SDOH screening a standard practice.

However, some members of HIMSS have raised concerns that the measures, as constructed, do not capture actionable information. The percentage of patients screened and the aggregate percentage of patients that have an insecurity provides insight into the needs of the larger community; but the measure does not provide specific actionable data that drives the care provider to take action addressing the specific insecurities impacting the patient. This can scale from understanding which insecurity/insecurities impact the largest portion of a health system's patient population, down to specific insecurity data elements triggering new interventions in an individual patient's care plan. In addition, the screening process required to capture HRSN data reflects additional burden (particularly for small provider practices and hospitals with limited resources). Several physicians shared that many patients are reluctant to provide SDOH data and measuring physicians on points outside their control only frustrates already burdened physicians.

Some HIMSS members suggested CMS consider alternative data sources for SDOH data to populate these measures as a means for reducing the data collection burden at the point of care. For example, American Community Survey Data provides aggregated data at the census track level that could be added to EHR and population health tools. Any patient data practices collected could be added to this robust data set. Primary Care has done this in the PRIME Registry and connected quality measures, patient

addresses, and diagnoses to provide physicians with hot spots and a view of patients who are at risk. Additionally, vendors could incorporate social care network solutions to connect at risk patients with support. Other vendors beyond the PRIME Registry have already added this resource to their platforms (Epic, Cerner, Athena, eClinicalWorks, Innovaccer, etc.).

HIMSS recommends CMS take the following actions:

1) Publish an action plan detailing a pathway for creating more actionable SDOH driven measures and detail how the data collected as part of the two HRSN screening measures will be utilized to support the action plan
2) Adopt the two measures as proposed but consider making the HRSN screening measures voluntary until more clinically actionable measures are available. As with quality measurement reporting, HIMSS has observed that voluntary reporting rarely generates enough volume of data to identify technical and specification challenges with accurately reporting data to CMS. In order to ensure robust reporting of screening measures during the voluntary period, HIMSS strongly encourages CMS to consider adding significant IQR scoring bonuses to EHs who submit their screening data during the voluntary reporting period. HIMSS also encourages increasing financial incentive payments for EHs that report on the measures
3) Explore reimbursing EHs for providing services and interventions that alleviate health related social needs, like food insecurity, housing, or ability to afford care as part of the long-term plan for utilizing SDOH measures.
4) Leverage work being conducted by consensus-driven efforts like the HL7 Gravity Project to develop standards for SDOH data to enable more efficient and actionable data collection

Support for the Addition of the Enabling Exchange Under the TEFCA Measure

In the Medicare Promoting Interoperability Program, Health Information Exchange (HIE) Objective, we support adding an option for EHs and CAHs to fulfill the objective by meeting the Enabling Exchange under TEFCA Measure through the criteria specified in the proposed regulation. We want providers to have options to meet this objective that enable more broad-based data exchange across the health ecosystem and utilize the TEFCA Network when it is appropriate. In addition, we endorse the agency's proposal to report the Enabling Exchange Under TEFCA Measure by a "yes/no" attestation.

However, we encourage CMS to be more specific in the language used to describe the criteria required to meet the measure. For Statement 3 under the measure—Using the functions of CEHRT to support bi-directional exchange with an HIE—we recommend CMS specifically cite USCDI to provide the detail that EHs and CAHs will need to report on the measure. The HHS Office of the National Coordinator for Health Information Technology (ONC) adopted the first version of USCDI as a standard in the ONC 21st Century Cures Act Final Regulation. USCDI sets a foundation for broader sharing of electronic health information to support patient care. CMS specifying the USCDI standard in this statement will ensure alignment with ONC's portfolio.

Explore TEFCA as an Option to Advance CMS Policy and Program Objectives

HIMSS supports the agency exploring the use of TEFCA to meet the evolving data exchange needs of all health system participants. Once TEFCA is established, the network can offer CMS an additional avenue to advance its policy and program objectives related to care coordination, cost efficiency, and patient-centeredness. We are watching the implementation of TEFCA very closely, as prospective qualified health information networks (QHINs) prepare to sign the Common Agreement and apply for designation and the recognized coordinating entity (RCE) begins onboarding and designating QHINs to share information. HIMSS expects that stakeholders across the care continuum will have increasing opportunities to enable exchange under TEFCA in starting in 2023.

HIMSS recommends CMS continue to consult with the community about the future use of TEFCA in CMS policies and programs. In particular, the CMS Innovation Center has the opportunity to leverage TEFCA Network integration as it develops and tests new healthcare payment and service delivery models, particularly around value-based care. Overall, CMS should present TEFCA as an optional means for encouraging broad-based information exchange until the TEFCA Network is firmly established and data point to effectiveness around the use of TEFCA.

It is important to remember that in addition to the significant role TEFCA could play in CMS functions, the agency could also serve as a major catalyst to help accelerate nationwide connectivity through TEFCA by health care providers and other stakeholders. Both of these considerations should be prioritized as deliberations on TEFCA continue. We provide more details in our responses to the questions included in the RFI:

- **What are the most important use cases for different stakeholder groups that could be enabled through widespread information exchange under TEFCA?**

  HIMSS recommends CMS align any TEFCA Use Cases with the required exchange purposes: Treatment; Payment; Health Care Operations; Public Health; Benefits Determination; and individual access services (IAS). Initially under TEFCA, only Treatment and IAS require a response in the TEFCA Environment, so CMS should plan to work closely with ONC and the RCE on the roll-out and phase-in of future required purposes. CMS should also plan to use its annual payment and policy regulatory processes to ask the community for input on current and future exchange needs that can be previewed in advance and implemented in subsequent years.

  In the near-term, we agree with CMS that encouraging information exchange under TEFCA for payment and operations activities such as submission of clinical documentation to support claims adjudication and prior authorization processes would be consequential areas to consider for inclusion.

  In addition, CMS should look at ONC's Interoperability Standards Advisory (ISA) for additional potential use cases for TEFCA. ISA is an ONC process that

coordinates the identification, assessment, and public awareness of interoperability standards and implementation specifications that can be used by the community to address specific interoperability needs including, interoperability for clinical, public health, and research purposes. The ISA process is updated on an annual basis, so it is current with new trends and projects underway across the community.

Overall, we recommend that CMS consider any TEFCA Use Cases that would enable providers, patients, and other community stakeholders to share and receive healthcare data in more efficient and effective ways.

- **What are key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different stakeholders, including those in rural areas, under TEFCA?**

  Broad-based, ubiquitous data exchange are cornerstones of many CMS programs. Value-based care delivery hinges on the ability to better coordinate care and requires data to follow individuals as they navigate the healthcare system. TEFCA is an opportunity to ensure that more data is available at the point of care, which helps clinicians deliver higher quality care and better outcomes to patients.

  In addition, more easily accessible data also supports CMS's efforts to reduce burden on clinicians. Once fully established, the TEFCA Network should be a means to help eliminate one of the unnecessarily burdensome actions that regularly occurs in the course of clinical practice—collecting patient data prior to and in the course of care delivery across multiple providers. HIMSS has always focused on policies that allow clinicians to be able to focus their time on actions that make sense, such as caring for patients and delivering better outcomes. Broad-based data exchange, enabled through TEFCA as well as other means, is one of the key instruments for clinicians to reduce their burden as well as be able to deliver better and more efficient care.

  TEFCA, as well as other broad-based exchange mechanisms, can also help CMS focus on achieving health equity. In the CMS Framework for Health Equity 2022–2032, the agency discusses how it promotes health equity by using policy levers as well as program authorities and engaging health care stakeholders across settings and communities. CMS consistently identifies and disseminates new and promising practices and embeds health equity into CMS programs to better meet the needs of all communities — particularly underserved communities. Priority 1 of the CMS Framework focuses on expanding the collection, reporting, and analysis of standardized data. With CMS striving to improve its collection and use of comprehensive, interoperable, standardized individual-level demographic and SDOH data, TEFCA can be an integral piece of reaching that goal.

  Moreover, as CMS thinks about how to deliver more equitable, less-burdensome, outcomes-focused care to rural and underserved communities, ensuring

providers in these areas have a means of exchanging health data becomes more critical. TEFCA is often more applicable in rural areas as state and regional health information exchanges and national networks may not provide adequate coverage. Also, TEFCA could help fill in gaps in care and ensure that data follows a patient from a rural provider to another care setting, and updated information is returned to that referring provider, helping to coordinate care and inform decision-making. CMS should explore using incentives tied to enabling broad-based data exchange and TEFCA across all its programs to ensure that individuals receive the care and the health coverage that they need and deserve, even if they reside in a rural or underserved area.

- **How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs?**

  We suggest CMS take a data-driven approach toward exploring how to incentivize broad-based data exchange and use of TEFCA. The CMS Innovation Center is best suited to develop and test new care models that incorporate the use of broad-based data exchange and TEFCA. For example, the CMS Innovation Center can deploy models that incorporate TEFCA and other means of broad-based data exchange and determine if there are statistically significant differences on many measures—clinician burden, patient outcomes, or cost, etc. There would also be opportunities to study if upward or positive payment incentives for providers result in greater use of TEFCA and delivery of better care outcomes. All options should be under consideration at the Innovation Center as TEFCA could play a significant role in CMS functions and serve as a major catalyst to help accelerate nationwide connectivity by health care providers as well as other stakeholders.

  As we have described, CMS Innovation Center models that focus on promoting value-based care delivery could include provisions that incentivize or encourage the use of TEFCA and studying these related questions could yield far-reaching conclusions that impact many prominent areas of the US healthcare system where we need to collect more data.

  In addition, CMS should explore the question about whether the agency should directly participate in TEFCA, by using the network to facilitate broad-based data across its programs and streamline reporting between CMS and the stakeholder community. Such a step from CMS would send a signal to the entire healthcare ecosystem about the efficacy of TEFCA, and may also demonstrate new, innovative use cases for use of the network to the entire community. There are many scenarios where CMS acting as a TEFCA participant, sub-participant, or as a QHIN, could help improve care coordination, reduce burden, and deliver more effective care. The agency could use the Innovation Center to test the options for direct CMS involvement in TEFCA or could use other payment policies to pilot the idea.

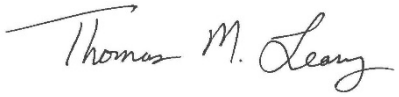
  Multiple federal agencies are looking at participating in TEFCA as a means to facilitate more public health-related data exchange, enhance veterans' health care delivery, and streamline benefits determination services, so HIMSS

encourages CMS to review its options around direct involvement in TEFCA as well.

We welcome the opportunity to discuss these issues with you and your leadership team. HIMSS would be happy to facilitate discussions between CMS staff, HIMSS Davies Awards recipients, and HIMSS members with unique subject matter expertise on these topics. Please feel free to contact Jonathan French, Senior Director of Thought Advisory, or Jeff Coughlin, Vice President Government Relations, with questions or for more information.

Thank you for your consideration.

Sincerely,



Thomas M. Leary, MA, CAE, FHIMSS
Senior Vice President and Head of Government Relations