

**Information Exchange Workgroup  
Subgroup 2  
Draft Transcript  
June 1, 2012**

## **Presentation**

### **Operator**

All lines are now bridged.

### **MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good afternoon everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup Subgroup #2. This is a public call, and there will be time for public comments at the end. The call is also being transcribed, so be sure you identify yourself before speaking. I will go through roll and ask for any staff members to also identify themselves. Cris Ross?

### **Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I am here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Cris. Larry Garber?

### **Larry Garber – Reliant Medical Group**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Larry. Chris Tashjian?

### **Christopher Tashjian, MD – River Falls Medical Clinic**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Chris. Deven McGraw?

### **Deven McGraw – Center for Democracy & Technology – Director**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks Deven. Arien Malec?

### **Arien Malec – RelayHealth**

Hello.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Arien. Are there any Workgroup members on the line?

### **Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Micky Tripathi.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Micky. And are there any staff members on the line?

**Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor**

Mary Jo Deering, ONC.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Mary Jo. Okay, Cris, I will turn it back over to you.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Fantastic. Alright, ladies and gentlemen, we've got a couple of things to do yet on our primary questions, and then we can move into secondary. So I would suggest that we proceed as following: one, let's resolve the issues related to the net neutrality and pricing issues that are raised on questions 52 and 54. And there were some e-mails associated with that. We'll get to those in a sec.

Then there's an open, highlighted question, comment, on 55 that Tari highlighted for us that we should get to. And then I would suggest that we look at any of the comments that were reported previously, and on an exception basis if someone thinks we need to edit or wordsmith them, we'll do so. Otherwise, we'll move on to the secondary questions. Does that work for everyone?

**W**

Yep.

**M**

Perfect.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So does everybody have the document that Tari put together, IEWG Subgroup 2 Meeting May 25<sup>th</sup> Draft Comment 2?

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**M**

Yep.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So far so good. So let's go the questions around pricing relative to net neutrality. We had some fantastic e-mail exchange on that topic. I think the last in the train, at least that I got, had comments from Tari this morning at 11:49 Central time that had—I had proposed—this all started with Deven and Arien talking about net neutrality, and Deven sent us a note on the 30<sup>th</sup>. I sent back a note Thursday mid-day that suggested four possible alternatives—hope everybody saw that. Arien then amended that to suggest that the pricing and limitations and so on be limited to essentially the items related to CTEs. And then I followed up with some information that some council of church groups came up with on some precedents. On a quick turnaround basis, we found something around ISO Guide 65 and ATCB. Everybody got all of that?

**M**

Yeah.

**W**

Yep.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alright, so I'd open it up to—

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky, could someone forward that thread?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Absolutely. I will do so right now.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Thank you.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Does someone want to take up proposal about favoring one of those?

**M**

One of your four?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

As amended with your comments.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, I would propose—I think that's option number one as amended with Arien's comments. So for the specific purposes of exchange among participants in two different NVEs, that that not be subject to an additional fee, but other services, of course, would not be subject to that net neutrality principle. Not very well articulated, but essentially all along I'd like the concept that exists on the Internet for the basic premise of being able to send and receive information from someone who is a participant in another NVE—that for that basic exchange, there ought not to be intervening fees in the middle for that.

**Arien Malec – RelayHealth**

Here's the concern that I have. If I am running a patient discovery node, for example—let's say I've got a value-added service where I am helping a number of organizations facilitate patient discovery.

**Deven McGraw – Center for Democracy & Technology – Director**

But that, to me, is a value-added service, Arien.

**Arien Malec – RelayHealth**

Well, that's one of the services that is, at least in the current RFI, is contemplated as one of the CTEs.

**Deven McGraw – Center for Democracy & Technology – Director**

Although I actually read that registry not to be a patient registry but a provider registry.

**Arien Malec – RelayHealth**

No, that's 55, and that is related to a provider registry?

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**Arien Malec – RelayHealth**

But, sorry, there are other CTEs that relate to patient discovery. So, for example, one that says that ... Mary Jo, if you can help me find the exact CTE that I'm thinking of? It's one of the interoperability CTEs.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

A special prize to whoever can find it.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, because I didn't read that in there, so.

**Arien Malec – RelayHealth**

Safeguards, interoperability... I'll find it at some point. So there are business models—I guess where I'm struck is there are net neutrality-like business models, and I'd say basic transport or direct is a net neutrality-like service where fees should be incurred between the ISP or the health ISP and the customers, but not between the HISP and its peers.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**Arien Malec – RelayHealth**

There are other services that may not be net neutrality-like. So if the condition—sorry, I'm looking at condition I-3: An NVE must have the ability to verify and match the subject of a message, including the ability to locate a potential source of available information for a specific subject. So that describes a record locator service. That's on page 52. I get the prize. And—

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So noted.

**Arien Malec – RelayHealth**

I can imagine all the claims of value-added services where I'm operating an NVE that implements that service and expects to incur a transaction fee or a fee for offering a service. And I might do that to my customers, but I also might do that to people who want to query me because I'm adding value.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**Arien Malec – RelayHealth**

So what I'm proposing is there's a class of net neutrality-like basic transport services, IFC-like services, to which net neutrality rules should apply, and there is a class of rules where reasonable and non-discriminatory should apply.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So, Arien, you have in mind, it sounds like, that if you think about the basket of things that an NVE would do, is that the items that would be subject to net neutrality—like basic SMTP, S9, and DNS from your example—sound like they are important and foundational, but maybe not the majority of the work that an NVE would do. Is that the general thought?

**Arien Malec – RelayHealth**

Correct. So I would propose that there be a category of net neutrality-like services for which option one would apply and a category of non-net neutrality services which option three would apply. I'm willing to be argued option three versus two position, but that's the framework that I have.

**Deven McGraw – Center for Democracy & Technology – Director**

That makes sense to me. This is Deven.

**Larry Garber – Reliant Medical Group**

This is Larry. Are you suggesting that in a case where there's actually just an exchange of a message from one NVE to another, passing information along, that that would be a free service, but that if, really, there's something that that second NVE is then providing back, some service that they're providing back, that there could be a charge for that service?

**Arien Malec – RelayHealth**

So what I'm proposing is that under governance there be a class of service to which net-neutrality rules apply because they are basic to the operation of the health information network—the nationwide health information network.

**Larry Garber – Reliant Medical Group**

And it's really moving messages.

**Arien Malec – RelayHealth**

That's primarily relating to transport, to moving information around. And for those, there should be no barriers to access to peers. And there's a wider set of barriers to access to peers than these, but there should be no barriers to access to peers, assuming that those peers are trusted entities and that there be other services that are not covered under those basic net-neutrality rules to which the limitations should be fair and nondiscriminatory.

**Larry Garber – Reliant Medical Group**

That's fair.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So to be explicit, just kind of for the record, Arien, I think all this makes sense. I think of the next stack of services above, for instance, SMTP and DNS, discovery of certificates to include things like an NVE might create a directory that has some value added to it. And that seems like that's fair game for commercially-based fees between one another and could include that, perhaps, one network even provides certificate services, not just location of certificate within their network.

**Arien Malec – RelayHealth**

Yep.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

There's a whole stack of things that we could see stepping up. Alright, it sounds like we have violent agreement. I would make the argument that number three, regulated prices by ONC, is a bridge too far, and that we should look at something like number three, which would be subject to other forms of market control and regulatory control, but not to ask ONC to take on the job of actually setting prices. Is that fair?

**Deven McGraw – Center for Democracy & Technology – Director**

Yes.

**M**

Yes.

**M**

Yes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alright. So, Tari, did you get that?

**Tari Owi – Office of the National Coordinator**

I got it.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky. Is it worth putting in the comment also just recognizing that that definition of basic dial-tone service will probably evolve over time, that we may want to include later that queries are free, for example?

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Great point. Great point. And maybe it isn't limited just to SMTP at some point. Perhaps it includes ... change at some point or something like that.

**Arien Malec – RelayHealth**

Right. So what I'm proposing is not that we ... determine a set, but that we determine a governance mechanism for determining the set of basic dial-tone services.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Brilliant. Alright. Excellent work on a hard topic.

**Arien Malec – RelayHealth**

It's a computer science axiom that all traditionally hard problems can be solved through an extra layer of ingression.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And a couple more acronyms. Okay, should we move onto—there's this open question on 55 that we didn't discuss: What data would be most useful to be collected or whether NVEs should report information by end-user type? Can someone help me dredge up where we were on that? I'm trying to remember why we did not answer that question. Did we just run out of time, or did we have some discussion item that was still open? I cannot remember. In my notes, I don't see it. I think possibly ... overlooked it.

**Arien Malec – RelayHealth**

My recollection is that we didn't know how to answer the question because it really depended on the type and class of service. That was my recollection as to where we were with that question. But I could be making it up.

**Larry Garber – Reliant Medical Group**

And I think there was also the issue that there may be a lot of transport going on that there's no way for them to actually measure that circumvents the NVE to some degree other than looking up the certificates.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

That's fair. So do we simply want to say that we don't know enough yet about what data should be collected? I mean, we've implied it with respect to transactional, sizing kind of data, but we haven't gone any deeper than that. Should we simply say that we think that operational data and adoption—data that indicates adoption and use is appropriate, and that other than that, we don't have comments?

**Larry Garber – Reliant Medical Group**

That's fair.

**Deven McGraw – Center for Democracy & Technology – Director**

Yep.

**Arien Malec – RelayHealth**

Works for me.

**Christopher Tashjian – Ellsworth Medical Clinic – Family Practice**

I'm okay with that.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Excellent. Tari, did you get that?

**Tari Owi – Office of the National Coordinator**

Sounds good.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Beautiful. Let's move on to—real quick, does anyone have any comments by exception around the comments that we have so far to questions 34 through 35? I hope people had a chance to read them. I thought that these were an excellent summary of our discussion.

**Deven McGraw – Center for Democracy & Technology – Director**

As did I. This is Deven.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Hearing no other comments, why don't we move ahead to question 24: appropriate level of assurance that an NVE should look to achieve in directly authenticating and authorizing a party for which it facilitates electronic exchange. So question 24 relates to authentication levels.

**Christopher Tashjian, MD – River Falls Medical Clinic**

There must be standards for this. You know, best practices? Although I'd hate to go as extreme as perhaps what they're doing for e-prescribing controlled substances.

**M**

Right.

**Larry Garber – Reliant Medical Group**

Well, if we're going to do this for controlled substances, people are going to have that available anyway.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Not everybody. Not everybody ... to—who wishes to use information exchange will also be doing scheduled prescribing.

**M**

Right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So this has to do with the issue about authentication and authorization of parties for which NVEs facilitate exchange. The comment here is it can be accomplished either directly or indirectly by the NVE. Let me give you the example—I think most people on the call probably know this—but for Surescripts, for example, we do not authenticate direct participants on the network. That's a task that's delegated to the EHR vendor.

**Larry Garber – Reliant Medical Group**

And in turn often delegates to another entity.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well, in the case of where we operate through someone like Relay Health, there's about four levels of indirection.

**Larry Garber – Reliant Medical Group**

Correct. That's right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

We have a contract with Relay that we require that Relay put in place for its vendors that it's required that that fee put in place for the particular practice.

**Larry Garber – Reliant Medical Group**

And then for the other side for which we contract with you, you delegate to us; we often delegate—and our typical practice is to delegate by contract and warrants to a health system that contracts with us.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right. I was thinking that example, but you're absolutely right. The model works the same on the pharmacy side.

**Larry Garber – Reliant Medical Group**

I was thinking of the prescribing side, but there's two business units that really help the contract with Surescripts for e-prescribing, not to bore everybody with contractual details there. And I'm thinking in services where we're an e-prescribing vendor, not a services vendor, we often delegate—and I think it's a pretty typical practice—we delegate to a health system that then takes on the burden of medication and identity assurance. There are installed software worlds where the EHR or EHIT vendor who might contract with the NVE actually has—can't authenticate or identity assure providers because all they do is install the software.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right. Although that license agreement imposes certain requirements as well.

**Larry Garber – Reliant Medical Group**

Correct.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So it's not just the contractual requirements; it's also the case that an EHR vendor that wants to e-prescribe is required to be certified, and part of that certification is that there is some form of essentially check-box that a patient's consent has been achieved or granted before a med history result is sent out to that doctor.

**Larry Garber – Reliant Medical Group**

That's really into a different CTE, and I agree with where you're going there as well. But there are multiple cases where the NVE itself has no direct relationship and satisfies requirements via contract and warrants.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So the condition—

**Deven McGraw – Center for Democracy & Technology – Director**

Go ahead Cris.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well, all I was going to say, Deven, is it sounds as though—I mean, the commentary of condition S-2 on page 39, I think, anticipates some of this and suggests that there's a NIST standard on electronic authentication that would be applied as a best practice. To Larry's initial point, there must be best practices. I'm not sure we've got a whole lot more to add to this, but, Deven, you've probably got last and best word on it.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, I don't know about that. We actually struggled as an entire team deliberations on authentication about whether we would pick a level of assurance that then under the NIST standards would translate into certain requirements with respect to authentication beyond username and password to requiring some sort of physical token or biometric.

What we wanted was a high degree of assurance that at an organizational level, the machine-to-machine contact for exchange was the right machine to the right machine with entities responsible for doing their own identity proofing and authentication of individual users within that system. But we really could not—we were reluctant to say, okay, we pick NIST level three because that—you know, if you say high assurance in the NIST world, it means something, and we just didn't think that—we were not persuaded that you necessarily needed to go to that level for a type of sort of organizational authentication.

**Larry Garber – Reliant Medical Group**

For a little bit of color commentary there, two things. First of all—

**Deven McGraw – Center for Democracy & Technology – Director**

Do you remember that conversation?

**Larry Garber – Reliant Medical Group**

I do remember that conversation. NIST explicitly said that their framework was intended for use by government. And I remember a really striking comment that Paul Eggerman made that just made me go, “Oh,” which is, okay, in a surgical center, in an operating room, in an operating theater, there are often—it is standard practice to have uncontrolled access to terminals because the last thing you want to do in the middle of a surgery is authenticate. And yet, there is absolutely no possible harm in that situation because the only—there are security controls that allow you to get into that operating theater.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

But they’re physical controls.

**Deven McGraw – Center for Democracy & Technology – Director**

Right. Physical controls.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

They stop to change their playlist on the iPod in surgery, so—

**Christopher Tashjian, MD – River Falls Medical Clinic**

Actually, they’re now using Xbox. Literally, they’re using those so that they can use the hand motions to control things.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky. I’m wondering if—just reflecting on the prior call—I guess it was earlier today, right? Yeah, it was earlier today—whether the best approach here is for transparency, and best practice recommendation and transparency rather than requirement and just—you know, in New York we went through this, and it was just an incredible challenge as they were trying to think about a statewide approach that was going down the path that Deven was suggesting. And they came up with very clunky language that said that, “The policy is too factorable; we’ll accept one factor for a very long time.” Maybe the best approach here is to say that transparency is the answer. If NVEs make transparent where they are, then they’ll be able to voluntarily decide whether that’s acceptable.

**Christopher Tashjian, MD – River Falls Medical Clinic**

I mean, the problem is when you’re sending a message across the country and it’s—you have no idea that necessarily that it’s going to bounce from one NVE to another—you need to pretty much assume that everyone’s at least got some baseline level of authentication going on because there’s really no way to say, “Wait a second, I’m not confident in this person, even though they told me I’m going to route it a different way.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Right. But I think the challenge is when you get from one to two, right? Everyone would agree on one?

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**Christopher Tashjian, MD – River Falls Medical Clinic**

... the person you’re connecting to directly, yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Knowing one factor. But then when you get to two, that’s where the big divide starts to happen.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**M**

Right.

**Larry Garber – Reliant Medical Group**

... something.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Yeah, and it's—I think this is going to—we're going to have different viewpoint, depending on what business models are allowed by the NVEs. So I think, for instance, there's another set of questions about encryption, and I know that the privacy and security tiger team has said establish a strong precedent around what it is that networks may do and what it is that endpoint provider systems may do. I think there is some reasonable precedent that says, however, that there's some value in NVEs providing value-added services in the middle to sometimes open and translate messages on behalf of parties, which I think is allowed under this privacy and security tiger team recommendation.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, I think so.

**Larry Garber – Reliant Medical Group**

And, Deven, if I remember, the tiger team came up with some language in this area?

**Deven McGraw – Center for Democracy & Technology – Director**

Oh, probably. But I'm not sure it's any better articulated than what we've just said, which is essentially that there is a responsibility for authenticating the participants in your NVE, and that it is acceptable to do that at an organizational level and leave to the organizations the responsibility for authenticating their—id proofing and authenticating their individual users.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

I wonder if we might supplement that with the—that sounds exactly right—what would happen if we supplemented that with the Eggerman rule, which was identify that in some instances there may be different levels of security and authentication that are imposed by the endpoint that are germane to the activity at that endpoint, like the surgical example, right?

**Deven McGraw – Center for Democracy & Technology – Director**

Right. But they've got to be transparent about that.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Exactly.

**Deven McGraw – Center for Democracy & Technology – Director**

And I guess under net neutrality principles, you can't let your authentication policies be your barrier to simple exchange, which is probably worth saying.

**Larry Garber – Reliant Medical Group**

Right, that is absolutely worth saying. If we require you to jump through five hoops—

**Deven McGraw – Center for Democracy & Technology – Director**

Right, give up your firstborn child before you can get in. That's, you know, that's tantamount to abuse of market power.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So does someone want to take a bash at summarizing that so that Tari can get it drafted?

**Larry Garber – Reliant Medical Group**

What Deven said was absolutely—I'm just wondering if we can put Deven on rewind and play it?

**Deven McGraw – Center for Democracy & Technology – Director**

I think it's the basic premise that NVEs are responsible for authenticating the participants that they are serving, and they can do this at an organizational level and float down to their individual participants the responsibility for id proofing and authenticating individual users and acknowledging that there may be circumstances where a recipient NVE, there might be additional criteria imposed in special circumstances—the surgical suite example—although I don't know if that's necessarily an ideal one—but that any higher level of authentication an NVE would have to be transparent about.

And it also can't—we also have to recognize that in allowing NVEs to set higher authentication requirements in some circumstances for some special services, that it cannot be applied in a way that disrupts the net neutrality principle of basic exchange services being not obstructed by fees or unreasonable conditions.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky. Isn't that still sort of begging the question of the question, which is—the question is: What is the most appropriate level?

**Christopher Tashjian, MD – River Falls Medical Clinic**

I mean, doesn't HIPAA say that? I mean, isn't this really part of HIPAA that there's a judgment call as to what's appropriate—the risks and benefits of physical security, all those other issues taken into account, and then you balance them out?

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, in essence, but I think what we want to try to avoid is NVEs all setting wildly different authentication requirements for exchange, especially when they're accepting information from outside of their own internal network and going across NwHin in a way because what's reasonable for one person who has very low risk tolerance—the security rule gives you a lot of flexibility to potentially impose conditions that could be obstructive in the name of security.

**Micky Tripathi – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

But, Deven, when you say it—just replaying what you said before—it was something like NVEs must authenticate. But it begs the question of what type of assurance are we talking about. It implies level—one factor in factor one.

**Deven McGraw – Center for Democracy & Technology – Director**

No, except I don't like to go to those factors because they have—I mean, an NVE has the legal responsibility, I guess, is the way that I would put it, to authenticate their own members. Where they set the level for how they play internally, I don't care if it's level one, two, three or four, because that's their own business operations. But when they then transmit to another NVE, I'm thinking about what the recipient NVE can impose.

**M**

Right.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Right. And you're ... this good because I think in my organization where we have physical security within our walls, one factor is fine. When we're having people coming in from remote access where we don't have physical security anymore, we require two-factor. My belief is that that's the right thing to do. But you're right; the hospitals in my community believe that one factor is fine even if you're coming from China, literally. And I find that concerning. So you are right; you do need to set some kind of floor.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

But if we're talking about authentic—we're talking about authentication of parties. What I'm trying to understand is where is the instance in which an NVE could, in fact, affect authentication? I mean, the authentication activity will happen within the context of the end-user application and not the NVE, so it feels like this is an issue about what should not be imposed on the NVE, but what should the NVE impose on participants on its network.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**Arien Malec – RelayHealth**

Just as a, again, a little bit of color, there are cases where the NIST levels are designed for person-level authentication. There are many cases where the NVE will provide machine-level or ATI-level authentication and where the person-level authentication will be provided by that end-user application. So the question of NIST Special Publication ... doesn't apply.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right. Yeah.

**Larry Garber – Reliant Medical Group**

Or if it does apply, it applies down at the, you know, down a couple of ...

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well as we were talking, I was trying to scan through at least the table of contents for that guide, and it doesn't appear that it talks about system-to-system authentication other than in an initial section on e-authentication models. Would it be fair to say something along these lines that the NVE should impose on parties that connect the appropriate level of authentication and authorization as described in NIST 6800 appropriate to the domain in which that application functions and as the NVE feels like ought to impose?

I'm not enough of an expert in this area, but it feels to me as though the machine-to-machine authentication ought to be at the highest level associated with one of those endpoints. I'm not sure that—when we've talked about this before, I'm not sure there's been a whole lot of concern that system-to-system authentication is complicated or expensive. It has to do with end-user authentication is where the gnarly problems are.

So are we in bad shape if we apply a high standard relative to the machine to machine and impose on the connecting parties to the NVE the appropriate level of authentication and authorization?

**Arien Malec – RelayHealth**

I'm of the full belief that at this level we should be setting policy principles and not pointing at specific technical ....

**Christopher Tashjian, MD – River Falls Medical Clinic**

Is it appropriate as a guideline to say that in the instances where there is lower physical security, we expect a higher level of authentication in general as a policy, because in a way, that's what we're talking about with the surgical suite with the people calling in from China. That's really what the differences is—or machine to machine. There's no physical security machine to machine, so you want to have a higher level of authentication.

**Arien Malec – RelayHealth**

Or some level of physical, anyway.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Well, I mean, from Boston to Los Angeles, there's no physical security between those two computers.

**Larry Garber – Reliant Medical Group**

I won't geek out on you, but that's ...

**Christopher Tashjian, MD – River Falls Medical Clinic**

Okay, you're right .... Well, I think the argument from a policy perspective was to place authentication on the application used where data is initiated and received, and the ... is focused just on machine to machine.

**Larry Garber – Reliant Medical Group**

Right. And I haven't heard anything—well, ... may be focused on machine to machine ... It may provide access to ... or whatever if it requires authentication, but I haven't heard anything to contradict Deven's policy-level summary.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Okay, that's fair.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alright, so I'm believing that Deven may have also answered question 26.

**Deven McGraw – Center for Democracy & Technology – Director**

I think so too. I did that on purpose.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Well done, a twofer. So I think we just want to say see 24 for 26. Do 25 and 27 raise issues separate than this? I think we answered on 25 the issue about indirect approach.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, and I thought we answered 26. Twenty-seven is a different topic.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yes. Okay, so, Tari, do you think you have the text necessary that we can apply for 24, 25, and 26?

**Tari Owi – Office of the National Coordinator**

I believe so.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alright, 27?

**M**

Whoo-hoo.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Opting-up, out, or some combination: what are the operational challenges, criteria?

**Arien Malec – RelayHealth**

I just have an existential problem here.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Okay.

**Arien Malec – RelayHealth**

And this really relates to question 30 where I can't answer questions 27, 28, or 29 until we answer question 30.

**Arien Malec – RelayHealth**

We don't have question 30. What's question 30?

**Arien Malec – RelayHealth**

Question 30: The process of giving patients a meaningful choice may be delegated to providers or other users of NVE services. In such instances, how would the provision of meaningful choice be validated?

**Arien Malec – RelayHealth**

Right.

**Arien Malec – RelayHealth**

I'm going to give what we do, and I'll give an overview of what Surescripts does, and Cris can correct me if I've got it wrong. We have business-associate agreements and other terms of use where part of those terms of use include warrants that, for example, providers will obtain appropriate consent prior to using information exchange services, and we provide mechanisms and audit those mechanisms and provide places for patients to go in and set their own preferences and all that. But that's the extent to which we can go. All we can do is to provide the place by which the provider can assert that they've obtained appropriate consent, but we have no control at all about how or what kind of consent is obtained, except by the warrant that we float out.

Surescripts has a medication history request response transaction that facilitates—it's a go between, actually, between a bunch of different parties, and all it does is there's a flag in the ... scrip transaction that says consent was obtained, and all it does was check that and say yep, okay. And it's really the PBM's business to determine the circumstances under which it's going to expose the information, provide the information. Surescripts contractually slowed down requirements to the HIT vendor, which in turn closed down requirements to end UI components and those kind of things to the provider.

But none of those parties can ensure that meaningful consent was obtained. Only the provider can ensure that meaningful consent was obtained, and the only control that Surescripts or the HIT vendor has is through warrants that flow down.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

It's slightly more complicated than that, because it's possible that the meaningful consent that I obtained for my patient was that I'm allowed to get medication history on everything except mental health, substance abuse. But I'm getting everything. So the question is—and I don't recall my Surescripts contract—is whether I'm allowed to have patients authorize certain segmentation of the data.

**Arien Malec – RelayHealth**

Nope, the PBM ... cannot supply that information, but there's no way in the ... transactions to filter server size.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right, so as we look at the opt-in or opt-out, it really has a lot more to do with what is it that patients are authorizing when they do give consent. Will we require that the opt-in or opt-out is going to be for everything, that you're completely in or completely out? Or are we going to allow some sort of rules as to which parties can participate, which types of data can be exchanged and things like that? So I don't think that's really addressed at all in any of this.

**Arien Malec – RelayHealth**

And again, I just go back to the point that an NVE can supply all kinds of mechanisms, but at the end of the day, they have no ability to obtain meaningful consent at all.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Agreed.

**Christopher Tashjian, MD – River Falls Medical Clinic**

So if Arien had a—what was it? An existential question? I have an ontological question, which is why would the NVE be in the business of managing consent at that level of granularity as opposed to the applications that are connected to the NVE? And I'm excluding where an NVE is operating, for example, as a patient portal. I think of that patient portal as being an application—or a provider portal.

But when it's providing transport activities, it's not clear to me at all why the NVE should have any awareness—I'm saying this to be provocative—why would the NVE have any awareness whatsoever about granularity of type of consent other than what was imposed—that appropriate levels of consent must be obtained? It otherwise would have no ability to observe, measure, manage, audit.

**Larry Garber – Reliant Medical Group**

So in terms of the data, it's self segregating, you're correct. Although in terms of possible destinations, you know, I give permission for these organizations to see my data, but not those organizations.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Fair point, Larry. Very good point.

**Deven McGraw – Center for Democracy & Technology – Director**

This is Deven. I personally think that—and I think this is also consistent with what we said as a policy committee on this choice issue—that the endpoints or at the application layer at the provider layer, is more often than not where consent, when it needs to be obtained, is obtained. And what the NVE responsibility—you know, it's really the provider's role or the entity at the level of engagement with the patient basically as to attest that consent has been obtained. And that's the best you're going to be able to do.

**Arien Malec – RelayHealth**

But it would be bad practice for an NVE to not include those warrants and other legal terms of use.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, right. I mean, I don't know why you would stand one up without protecting yourself in that ...

**Arien Malec – RelayHealth**

And it would be bad practice to facilitate a transaction where you had—where you did not accommodate for choice to be obtained.

**Christopher Tashjian, MD – River Falls Medical Clinic**

Yeah.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, in circumstances where choice needs to be obtained ... They're trying to draw sort of similar lines that we tried to draw at the policy committee level.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

But the more complicated we make this, the more difficult it is for the front-line provider.

**Larry Garber – Reliant Medical Group**

That's right.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, agreed.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So we've got about ten minutes left and two other domains to handle past 27 here. Does someone want to take a bash at answering 27? And if, Arien, you want to include your answer to 30 or suggest that we should answer 30 as well, I'm happy with that. Where are we landing on that?

**Arien Malec – RelayHealth**

I would suggest that we answer 30 and refer questions 27, 28, and 29 to our question to 30.

**Deven McGraw – Center for Democracy & Technology – Director**

Right.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Okay, so what's your answer to 30?

**Arien Malec – RelayHealth**

Our answer to 30 is that in most cases the NVE's responsibility—or the meaningful choice can be obtained by the provider and the patient and that the NVE's responsibility is to ensure that the appropriate legal framework is in place such that providers use services offered by the NVE only when such choice has been obtained.

**Deven McGraw – Center for Democracy & Technology – Director**

Right. This is the concept of flow down, right?

**M**

Yes.

**Deven McGraw – Center for Democracy & Technology – Director**

They flow down that responsibility, the NVEs flow down that responsibility, to the participating entities, the providers. And certainly they would want to take whatever means necessary to make sure that there's an understanding on the part of the provider that that's their responsibility, whether it's through reps and warranties. But I don't even know that we need to say that.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So then let me answer just for completion sake the main question on 27 is: What are the operational challenges for these different approaches? I would suggest that we answer 27 by saying that asking an NVE to take on forms of authentication or authorization that are different than how we just answered number 30 will create operational challenges, in general, from a policy perspective. But if what the NVE is asked to do is congruent with our answer in 30, it should be something that could be implementable.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**Arien Malec – RelayHealth**

And ... as a general policy question for 27, as I think the tiger team policy committee noted, it really depends, that there are services like directed exchange for treatment purposes that fall cleanly within the provisions of HIPAA. There are query-retrieve services in the confines of an OCA that fall well within the boundaries of HIPAA. There are directed-exchange services that require high levels of consent, for example, a directed exchange supplying information for a clinical trial. There is no overall framework that can determine the appropriate choice or consent that is required to use or utilize a particular service.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Good.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Tari, have we given you enough to draft our comment?

**Tari Owi – Office of the National Coordinator**

You've given me a lot.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

I expect that what I—I'm sorry, I should have said this up front—I'd asked Tari if possible if we could get drafted comments to circulate so that if people have a chance to look at it now between now and Monday's meeting and offer comments, we could do so. If we have a big problem, we can call for those who are interested. Otherwise, I'll take responsibility with Tari and Micky to take any comments via e-mail and get them included in an amended comment.

**Tari Owi – Office of the National Coordinator**

Yeah, I'll be sending the comments out tonight, if anyone has a chance to respond ...

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Fantastic. So should we go to question 31 that relates to exchange only of encrypted IIHI? We'll note that under the condition the RFI says, "To satisfy this condition, we believe an NVE would need to either 1) Exchange already encrypted, 2) Encrypt IIHI before exchanging, or 3) Establish and make available encrypted channels. Feels like that covers almost any model of encryption that you might want to offer as an NVE.

**M**

Yeah.

**Deven McGraw – Center for Democracy & Technology – Director**

Yep.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

And would we say that if those three exist that that seems reasonable and that those three don't seem to indicate that there should be additional exceptions?

**Arien Malec – RelayHealth**

The only exception—and I'm not sure whether you'd be an NVE if you followed this exception—is in transport that is where you have appropriate physical security over the tubes through which you're doing the transport. So for example, I think we encrypt within our data center movement, but all that transport is also within a cage and controlled by biometrics and all the other layers of physical security that are appropriate. That's the only exception that I can think of where I think we do—I think we do self suspenders there, but—

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Got it. So the encryption requirement would not apply where appropriate physical custody and security was assured?

**Arien Malec – RelayHealth**

Correct.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

The other point—and I guess I'd want to make this point explicitly—I believe what's in those three models would allow the case of where an NVE might open a package and provide translation services on a value-added basis. I'll use the Surescripts example again. Surescripts receives data that may be in one NTP format, ..., and translate it into ... for purposes of efficient interoperability, and that requires that the package be opened in order to do that.

**Arien Malec – RelayHealth**

Right. So is the question of data in motion, whether that would be considered data at motion or data at rest. And that's where I was—the appropriate physical safeguards and security must be in place if encryption isn't obtained.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yeah, and, Arien, you can speak better to this than I can, but I'm assuming there's also a lot of functions in the lab world where translating LOINC codes, for example, may be of value.

**Arien Malec – RelayHealth**

Or content representations. There's all kinds of services. And I'd say that in financial ..., for example, this is not unique to healthcare, financial ... do this all the time as well. But the principle is you do that in areas where you've got appropriate additional safeguards to ensure that you're not inadvertently disclosing PHI.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Got it. Again, Tari, do you have enough there to draft from?

**Tari Owi – Office of the National Coordinator**

I believe so.

**Larry Garber – Reliant Medical Group**

Alright. There might be some language that we can borrow from—I forget. I thought that when we're in the definition of EHRs, going back to meaningful use stage 2 in the 2014 edition, wasn't there something about whether the—and I forget what it was—whether security components would apply for base EHR components in a hospital setting for example, for each component in a hospital setting if they were all under the same safeguarded umbrella or something like that.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yeah

**Larry Garber – Reliant Medical Group**

I don't know if it's necessary, but there may be some analogous language we can borrow there if we're struggling with language.

**M**

Yep, great idea.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alright, do we want—?

**M**

Five minutes.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yeah, lightning round. We still need to do public comment. Let me just ask the question of staff and members. Is it acceptable for us to go five minutes over time, or is not based on the rules of public comment?

**MacKenzie Robertson – Office of the National Coordinator**

This is MacKenzie. It's okay if you run five minutes over.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So Workgroup members, can we take five more minutes to deal with 32, 35, 36, which are all in a chunk?

**Arien Malec – RelayHealth**

Works for me.

**M**

Yep.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Alrighty. So those sets of questions relate to conditions S-5 around and NVE must make publicly available a notice of its data practice describing why IIHI is collected, how it is used, and to whom and for what reason it is disclosed. And you can read the commentary on page 43 and 44 of the RFI.

**Larry Garber – Reliant Medical Group**

Didn't we already comment on this one and suggest it's appropriate as long as it's categorical? Or maybe I'm mixing workgroups. I don't think I'm mixing workgroups.

**Deven McGraw – Center for Democracy & Technology – Director**

No, you're not. We did. In a direct answer to another question on this same CTE, we said that a notice, as long as it's in categories would not be burdensome. If it—have to list every single activity, that's going to be burdensome is what we said. So that, arguable, is a form of summarization.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yeah, that was question 34. This is interesting. Yeah, we already answered question 34.

**Arien Malec – RelayHealth**

Did we answer question 33 as well in our answer to question 34?

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah.

**Arien Malec – RelayHealth**

And I think our answer to question 34 also included the notion that the categories should be well defined, which I think also answers question 32, although they're asking for other specific categories that should be explicitly highlighted or flagged. And I can answer some, I guess, but I'm not sure I can answer the universe right now.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, what would you put on your list in terms of—

**Arien Malec – RelayHealth**

So research purposes, disclosure to organizations who are not using the data for treatment or operations purposes or not using the data to provide healthcare services to individuals—kind of a broad category. I'm trying to figure out how to frame the IMS issue, although everyone should recognize that NVEs have no relationship to how IMS gets its data.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, I mean, that's—

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Say that multiple times. That's important actually.

**Deven McGraw – Center for Democracy & Technology – Director**

That's sort of taken care of though with transparency about whether you disclose the identified data.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Yeah, and if we're going to allow—and in our commentary before it said that we wanted to allow NVEs to work with the identified and aggregated data for a variety of treatment and innovation reasons. If we want that to be the case, I think we would want to have a relatively high standard around disclosure that the NVE is doing it.

**Deven McGraw – Center for Democracy & Technology – Director**

I would support that, Cris.

**Arien Malec – RelayHealth**

I guess what I'm pointing out is there's a very different level of disclosure for using de-identified data for what would generally be under the operations purpose, so for example, benchmarking, profiling, providing clinical decision support. There's a whole set of activities that I think would normally fall under the operations umbrella. And there's a set of activities for de-identified data that aren't being used to provide healthcare services or improve healthcare operations.

And so, for example, I don't think you could claim that helping pharma reps profile provider prescribing practices falls under the category of healthcare operations. So I'm just suggesting there may be an explicit categorization of de-identified data for healthcare operations versus—

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Sure. So it seems like we may want to have something along the lines of—not of safe harbor, but a category related to things that are otherwise managed under things like HIPAA CLIA, and state privacy laws, meaning that an NVE, for example, could say that we do certain activities that are regulated by those laws and statutes.

**Arien Malec – RelayHealth**

So I'm interested in both sides of this issue. Number one is I'm interested in providing patient's clear guidance as to how we're using de-identified data, so that they have a better understanding of what they're getting into and that we're not mixing what I would consider to be positive or wholesome uses of de-identified data and uses of de-identified data that I would argue would require additional levels of consent or choice.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Agreed.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah, that's an interesting way of looking at it, Arien. I hadn't thought about it that way.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So do you want to summarize that, Arien?

**Arien Malec – RelayHealth**

So my summarization is that a categorization should make explicit the difference between use of de-identified data for improving health or healthcare, such as would normally fall under the operations portion of TPO, and that should be described categorically different from use of de-identified data for purposes that are not healthcare specific or associated with improvement of care.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, not regulated by HIPAA, basically.

**Arien Malec – RelayHealth**

Not regulated by HIPAA as well, yeah. That's right.

**Deven McGraw – Center for Democracy & Technology – Director**

Yeah. Because I think you can throw a lot of activity under the bucket of improving care.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Right. Research.

**Arien Malec – RelayHealth**

That's right. Yeah, so it's now regulated by HIPAA, and two categories might include research—two categories that would fall under that might include research and might include use of healthcare data for marketing, selling, profiling, etc.

**David Holtzman – U.S. Department of Health and Human Services, Office for Civil Rights – Health Information Privacy Specialist**

Hi, and I'm sorry to interrupt. This is David Holtzman. How are you? I'm wanting to ask if it's de-identified, it's outside of the HIPAA privacy and security rules, so I was curious as to why the distinction of whether or not it qualified for TPO as necessary.

**Arien Malec – RelayHealth**

This is relating to an NVE, and, Deven, please just correct me if I get this wrong, but my understanding is that the provision for de-identified data applies to the covered entity and that any data use for de-identified data must be explicitly provided to the business associate. And these notices would normally be provided by a business associate, not a covered entity. That's the distinction in my mind at least.

**Deven McGraw – Center for Democracy & Technology – Director**

Well, you know, David, so I don't—Arien, I don't know if you know David, so David's with the Office for Civil Rights, so he's even much more of a HIPAA expert than I am. I think what we're trying to do here, David, is create some greater transparency around the uses of de-identified data and making an even finer distinction between uses of de-identified data that while not necessarily regulated by HIPAA, since HIPAA only regulates PHI, falls into the categories of activities that do typically fall within HIPAA's constructs. You can use de-identified data to use operations. You could use de-identified data to do certain types of public health activities, although clearly not—some, but not others.

But then there are sort of classes of activities of de-identified data that are—maybe don't fall within a HIPAA constraint. Although even as it's coming out of my mouth, David, I'm realizing that it's a little bit tougher to describe because if it were PHI being used for commercial purposes, in fact, it is regulated by HIPAA and would require specific authorization from the patient. I mean, all activities with PHI are essentially regulated by HIPAA. Once it gets to the de-identified data stage, none of it gets regulated by HIPAA.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So I'm hearing Arien really propose three classes of data here, one of which is all of that is managed and controlled by HIPAA. Another of which is what was referred to as wholesome use of activity to improve healthcare that might not be regulated by HIPAA. And then a third category which is presumably all de-identified and aggregated data that would be used for what we would recognize as commercial purposes like targeting commercial activities and the like.

**Arien Malec – RelayHealth**

I think we're well out of time. I don't think that captures the distinction that I'm trying to create. Everything I'm trying to create really relates to the use of de-identified data and to better notice on the various uses of de-identified data and categorization of uses of de-identified data. But I'm not sure that we're going to get closure in the time we have allotted.

**MacKenzie Robertson – Office of the National Coordinator**

Hi, this is MacKenzie. Sorry to chime in. We are going to have to end the call and go to public comment because we have another call at 4:00, and we need the half hour in between.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Absolutely. So I guess let's take what comments we can get on this, Tarry, if you could indicate where you think we've got open questions and exchange it, let's see what we can do via e-mail over the next 72 hours. And if we can't answer a question, we won't answer a question. Should we go to public comment, MacKenzie?

**MacKenzie Robertson – Office of the National Coordinator**

Sure. Operator, could you please open the line for public comment?

## **Public Comment**

**Operator**

If you are on the phone and would like to make a public comment, please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. There are no comments at this time.

**Deven McGraw – Center for Democracy & Technology – Director**

Alright. We'll pay attention to our e-mails.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

So I thought it'd be useful—we're not going to be a best workgroup ever if we don't answer the questions I'm afraid. So hopefully we'll do our best to conclude this via e-mail, and we'll look, Tarry, for your notes.

**Deven McGraw – Center for Democracy & Technology – Director**

Thank you all.

**Arien Malec – RelayHealth**

Thank you.

**Cris Ross – Surescripts – Executive Vice President & General Manager, Clinical Interoperability**

Thanks to everyone. Nice work today.