June 17, 2019

Donald Rucker, MD
National Coordinator for Health Information Technology
US Department of Health and Human Services
Washington, DC 20201

Dear Dr. Rucker:

On behalf of the Healthcare Information and Management Systems Society (HIMSS) and the Personal Connected Health Alliance (PCHAlliance), we are pleased to provide written comments in response to the Trusted Exchange Framework and Common Agreement (TEFCA) Draft 2. We appreciate this opportunity to utilize our members' expertise in offering feedback on this document, and contribute to developing the principles necessary for engendering trust across the ecosystem and implementing a governance model to scale a functioning system of connected networks that will grow over time to meet the demands of patients, clinicians, payers, and other stakeholders.

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 companies, 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.

As an association, HIMSS encompasses more than 77,000 individual members and 650 corporate members. We partner with hundreds of providers, academic institutions, and health services organizations on strategic initiatives that leverage innovative information and technology. Together, we work to improve health, access, and the quality and cost-effectiveness of healthcare. Headquartered in Chicago, Illinois, HIMSS serves the global health information and technology communities with focused operations across North America, Europe, United Kingdom, the Middle East, and Asia Pacific.

PCHAlliance, a non-profit membership association, works to advance evidence-based two-way digital communications between patients, their caregivers, and providers through the development of open technical standards, real-world testing, and health plan coverage of evidence-based connected care.

HIMSS and PCHAlliance appreciate ONC's work to create TEFCA and provide a single on-ramp to nationwide connectivity. The concept behind TEFCA is well-placed: to offer healthcare stakeholders a mechanism to allow electronic health information (EHI) to securely follow the

patient when and where it is needed and advance exchange opportunities to areas as well as providers that may not typically have the ability to share and access data.

However, as HIMSS described in its TEFCA Draft 1 Public Comment Letter in February 2018, we were concerned about the impact that TEFCA would have on the current efforts underway across existing interoperability exchanges, networks, and approaches. We endeavored to find a path forward that allowed existing interoperability entities to largely continue to function under their business models, qualify as Qualified Health Information Networks (QHINs), and have them report to the Recognized Coordinating Entity (RCE) as the primary oversight mechanism of TEFCA.

HIMSS recommended this path forward given the significant momentum being built across the community to support broader nationwide exchange. All of the major interoperability approaches ONC identified as part of the process to implement the 21st Century Cures Act have made considerable progress in building the reach of their networks and stakeholders, increasing collaborations/partnerships with other approaches, and enhancing the services that they offer to providers and participants. Overall, HIMSS was concerned that the community would not be able to maintain the current upward trajectory of nationwide interoperability if these entities had to make significant adjustments to their workplans to qualify as a QHIN under TEFCA.

For this iteration of TEFCA, HIMSS and PCHAlliance remain apprehensive about the proposed structure and the impact that it could have on existing exchange processes. We offer the following thoughts and recommendations for creating a nationwide exchange environment where the work of current interoperability efforts are fully leveraged to achieve the goal of a single on-ramp to connectivity across the country:

- **Relax Requirements Around Provisional QHIN Status and Provide a Longer Glidepath to Full Adherence to the Common Agreement (CA)**

HIMSS and PCHAlliance are advocating for a revised TEFCA structure that does not disrupt the existing successful business models of state and regional health information exchanges (HIEs) and health information networks (HINs) as well as other exchange entities, but rather builds upon their innovations, partnerships, and successes thus far. ONC should use this strong HIE and HIN infrastructure as a foundation to empower information exchange through enabling market-driven solutions and removing participation barriers.

We envision that interested information exchange approaches would indicate their interest in participating in TEFCA by seeking to join newly-formed Provisional QHINs. We also expect that HIEs and HINs would join together in trusted partnership to create their own Provisional QHINs.

We ask ONC to place guardrails around the entire enterprise, rather than defining granular, prescriptive, inflexible, and restrictive minimum and additional terms and conditions. ONC should use TEFCA guidance documents as well as federal interoperability and information blocking regulatory instruments to create a reasonable but ambitious set of exchange capabilities it expected to see in the American healthcare system and define the roles and responsibilities of entities that want to participate in TEFCA.

Each Provisional QHIN would have the autonomy to choose how (i.e., through what existing means or exchange capabilities) they would meet these general baseline guardrails and exchange expectations. The autonomy granted through such guardrails to Provisional QHINs corresponds to a higher-level definition of what ONC described in Draft 2, as the Trusted Exchange Framework (TEF), and Minimum Required Terms and Conditions (MRTCs). In addition, the QHIN Technical Framework (QTF) would not dictate the internal requirements or business structures of QHINs. Instead, it would provide QHINs with the appropriate amount of flexibility to provide the services and support the various stakeholders. TEFCA posited that not all QHINs would be composed of the same types of Participants and Participant Members, and depending on its internal structure, there could be several different combinations of Participants and Participant Members within and across QHINs.

HIMSS and PCHAlliance ask that this initial set of exchange expectations be crafted in such a way that there would be a strong business case for the vast majority of exchange participants to join TEFCA and be able to utilize a network they already participate in without their current participation agreements being re-written or the policies of their chosen network being forced to change. ONC and the RCE may want to explore the use of one use case centered on an alert and message delivery system for Admission, Discharge, and Transfer (ADT) Feeds across the TEFCA enterprise. This use case could demonstrate value for all participants about how such a system would work and persuade other organizations to want to join.

Under such a scenario, the Provisional QHINs would then work with ONC and the RCE to define the glidepath and timeframe for provisional QHINs to become full TEFCA partners and initiate adoption of modified MRTCs and adherence to the CA. We recommend that Provisional QHINs as well as their Participants and Participant Members have the ability to maintain their provisional status for a significant period of time, but during that timeframe, they would gradually incorporate additional, more ambitious capabilities, exchange modalities, and exchange purposes, that could be met by adapting the existing ecosystem of HIEs and HINs. The ultimate goal of this approach would be full adherence to the CA by the end of this time period, ensuring numerous opportunities for stakeholder engagement and feedback with ONC and the newly-created RCE as TEFCA development proceeds.

HIMSS and PCHAlliance support this approach because it capitalizes on the current infrastructure of exchanges, networks, approaches, and frameworks, and does not necessitate significant or immediate changes to existing participation agreements and trust frameworks to support the evolution toward becoming a QHIN, Participant, or Participant Member. An extended time period would be a reasonable glidepath for these entities to make changes to their policies and participation agreements.

This approach also takes advantage of the [nearly $550 million federal investment in state HIEs](#) that began in 2010. In total, 56 states, eligible territories, and qualified State Designated Entities received awards. As TEFCA Draft 2 is currently proposed, HIMSS and PCHAlliance are concerned that many state HIEs would have to make significant changes to their business models or may choose to forgo such changes and not want to participate. Our recommended alternative approach would allow a realistic runway for HIEs to join a QHIN and participate in TEFCA.

Moreover, our extended phase-in is along the lines of what Senate Health, Education, Labor, and Pensions Committee Chairman Lamar Alexander (R-TN) discussed during a recent hearing when he observed that, "the best way to get to where you want to go is not by going too far, too fast." By relaxing initial requirements for Provisional QHIN status and providing a longer glidepath to CA adherence, ONC could ensure that the push to nationwide connectivity could proceed at the appropriate pace.

- **Expand the Exchange Modalities to Include Push Transactions**

HIMSS and PCHAlliance support the three exchange modalities included in TEFCA Draft 2: QHIN Targeted Query; QHIN Broadcast Query; and, QHIN Message Delivery. The combination of "pull" and "push" transactions provides a cohesive backbone for nationwide exchange capabilities and allows different modalities to be used in the situations where they are best suited. Adding QHIN Message Delivery will be a huge benefit to public health use cases, as push transactions play a vital role in supporting transitions of care and public health use cases and are necessary to fully support required public health reporting requirements.

In addition, we endorse ONC's plan to phase in new exchange modalities in the CA to support additional use cases. The idea of adding "Population-Level Data Exchange" as a future modality is attractive to HIMSS and PCHAlliance. We agree that a phased approach will allow the industry and potential signatories to adequately prepare the incorporation of necessary standards into their architectures, as well as resolve the variation in standards and policies that exist today. We also offer to work with ONC, the RCE, and the National Institute of Standards and Technology (NIST) to help define and pilot these future use cases.

In our February 2018 Public Comment Letter on TEFCA Draft 1, HIMSS expressed support for the Population Level Data Use Case outlined in the draft guidance but asked ONC to provide some clarity around the standards that need to be in place to do batch queries for this use case. As such, this may be the ideal example to pilot for further development and refinement.

With the enormous reach of the QHIN Broadcast Query, HIMSS and PCHAlliance also encourage ONC and the RCE to develop a hierarchy of query functions to minimize the burden that frequent broadcast queries could pose upon QHINs, Participants, and Participant Members. If a Participant is querying for information on a specific patient, it may be advantageous for that Participant to start with a QHIN Targeted Query rather than a full broadcast query. There is also the opportunity here for a QHIN to differentiate itself from other QHINs by providing a centralized record locator service to track the location of patient records under the QHIN's domain. Some QHINs may already offer this service, while others may rely on their Participants to locate records and share those locations with the QHIN.

However, the key component in this scenario is having a provider ask the patient or caregiver for information on where that patient may have sought care in the past. Such an interim step may save a great deal of unnecessary negative query responses. A broadcast query may still be necessary, but at least there is an attempt to minimize the burden on other providers. As ONC stated, QHINs, Participants, and Participant Members have a duty to respond to all requests for EHI they receive

for any of the Exchange Purposes with the EHI they have available—such a requirement could quickly add to the strain on an already overburdened health system.

- **Streamline the Exchange Purposes in the Initial Roll-Out, But Ensure TEFCA is Positioned to Expand Activities**

We applaud ONC's move to focus the exchange purposes on a subset of activities in Payment (Utilization Review) and Health Care Operations (Quality Assessment and Improvement, and Business Planning and Development) as defined in the HIPAA Privacy Rule. As TEFCA Draft 2 describes, requiring the full Payment and Health Care Operations Exchange Purposes would likely be too burdensome to implement immediately. The initial focus on Treatment, Public Health, Benefits Determination, and Individual Access Services will help fortify and reinforce the CA as more participants begin to get onboard.

We do ask that ONC and RCE work to carefully define what is included under each of these purposes, as there needs to be clarity around the parameters for each purpose if we want QHINs, Participants, and Participant Members to join this effort. For example, how some exchanges currently define "Benefits Determination" is different from how ONC proposed to define it in the draft guidance. Depending on how it is described, it could include or exclude some potential Participants or Participant Members from TEFCA exchange processes.

We would also like to see new, innovative stakeholders that we cannot even conceive of now be attracted to enter the exchange market, adopt the CA, and facilitate greater nationwide data exchange. For this reason, the idea that ONC proposes to phase in new Exchange Purposes in the Common Agreement to support additional use cases is essential and has merit. We call on ONC to work with the RCE to create an annual process to review the purposes that are part of TEFCA and evaluate what needs to change going forward, but allow for an 18-month implementation period (at a minimum) before new purposes are included. Such a phased approach will allow current industry players and new market entrants time to prepare and be successful.

Ultimately, HIMSS and PCHAlliance would like to see the full Payment and Health Care Operations Exchange Purposes added back into this paradigm. As previously stated, the focus on Treatment for the time being makes sense, but as our health system evolves, and we continue to push toward value-based care delivery, all stakeholders will need access to the complete Treatment, Payment, and Health Care Operations information if they are going to appropriately be positioned to transition from a fee-for-service environment.

- **Ensure a Robust Role for Connected Care Use Cases in the Future Framework**

As TEFCA evolves beyond its initial roll-out, HIMSS and PCHAlliance want to ensure that ONC recognize and prioritize the multiple connected care touchpoint opportunities in the Framework. Overall, we want clear inclusion and a path forward for connected care, specifically, an individual's ability to contribute device data to TEFCA exchange processes.

As previously discussed, we recommend that the Exchange Purposes be expanded in the future, and the contribution of data from individuals, specifically patient-generated health data (PGHD),

needs to be included as part of this paradigm. HIMSS and PCHAlliance want ONC and the RCE to establish a process for QHINs to collect these kinds of data, and use the data to augment an individual's health record. When requested by an individual or clinician, clinically-relevant digital biometric data should be a mandated component of TEFCA's exchange processes.

In addition, the Individual Access Services Exchange Purpose could also support connected care by adding two-way information exchange, rather than focusing solely on the retrieval of an individual's data from across the network. We propose that when an individual requests a roll-up of their health data from across the nation through Individual Access Services, that a means is established for that individual to contribute their PGHD or other clinically-relevant information and make that data a permanent part of their health record. As appropriate, this information should also be part of a message delivery push transaction, to ensure that this EHI securely follows the patient when and where it is needed. Moreover, it is important to note that HIMSS presumes that QHINs would be charged with storing only the clinically-relevant data on behalf of individuals given the substantial resources that would be involved and costs that could be incurred.

HIMSS and PCHAlliance want to acknowledge how invaluable an individual's contribution of their biometric data is to the core of care management. Support for connected care, patient engagement, and chronic care management functions are the foundation of a health system focused on quality care delivery.

- **Align Privacy and Security Obligations Across the Healthcare Landscape**

As TEFCA Draft 2 states, the CA will require non-Health Insurance Portability and Accountability Act (HIPAA) entities (such as developers and smartphone applications), who elect to participate in exchange, to be bound by certain provisions that align with the safeguards included in the HIPAA Rules. ONC anticipates that this requirement will encourage robust data exchange across the landscape and improve the health of patients, as well as bolster data integrity, confidentiality, and security in our evolving cybersecurity threat environment.

HIMSS and PCHAlliance want to ensure that there is alignment between TEFCA and HIPAA privacy and security obligations. Such alignment will minimize the impact on Covered Entities (CEs) and Business Associates (BAs) and increase the probability that they will move toward adopting TEFCA. This added clarity should describe new obligations that are beyond HIPAA, and that may require updates to existing policies, agreements, and operations, as well as illustrate where meeting existing obligations for CEs and BAs would also meet TEFCA requirements. In addition, it may be helpful for ONC and the RCE to develop a mapping process between existing HIPAA contractual terms and conditions and TEFCA's terms and conditions.

Moreover, the meaningful choice provisions of TEFCA Draft 2 place requirements around the process for individuals to request that their EHI not be used or disclosed via the CA, except as required by Applicable Law. There is concern about how these requirements would be operationalized to apply to both uses (inside an organization) and disclosures (external exchanges with other organizations). Applying these requirements inside an organization would impact internal processes not involved in external information exchange, and therefore should be beyond the scope of TEFCA.

- **Push for the Creation of a Patient-Focused and Driven QHIN**

We are cognizant of the importance of Individual Access Services as one of the Exchange Purposes in TEFCA Draft 2. In support of unencumbered patient access to their own information, HIMSS and PCHAlliance would like ONC to ensure the creation of at least one QHIN where an individual could request a roll-up of all their EHI without the intervention of a clinician or provider organization. ONC could also meet this functionality by requiring all developing QHINs to provide a means for individuals to request their health information without provider involvement.

As our health system seeks to empower patients with control of and access to their own health information, ensuring that individuals have direct access to their own information through the TEFCA enterprise is paramount. Individuals can then direct this information to the provider, application programming interface (API), or app of their choosing, but would not necessarily be required to if they seek to manage their own care.

We also support the ideas included in TEFCA Draft 2 that QHINs *may not* charge another QHIN any amount of money to exchange EHI for Individual Access Services. We also endorse the policy that QHINs must publish and make publicly available a written notice describing their privacy practices regarding the access, use, exchange, and disclosure of EHI. As ONC describes, this notice should mirror ONC's Model Privacy Notice and include information with an explanation of how an individual can exercise their meaningful choice and who they may contact for more information about the entity's privacy practices. Moreover, for Individual Access Services, the exchange participant is only allowed to use, exchange, retain, aggregate, and disclose EHI for this purpose.

ONC and the RCE should also explore a process that QHINs have to undertake related to vetting the APIs and apps that are used for Individual Access Services. Although patients should have the ability to use whatever app or service they want, some patients may appreciate a degree of vetting that provides further guarantees on the privacy and security of their health information. Establishing a measure of trust for apps at the QHIN level would provide those assurances to the Participants and Participant Members that work with that QHIN. Beyond vetting, QHINs should also explore real-world testing and surveillance services on apps that are accessing individuals' data, to be able to shut down those bad actors that are abusing their privileges.

- **Clarify the Role of QHINs in Future Uses of Patient Data**

There is some ambiguity in TEFCA Draft 2 around the ability of QHINs to employ the data that they are exchanging across their networks in additional future use cases. TEFCA should clarify that QHINs cannot use or sell the data that they are facilitating the exchange of without the consent of the entities that brought the information into the broader network. QHINs should be allowed to establish additional data sharing use case agreements with their Participants, Participant Members, and Individual Users, but without the existence of such agreements, future uses of the data need to be restricted.

HIMSS and PCHAlliance support the ability of QHINs to have additional business lines outside of TEFCA, with Participants, Participant Members, as well as Individual Users, but also beyond those entities or individuals. However, using or selling the data that is part of TEFCA exchange processes without the appropriate consent requirements should be prohibited.

- **Answers to Specific Questions Embedded in the Draft Guidance Document**

Overall, HIMSS and PCHAlliance emphasize that as newer technologies or technical standards are developed, we encourage ONC and the RCE to ensure that TEFCA's current standards are reviewed and tested for additional refinement opportunities.

- o *ONC Request for Comment #1: Should the QTF specify additional standards or approaches for securing QHIN Exchange Network transactions (e.g. OASIS Web Services Security)?*

  The QTF should support Open Authorization (OAuth) standards, or at a minimum the JavaScript Object Notation (JSON) Web Token format (JWT) that may support Security Assertion Markup Language (SAML) Token or OAuth Bearer Token options. Overall, the standards included in the QTF should be consistent with industry-adopted standards as published by entities like Health Level Seven International (HL7®) and Integrating the Healthcare Enterprise (IHE). HL7 Fast Healthcare Interoperability Resources (FHIR®) recommends OAuth for authentication (see FHIR Security); IHE Internet User Authorization profile (IUA) uses OAuth to add authorization information to HTTP Representational State Transfer (RESTful) transactions and IHE IUA requires all actors to support SAML Token or OAuth Bearer Token options (see IHE ITI-IUA).

- o *ONC Request for Comment #2: What specific elements should a SAML assertion for User Authentication include?*

  We support the use of the elements through Carequality query exchange using SAML, which must include organization ID, home community ID initiating the query, subject/user role, purpose of use (treatment, payment, and operations), information on the user-initiating query, and organization name.

  The elements that are generally used to determine release are querying organization, and nature of the request (certain processes are based on purpose, which may require consent before release). The rest of elements are for auditing purposes. Moreover, the role of user is required for SAML tokens, but query responders cannot use that to release information because they cannot make a determination on the person requesting vs. the person using the information. For example, in a clinical setting, requests are often initiated by front desk staff though the information received will be sent to the clinician. It is important to consider how permissions blocking release to only clinicians might affect these types of workflows. This is an area where the industry needs improved data provenance standards for when requests are submitted. ONC should consider a whether it

should be required that an adequate amount of provenance is exchanged with an electronic signature.

- o *ONC Request for Comment #5: The IHE XCA profile supports a number of defined queries (e.g., FindDocuments, GetAll, GetDocuments, GetRelatedDocuments, etc.). Each query includes a number of optional parameters. Should the QTF specify which queries/parameters a QHIN must support? Which queries/parameters are most widely implemented and/or useful today?*

    The QTF should not specify which queries/parameters a QHIN must support. The IHE IT Infrastructure (ITI) XCA and XDS supplement profile as well as the XDS MetaData Update has specified optionality (with R for Required or O for Optional) for associated parameters of each query. Overall, the QTF should adopt IHE's profile and work with IHE on any new requirements.

    IHE also has the processes in place for selecting and developing standards and testing infrastructure for interoperability solutions. The QTF can recommend health data exchange communities follow the principles documented in the IHE ITI White Paper: Health Information Exchange: Enabling Document Sharing Using IHE Profiles, IHE ITI TF-3 Cross-Transaction Specification and Content Specification, and the IHE ITI Handbook: Document Sharing Metadata Handbook as well as XDS MetaData Update.

    For the FindDocuments query, we recommend the IHE ITI Handbook: Document Sharing Metadata Handbook. Section 2 indicates "The XDS/XCA Query transaction has several query capabilities. The FindDocuments query is one of the most powerful." It is important to note that 7 out of 17 query parameters supported in the FindDocuments query are listed as "critical few".

- o *ONC Request for Comment #6: The IHE XCA profile is content-agnostic; it enables queries for documents based on metadata about the document but not the contents of the document itself. Therefore, the XCA profile does not necessarily support more granular queries for discrete data (e.g., a request for all clinical documents about a patient that contains a specific medication or laboratory result). Comments are requested on other appropriate standards to consider for implementation to enable more discrete data queries, such as emerging IHE profiles leveraging RESTful APIs and/or use of HL7 FHIR.*

    We strongly encourage that ONC look to the IHE Query for Existing Data for Mobile Profile (QEDm) and the IHE Mobile Cross-Enterprise Document Data Element Extraction (mXDE) Profile.

    The IHE QEDm profile has been designed to be used in conjunction with IHE mXDE profile. Combining mXDE and QEDm profiles provides the means to access data elements extracted from shared, structured documents and enables the

deployment of health data exchange infrastructures. These two profiles provide both document-level and data element-level granularity.

In addition, the Proposed ONC and Centers for Medicare & Medicaid Services (CMS) Interoperability Regulations were extensive on FHIR and FHIR-based exchange resources, but, in general, these elements seem to be missing in the QTF and should be included in discrete data queries to work toward TEFCA's single on-ramp for exchange. The profiles proposed above are updated IHE profiles to support FHIR and the start of FHIR-based resource bundles that should be explored for use in discrete data queries.

o *ONC Request for Comment #7: The IHE XCPD profile only requires a minimal set of demographic information (i.e., name and birth date/time). Should QHINs use a broader set of specified patient demographic elements to resolve patient identity? What elements should comprise such a set?*

The issue of patient matching across the healthcare ecosystem continues to be a serious obstacle to interoperability and impacts patient safety. HIMSS and PCHAlliance strongly encourage ONC to use all its regulatory policy levers to address patient matching issues. TEFCA can provide an opportunity to continue examining patient matching solutions, but discussions also need to continue in other venues. We recommend that ONC collaborate with the RCE to provide direction on creating future user guides on how to match patients using demographic data, including information on approaches for patient identity resolution and matching performance benchmarks.

o *ONC Request for Comment #8: There are many possible approaches to Patient Identity Resolution, each with its own benefits and risks. For example, a centralized index of patient identity information may be more efficient for resolving patient identities across disparate communities, but also poses a greater risk to privacy if the system is compromised. Federated approaches may be less susceptible to external threats like cyberattacks, but harder to scale across many communities. Recognizing that new technologies and business entities with robust identity matching solutions may disrupt traditional approaches, should the QTF specify a single standardized approach to Patient Identity Resolution across QHINs?*

As discussed, patient matching solutions are a priority but ONC needs to facilitate a broader discussion on the topic beyond TEFCA guidance documents. ONC should work with the RCE to determine the details and the best approach to move forward.

o *ONC Request for Comment #9: Different communities tolerate different degrees of risk with respect to accurately matching patient identities. Should QHINs meet a minimum performance standard (e.g., a minimum acceptable matching accuracy*

rate) over a specified time period? Likewise, different algorithmic techniques for matching patient identities use different approaches and must be tuned to the applicable patient population and continuously refined over time. Should QHINs measure and report on the performance of the algorithm(s) they rely on (e.g., by calculating precision, recall, etc.)?

It is important to recognize the amount of partial/potential matches that typically occur across the health system and the need to determine a robust way to handle these situations.

In previous public comments on patient matching, HIMSS has strongly supported the use of matching algorithms as part of an overall patient matching strategy. However, we think that an explicit mandate of a specific patient matching algorithm at this time is premature, especially considering there is no current way to benchmark the accuracy of those algorithms. We have asked that all relevant components of the Department of Health and Human Services work together with the private sector to create a benchmark measurement for algorithms that have been and will be developed. This benchmark would help providers, organizations, and potentially ONC decide which algorithm to use moving forward.

Overall, these patient matching algorithms could be improved with more standardized data elements. HIMSS has offered the following additional data elements as a suggestion to improve patient matching: maiden name, multiple birth indicator, birth order, telephone number types (specifically mobile), and email address. More generally, data collection standards and their consistent application by health plans, providers, and exchange organizations are a critical determinant to matching accuracy. HIMSS believes the biggest opportunity to immediately enhance matching rates is standardized formats for demographic data among data sharing participants.

Moreover, HIMSS and PCHAlliance encourage ONC to charge its Health IT Advisory Committee with further investigation of these questions and provide recommendations on a path forward for TEFCA as well as ONC's other regulatory measures.

o *ONC Request for Comment #11: Should the QTF require QHINs to implement Directory Services? Recognizing there are many possible approaches for implementing Directory Services, should the QTF specify a single standardized approach? If QHINs implement Directory Services, which entities should be included in directories? Should directories be made publicly accessible?*

Directory services should be managed at the RCE level to ensure universal public access across all QHINs, rather than allowing different solutions to be implemented on a QHIN-by-QHIN basis. However, ONC and the RCE should look to leverage effective solutions that HIEs and HINs have been using to manage their directories to this point. We recommend that ONC and the RCE work with CMS to utilize the

National Plan & Provider Enumeration System (NPPES) as a starting point for a centralized directory, and then determine where it needs to be supplemented with the help of the broader healthcare community. We support this approach given the proposed requirement in the CMS Interoperability Regulation that calls for public reporting of providers that do not list their contact information in NPPES. If this provision is included in the final regulation, it will likely have a positive impact on how robust a resource that NPPES becomes for exchange capabilities.

HIMSS and PCHAlliance appreciate the opportunity to contribute our ideas about TEFCA Draft 2 and how ONC can facilitate greater data exchange across the healthcare ecosystem. We are committed to be being a valuable resource to ONC and the entire community to help enable nationwide interoperability.

We look forward to the opportunity to further discuss these issues in more depth. Please feel free to contact Jeff Coughlin, HIMSS Senior Director of Federal & State Affairs, at 703.562.8824, or Eli Fleet, HIMSS Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,

Harold F. Wolf III, FHIMSS
President & CEO
HIMSS and PCHAlliance