# Trusted Exchange Framework and Common Agreement Task Force

Transcript
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Virtual Meeting

## SPEAKERS

| Name | Organization | Role |
|---|---|---|
| **Arien Malec** | **Change Healthcare** | **Co-Chair** |
| **John Kansky** | **Indiana Health Information Exchange** | **Co-Chair** |
| Noam Arzt | HLN Consulting, LLC | Public Member |
| Laura Conn | Centers for Disease Control and Prevention (CDC) | Member |
| Cynthia A. Fisher | WaterRev, LLC | Member |
| Anil K. Jain | IBM Watson Health | Member |
| David McCallie, Jr. | Individual | Public Member |
| Aaron Miri | The University of Texas at Austin, Dell Medical School and UT Health Austin | Member |
| Carolyn Petersen | Individual | Member |
| Steve L. Ready | Norton Healthcare | Member |
| Mark Roche | Centers for Medicare and Medicaid Services (CMS) | Member |
| Mark Savage | UCSF Center for Digital Health Innovation | Public Member |
| Sasha TerMaat | Epic | Member |
| Grace Terrell | Envision Genomics | Public Member |
| Andrew Truscott | Accenture | Member |
| Sheryl Turney | Anthem Blue Cross Blue Shield | Member |
| Denise Webb | Individual | Member |
| Lauren Richie | Office of the National Coordinator | Designated Federal Officer |
| Cassandra Hadley | Office of the National Coordinator | HITAC Back Up/Support |
| Zoe Barber | Office of the National Coordinator | Staff Lead |
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| Alex Kontur | Office of the National Coordinator | SME |
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| Michael Berry | Office of the National Coordinator | SME |
| Debbie Bucci | Office of the National Coordinator | SME |
| Kathryn Marchesini | Office of the National Coordinator | Chief Privacy Officer |

**Operator**

Thank you. All lines are now bridged.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**

Good afternoon, everyone and welcome to the TEFCA task force meeting. Today, they will be continuing on with their discussion on the recommendations. So, let's get started and I'll go through the role of who we have here. John Kansky and Arien Malec, your co-chairs, are here as well as Carolyn Petersen, Denise Webb, David McCallie, Mark Savage, Noam Arzt, Grace Terrell, and Laura Conn. And other members will be joining as we go along. So, I'll toss it over to John. Thank you.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Thank you. So, you received materials for the call this morning. Apologies for the short notice but changes were being made over the weekend. And we got them out as soon as we could when they were ready. Picking up where we left off, the object of the game today is absolutely positively to get through the bottom of the letter. It's through Recommendation 24. And we left off during – we kind of finished up meaningful choice but we want to pick up there to make sure that everyone is comfortable with the changes that we made and see if there is any new input there. Okay. So, with that, if we can direct your attention to Recommendation 11 and the words before it. If we could scroll up the screen just a smidge just to get the whole picture. Thank you.

So, I appreciate Mark Savage coming forward on the last call and being willing to offer some text to try and capture the sentiment of the group. And I'm going to ask him to walk us through the edits that he's proposed.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Sure. And my browser, for some reason, is still having trouble working with Adobe Connect. So, I understand that they cut and pasted what I sent so I'll work off of the email that I sent and assume that that's roughly what it is but it may not line up perfectly with what you see on the screen. So, I volunteered to try to identify which bullets about meaningful choice were new and necessary and which were already included in TEFCA Version 2 and thus were unnecessary. In the course of doing that, I found some other things that looked a little ambiguous to me and thinking about it seemed like it was good to add clarification. So, for example, we keep talking about meaningful choice. And we know that it's meaningful choice not to have your data exchanged.

But from the conversations on the call, when I actually looked at the language, it was ambiguous to me where in the language it specified that that's what it was, a choice to opt in, a choice to opt out. I didn't think the actual language was clear. Also, the second point is thinking about opting out of exchange. It's just TEFCA exchange. It's not all of the other exchanges that might be happening under HIPAA for treatment, payment, and operations. Given that we are concerned to preserve trust and that the individuals understand exactly what they were doing, clarity about that you're just opting out of TEFCA exchange was something that occurred to me to try to put in. And the third implication of this is that when

we talk about meaningful choice of what that effects revocation of what. And I did look at the bullets.

Let me see to actually see if my screen is still not connecting. Sorry. So, I did look at the bullets as requested. I found that two of the bullets I thought were – actually, it says the first, second, and sixth bullets were already implicated in the definition of meaningful choice. But as I thought about it, it seemed better to have a complete list so that people know what we think an inclusive list should be but to call out that we, the task force, think that some of those are already included. And that's the reason for the parenthetical. It says that the current definition already captures them. The place in the language that I proposed to be clearer about meaningful choice is in the body of Recommendation 11, the second sentence where it starts the task force recommends clearer definition of meaningful choice and its scope. John, is that a good enough introduction?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yes, thank you. And we'll know if we get any questions or comments. It made sense to me. And it's pointing out the clarification on the bullets was good leaving them all in but explaining to the ONC that we do understand that most of this stuff is incorporate but wanted the whole list there because it does come from a cited source. But also, just a Kansky opinion comment that while I think it makes perfect sense in the context of TEFCA that an individual's meaningful choice would be applied to their TEFCA transactions, I don't know how we're going to bring the average human into an understanding of what that means in practice. We have a couple of hands up. So, I don't know who was first. I've got Arien and Noam.

**Arien Malec - Change Healthcare - Co-Chair**

Noam was first.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Thank you. It doesn't really matter. I would say that these changes as I see them certainly continue to make this clearer. I actually never thought that it was terribly unclear. So, to me, of course, this only applies to TEFCA. If you feel a need to state it, no problem. But that's sort of true of all of this, right. My only nit is the addition to the last bullet. Does one really revoke meaningful choice or is the revocation their meaningful choice just from a language standpoint? I'm not sure you're revoking meaningful choice. The revocation is your choice.

**Arien Malec - Change Healthcare - Co-Chair**

You're making a choice.

**Noam Arzt - HLN Consulting, LLC - Public Member**

You're making a choice and the choice is revocation.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

But I think the point there is that once you've decided to opt out, you can decide again to opt back in. So, revoke their meaningful choice and resume use and disclosure.

**[Crosstalk]**

**Arien Malec - Change Healthcare - Co-Chair**

I completely agree. We should not conflate the choice and the outcome of the choice. So, the choice is whether it's participated or not and then, the express choice in one case is an offer to participate and then, that express choice can be revoked to a different choice calling the meaningful choice. The switch really goes against the notion of meaningful choice.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. I think we're all agreeing with each other. Can anyone offer an on the fly edit that fixes that?

**Arien Malec - Change Healthcare - Co-Chair**

Revoke the decision to participate.

**David McCallie, Jr. - Individual - Public Member**

Or change their decision regarding participation.

**Arien Malec - Change Healthcare - Co-Chair**

That's right.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

I think, Arien, you mean revoke their decision not to participate.

**Arien Malec - Change Healthcare - Co-Chair**

Yes, thank you. And I think David's amendment is much better because you can change your decision not to participate and change it to participate. And you can change your decision to participate to a decision not to participate.

**David McCallie, Jr. - Individual - Public Member**

Yeah. I think the word revoke is misleading. So, you have the right to change it. You changed your mind.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. And David and Arien both have their hands raised and are talking. So, I guess it's not broken. Do you guys have more?

**Arien Malec - Change Healthcare - Co-Chair**

I do. And I'm sure David does as well. Mine is really minor. But I do think this discussion should make it clear that what we're talking about is a floor level of options to choose from that a QHIN and their participants must provide. But a QHIN and their participants could offer more nuance and we might imagine that individuals would want to make the decision about

flavors of participation. So, we should not interpret this as being constraining on additional nuance of decision making.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

This may be an ONC question or I may be the only one who doesn't know the answer but is TEF 2 as drafted, does it already give the RCE the authority to tweak those requirements treating this as the floor but raising it?

**Arien Malec - Change Healthcare - Co-Chair**

These are MRTCs. So, I think the answer is no because they're mandatory.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Got it. Any contrary opinion from the ONC? Hearing none, okay. David, you have your hand raised still.

**David McCallie, Jr. - Individual - Public Member**

Yeah. Just a comment that this is, even though it is maybe more limited than some of us privacy advocates would like, it's still quite powerful to the degree that TEFCA becomes the means whereby your health record information is shared broadly with other providers. This is still quite a powerful decision you have to make. It doesn't cover everything but it's still very powerful. And I think we should just remember that.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, I'm hearing general support after these tweaks for Recommendation 11 and no great controversy. So, can we go on? There was one additional edit to 12A given that these are alternatives, which we know we have some degree of split on. But this was Mark's attempt, I believe, at clarifying what these 12A opinion holders that there's an acknowledgment that this doesn't necessarily mean that one must delete the individual's EHI from one's records. I think that does help to acknowledge some of the complexity. Kansky opinion, I'm not sure that addresses completely the challenges of those who were concerned about how you implement 12A. David, you have your hand up.

**David McCallie, Jr. - Individual - Public Member**

Well, just clarifying the language here. It's treating exercise of meaningful choice as if that is equivalent to opting out of sharing. And we just have to be consistent about exercising choice as to whether to share or not. And if you choose not to share, 12A would be – it should apply to previously disclosed EHI. I'm just trying to line up the consistent – let's not conflate the notion of choice with being opt out. Choice is choice. It could be either direction as per previous conversations.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right. Thank you.

**David McCallie, Jr. - Individual - Public Member**

We're wordsmithing. That's all.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. So, I don't think our intent, correct me if I'm wrong, Arien or Zoe is to vote on or resolve the alternative recommendations today. We have Arien and Denise with hands raised.

**Arien Malec - Change Healthcare - Co-Chair**

Again, Denise was first.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Thank you.

**Denise Webb - Individual - Member**

Okay, thanks. So, I'm just trying to sort out in my head on 12A. If we say that the use and disclosure of an individual's information that was previously disclosed will no longer be disclosed and then, we say that it seems you don't have to delete it from their records, I'm trying to envision. If I've allowed my information to be shared and then, a provider incorporates it in my record that that provider retains, are we saying that once that provider has incorporated my record while they don't have to delete it, they do have to not share that piece of information? Or is it the whole record?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Omit it from – I believe the intent was you don't have to delete it but you would be expected to omit it from future TEFCA transactions.

**Denise Webb - Individual - Member**

All right. Wow, that seems complex. If I was a provider, I would just not share any of the records because trying to keep track of what pieces I said I don't want shared –

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Then, you'd be information blocking but that was an editorial comment.

**Denise Webb - Individual - Member**

True, I would be. You're right. Okay. It almost seems like there is some contradiction there. You don't have to delete it but you do still have to protect that piece of information from being further disclosed or used. But isn't the provider actually still using it every time they open the person's record?

**Arien Malec - Change Healthcare - Co-Chair**

Yeah. Hold on. I think Mark is trying to get in because I think he was the originator of this concept. And I raised my hand because I had the same issue as you did. And I'd love for Mark to clarify what is intended so that we can understand it.

**Denise Webb - Individual - Member**

All right. Thanks, Arien.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

So, I added the since and I'm sorry, I forgot that I had added that. So, I should have said something initially. Just because I think it captured what we'd already been discussing and what is the expectation. To your point, Denise, I think this is the same as what providers have to do with especially sensitive health information that's protected by particular state privacy laws. They have to keep track of it separately. Depending on state law, they have to get the patient's prior consent before sharing with another provider. Those mechanisms, the general structure and expectation are already out there. I don't know if it's easy or not but it is out there.

**Denise Webb - Individual - Member**

Yeah. What about use though? I can see that but isn't that provider still using that information because they regained it in the record?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Again, we're talking about TEFCA use.

**Denise Webb - Individual - Member**

Okay. I guess. I guess I wasn't clear.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. Not to make it sound like that's an easy thing, I'm just trying to apply consistently. We have Noam and David and Arien.

**Arien Malec - Change Healthcare - Co-Chair**

I withdraw my hand raising because I had exactly the same question that Denise did.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Yeah. I still have the same question Denise did. I don't think it helps to say if TEFCA use because TEFCA use is how I the provider got that information in the first place. Let's say I got it from somebody else in a permitted TEFCA transaction. That's TEFCA use. Now, the patient makes a meaningful choice and I who received it in a TEFCA transaction am told I'm not supposed to use or redisclose it in another TEFCA transaction. So, that doesn't take away the first TEFCA transaction, does it? I'm stuck on the use just like she is if it's in my records.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I'm going to pile on a bit in that remembering that meaningful choice is all or nothing, my quandary is if an individual exercises meaningful choice and I'm not to use or disclose in TEFCA transactions, their information that was brought to me through a TEFCA transaction but not the information that I natively know about them or got through other means. And if I say this is just too complicated so I'm just going to not include any of their data in future

TEFCA transactions, including the stuff I generated natively, now do I have an information blocking problem or is it just hopelessly complicated?

**Noam Arzt - HLN Consulting, LLC - Public Member**

Yeah. It becomes a provenance problem, right, that I've got to figure out the source of every piece of data and the type of transaction that brought it to me let alone if the same or essentially the same data from multiple sources. How do I sort through that quagmire to know then what I can do with it?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right. It sounds like we're a couple of 12'ers. David?

**David McCallie, Jr. - Individual - Public Member**

Yeah. I'm going to pile on and say it's just almost infeasible to imagine how you could implement this at least in the context of EHR data. There may be databases where outside reference data is kept segregated or provenance is totally clear. But I can't imagine that there are very many circumstances like that. And what happens in an EHR with something like TEFCA at least as it's implemented in the real world today with Common Well or Care Quality is a provider and in some cases automation will synthesize the sense of the external record and look at what evidence shows up from multiple different sources, make a decision based on that for what they want to include in their own record.

And that may involve actually transforming the data or picking an outside point of reference that doesn't agree with everything. So, one provider may call it a tension headache. One provider may call it a migraine. One provider makes no comment. The receiving physician may make a synthesis of that and decide what they want to incorporate in their record. That's workflow that all of the EHR vendors support to some degree. So, the data doesn't just land and stay in a little, tiny place where you could put a lock over it. It gets merged in incredibly intricate ways. And so, there is no way to implement this kind of a recommendation. You can put it as a minority but anyway.

**Arien Malec - Change Healthcare - Co-Chair**

Just to pile on the 8B'er side, when I was in the hospital, I was routinely and appropriately asked to confirm allergies and confirm key med list items. And each one of those, theoretically, was a new data entry that I was providing or proffering. But no EHR that I know of gives the ability, nor is it appropriate workflow, to have all of those duplicate entries have separate provenance. And if you originally got the data through TEFCA and then, reconfirmed it with the patient, we'd just be in this operationally difficult area of needing to keep track of every reconfirmation and the context of every reconfirmation of data. That just piles on for 8B or 12B.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, anticipating that we may be voting on this in the future and we only have a couple more calls, is anyone also wanting to advocate for 12A besides Mark or is he on a bit of an island?

**Carolyn Petersen - Individual - Member**

This is Carolyn. I'm good with 12A.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. So, we may be voting on this and having a majority/minority view on this later. Is it okay to move on for now? Seeing no hands, I'll take that as a yes. Now, Recommendation 12.5 is a Kansky invention to try and address something that came up in a previous call. It's only 12.5 because I didn't have anything between 12 and 13 if any of you who remember **[inaudible] [00:23:22]**. I was out of line numbers. Thank you for somebody chuckling on that one.

**David McCallie, Jr. - Individual - Public Member**

I remember **[inaudible] [00:23:31]**. I'm that old.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. So, the point here – let me not speculate. So, the point here is that once an individual has exercised their meaningful choice as a draft in the second draft of TEFCA. It specifically constrains the future use and disclosure to exchange purposes only. Whereas prior to the individual exercising meaningful choice, the use and disclosure of their information were constrained by 2.2.2, which is subtly broader than just exchange purposes. So, for purposes of clarity, my proposed recommendation here suggests that the use and disclosure of the data should be governed by 2.2.2 before and after meaningful choice. Is anybody willing to say – we had a hand. Noam.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Yeah. I've got to think about that issue and read what 2.2.2 says. But just for clarity, do you mean once an individual exercises their meaningful choice to restrict their data, right, because that meaningful choice could go either way? Or are you not saying that?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right. I think this is a reasonably obvious point but I explained it horribly. So, let's say there is an individual whose information is active in the TEFCA ecosystem and they have not exercised meaningful choice. The use and disclosure of that data are governed by 2.2.2. It says exchange purposes and has a couple more bullets about things that define the use and disclosure of that data. Then, the individual comes along and says I would like to exercise my meaningful choice to not have my data, my future, prospective data used or disclosed in the TEFCA ecosystem. So, great. So, they exercised the meaningful choice. And their prospective data is not used to disclose. But what is the way that you can use and disclose the data that you already have?

The answer, I think, is that it should be just as it was before. The exercise of meaningful choice, Recommendation 12 notwithstanding, that the exercise of meaningful choice shouldn't change the rules that govern the use and disclosure of the information from prior to the exercise of meaningful choice. Did I get it right that time?

**Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead**

John, maybe if I could jump in to try to help clarify a little bit and point everybody to the language on the screen. And I think what you're saying, and correct me if I'm wrong, is basically it's changing these two words. So, in this sentence in 2.2.3, it says that an individual's EHI that has been used or disclosed prior to the individual exercising meaningful choice may continue to be used or disclosed for an exchange purpose. And you're suggesting to change that last part for an exchange purpose to any purpose under the framework agreement, which is slightly broader and includes that permitted and future use of data as opposed to just the narrower use and disclosure of the exchange purpose.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Correct. It's just resolving, I think, an unintended inconsistency. Zoe used a lot fewer words than I did, which means she's right.

**David McCallie, Jr. - Individual - Public Member**

Could I ask what the word exchange purpose means? If you have exercised your choice to no longer have your data exchanged through TEFCA, what is an exchange purpose that you're still – I'm confused now.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. Exchange purpose is capitalized because it's the – there you go. Thank you.

**David McCallie, Jr. - Individual - Public Member**

So, I would say that's not exchange. Well, it's not TEFCA exchange. So, you can opt out of TEFCA exchange but you're still allowing for this kind of exchange. I think we were all saying that's 12B, basically.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I don't know if it's helping but can we show 2.2.2 to show what I'm trying to say here?

**David McCallie, Jr. - Individual - Public Member**

He had it there a second ago.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. So, 2.2.2 is the thing that says – see the first bullet says one or more of the exchange purposes. So, what Zoe said is the as written, it's constraining the future use to just Roman numeral little I. I guess it's not really Roman, is it? And what I'm suggesting is that before they exercise meaningful choice, it was all of those parentheticals. So, let's just to be not confusing leave the use of that information the same before and after the exercise of meaningful choice. If you can still use it, disclose it because it was information that was exchanged before the individual's exercise of meaningful choice. That exercise of meaningful choice shouldn't change the use and disclosure rights or uses that are permitted. It's just confusing and unnecessarily complicating.

**Arien Malec - Change Healthcare - Co-Chair**

Just as a point of terminology, we keep falling back into the habit of using meaningful choice as a shorthand for opting out. And we should be very clear that meaningful choice is the choice to participate or not participate that's appropriately offered to the individual. And one of those choices is to not participate.

**David McCallie, Jr. - Individual - Public Member**

And that decision applies, essentially, only to participation of your data being exchanged via TEF mechanisms. Otherwise, it doesn't change anything. That's, John, I think what you're suggesting clarification here.

**Denise Webb - Individual - Member**

And that's what Page 36 says. It's a definition.

**Noam Arzt - HLN Consulting, LLC - Public Member**

It doesn't necessarily not change anything. It depends on how your HIN racks this policy.

**David McCallie, Jr. - Individual - Public Member**

You're always permitted to go further.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, this Recommendation 12 plus 1 as it's now displayed on the screen is not an opinion or philosophy thing. It's a one way or the other thing. And I'm trying to find out if the opinion of the group is generally agreeing. I wish I had a diagram for this. If you can use the information as defined by 2.2.2, it's like Zoe said. It's currently there are words in there that say exchange purposes that unintentionally, I believe, constrained the use of data. And I'm not saying this well.

**Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead**

Let me give you an example. An example might help, John. I think we've talked a lot about how 2.2.2 allows per applicable law. So, if you get the consent of the individual then, you can reuse and disclose data for other purposes outside of the exchange purposes like research, for example. So, it's sort of the difference between the narrow use and disclosure of just the exchange purposes and just sending back and forth versus the permitted future use maybe doing some kind of quality assessment and improvement or something with the data that you've received.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right. So, if for this particular patient you've got data from them before they exercise their meaningful choice rights and you were entitled to use that information for research before when they exercise meaningful choice prospectively that shouldn't remove your right to use the earlier data for research.

**Arien Malec - Change Healthcare - Co-Chair**

That's, essentially, 12B, right, functionally?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

No, it's different. No. Oh, thank you and very important No. So, 12B is just agreeing with, largely, as drafted that says if you've got some data before and then, the individual says please don't use my data in the future, you can continue to use my data before. That's what TEF 2 as drafted we think says. But when you read it specifically, it actually says if an individual exercises their meaningful choice then, you can continue to use and disclose the data you got before only for exchange purposes, which is narrower than what you could use it for before.

**Arien Malec - Change Healthcare - Co-Chair**

Oh, great point. So, it should say all permitted purposes.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Correct. Thank you. We got there. Cynthia has her hand raised.

**Cynthia Fisher - WaterRev, LLC - Member**

Hi, yes, thank you. Can you please clarify in this language how a patient can make a choice to basically wipe their slate clean of any use for research? So, on the other hand, is that a patient is informed and the patient is fully informed as to how their data is going to be used and they have a choice to just say strike it clean, I don't want anybody to have it?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I believe that's 12A versus 12B if I understood your point. So, 12A meaning a potential recommendation that an individual be able to say I've decided I don't want you to use any of my information for TEFCA anything going forward, even if I gave it to you before versus 12B, which is closer to as drafted that says for practical reasons, we think it's okay to have the data be used prospectively as drafted. David has his hand up.

**Cynthia Fisher - WaterRev, LLC - Member**

I think the question I would also have is for patient, is there a confirmation of that of either any of those choices that sort of restates and makes it very clear to them what is being used, what choice they made, and a confirmation that, yes, I don't want any of my records or data shared and a confirmation that that has been confirmed and received? And also, will they have a trail to say this is where it is being used. Is there any audit trail or communication to the patients that hey, this is where it's used? This is someplace like block chain would be ideal. But if a patient can then, basically, have the keys to their own kingdom of their own data to turn off or turn on.

And so, even if a patient then becomes say dissatisfied with the research or the research at all or wants to drop out or there has been a mis diagnosis or mistreatment and is in masse, do they get to turn it off and extract their data? That's a question that as a patient's right to control their own data.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Well, I believe some but not all of the questions you raised are addressed in Recommendation 11 but to say that Recommendation 11 fully addresses what you said would not be accurate. We're going to get to issues around summary of disclosures in a couple of recommendations at 5.2. But I also think you're shining some light on the challenges of the fact that this is only TEFCA exchange purposes and other uses that are being governed here. So, I think you're describing something broader that may or may not be addressed in TEFCA period. David, you have your hand raised.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. I just want to be really sensitive to the patient. This is their information and having – we know how it's going to be used. We know the race of artificial intelligence. We know the race of big data. And in that race in this time of a concern of privacy being front and center or choice being front and center for the patient and the patient getting access to all of this is, not only should they have access but how do we through TEFCA and even through our awareness on HITAC, are we really addressing what is in the patient's best interest here for the control and use of the health information?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I understand.

**David McCallie, Jr. - Individual - Public Member**

John, it's David. I think that however worthy those goals are, TEFCA is much too tiny a stick to try to achieve them. You're really talking about the right to be forgotten. And sweeping changes that would have to occur at the national level and touch HIPAA and many other laws to be implemented. TEFCA is just about exchange via a very prescribed network and a very set of contextualized uses. And TEFCA can control what happens going through the TEFCA pipes but it doesn't have the power to control very much else. So, I think we want to make the best use of the control over those pipes and accountability for what happened to the data as it flowed through the pipes. But beyond that, TEFCA just doesn't have the power to effect it. It's a voluntary framework that doesn't address those things. It doesn't change anything in HIPAA or any of the other myriad interlocking privacy laws.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Correct.

**Cynthia Fisher - WaterRev, LLC - Member**

Yeah. I respect that. I guess if we look at everything has its own rabbit hole that we go down. So, TEFCA is one. They re cross pollinated as it deals with the patient data. So, as we're working on this project here, I would just ask each of you how would you suggest in these recommendations that we empower the patient to the best of our abilities in this pipe of exchange so to speak, in this lane?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

If I take the average of the point that David made and the point I think you're making, Cynthia, I think our answer to that is Recommendation 11. Go ahead.

**David McCallie, Jr. - Individual - Public Member**

This is David. I just want to go back to the comment I made at the very beginning. It is, in fact, a very powerful option to disallow the network based sharing of your data with other providers. Whether that's good for your healthcare or not, it's a point we can argue about. But even the limited scope of TEFCA, it's still a very powerful choice you could make. And so, to that sense, I think it's very consistent with what Cynthia is calling for just constrained by the limits of what TEFCA is able to address. You can choose not to have your – yeah.

**[Crosstalk]**

**John Kansky - Indiana Health Information Exchange - Co-Chair**

After all of the TEFCA task forces, we have our charge that limits us.

**Cynthia Fisher - WaterRev, LLC - Member**

Can you be selective with that?

**David McCallie, Jr. - Individual - Public Member**

At the moment, TEFCA is set up to be all or none. I think it's totally possible technically to evolve capabilities to be more selective. So, you could say it's okay to share with these providers but not those providers. Or maybe even some day, it's okay to share this kind of data but not that kind of data, although that's a deep rabbit hole.

**[Crosstalk]**

**David McCallie, Jr. - Individual - Public Member**

The way it's written now, it's all or none.

**Cynthia Fisher - WaterRev, LLC - Member**

You could imagine if there's a mental health or a physician note that the patient disagrees with and hasn't been able to have corrected or changed or if it was erroneous. Say that –

**John Kansky - Indiana Health Information Exchange - Co-Chair**

That gets to our specific recommendations on IAS, which I can give you a number if –

**David McCallie, Jr. - Individual - Public Member**

But it's broader than IAS. And it's certainly feasible for the future but it's not technically feasible today.

**Cynthia Fisher - WaterRev, LLC - Member**

Why is it not – is there a way that a patient could pull that it's not everything and all or

nothing? Because you could imagine cases and specifics where the patient would want to control what was shared broadly and have privacy protected for something that was an anomaly or an error or something they want to choose to keep very private.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

This is already happening with especially sensitive information under state laws.

**David McCallie, Jr. - Individual - Public Member**

Well, in general, the way you do it is you choose not to have it paid for with the HIPAA transaction. You pay cash on the barrel and keep it out of the data. That's the only guaranteed legal way to do it, I believe.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, in the interest of trying to get our work done – was that just Mark that spoke up? Because you had your hand raised.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Mark Savage, yes. So, put it down.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Thank you. So, in the interest of getting our work done, is there a specific new recommendation that we're proposing? I feel like nuggets of what we're discussing are covered in recommendations that we have drafted, some of which we're about to discuss.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Well, did we ever address or do we want to address the sort of all or nothing nature of meaningful choice? Maybe we did and I just don't remember in the swirl of all of this.

**Arien Malec - Change Healthcare - Co-Chair**

That was the intent of my comment and recommendation that we should ask ONC to clarify that although the TEFCA and the MRTCs are providing an all or nothing choice that that is a floor and should not be presumed to interfere with the ability of organizations that want to offer a finer grain set of choices. But they have to offer at least the ability to give the two flips of the switch.

**Noam Arzt - HLN Consulting, LLC - Public Member**

And did you write that somewhere here?

**Arien Malec - Change Healthcare - Co-Chair**

Hopefully, we captured that comment. And if not, since I have editing rights, in my next editing pass, I'll make sure it gets in there.

**Noam Arzt - HLN Consulting, LLC - Public Member**

No, I just want to make sure I didn't miss it.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I remember reading it. Is it around 8, Arien? I shouldn't put you on the spot because I do remember reading that.

**Cynthia Fisher - WaterRev, LLC - Member**

I'm sorry, could you repeat that? I couldn't hear. I'm sorry, was that Mark?

**Arien Malec - Change Healthcare - Co-Chair**

There is the comment right here on Recommendation 11.

**Noam Arzt - HLN Consulting, LLC - Public Member**

But there are some comments noted around 8. You're right 8A, 8B. But I'm not sure what got resolved.

**Arien Malec - Change Healthcare - Co-Chair**

Well, I think the intent is in our next editing draft, we will ensure that the language reflects that recommendation.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Okay. Because I'm not sure that what you just said that, essentially, all or nothing is a floor, not a ceiling is actually ONC's intent at all. And I'm not quite sure I know what that means. I see all as a ceiling, not a floor. It's all or it's not all.

**[Crosstalk]**

**Cynthia Fisher - WaterRev, LLC - Member**

Well said.

**David McCallie, Jr. - Individual - Public Member**

No, but all or nothing means it's coarse grain control. And that's the floor because that's the easy thing to do. Spicket on, spicket off. Fine grain control is much harder. That's the ceiling.

**Noam Arzt - HLN Consulting, LLC - Public Member**

But a patient has to know what to expect. You can't tell patients well, it's either going to be granular or it's going to be coarse.

**David McCallie, Jr. - Individual - Public Member**

No. I think what we're saying is you start with granular. You may choose to not have your data shared. You may choose to remove the system's ability to share your data across the TEFCA network. Do you want to share your data or not share your data? Check yes, check no. That's –

**Noam Arzt - HLN Consulting, LLC - Public Member**

You mean start with coarse.

**David McCallie, Jr. - Individual - Public Member**

Yeah. It starts with coarse.

**Cynthia Fisher - WaterRev, LLC - Member**

But in reality, isn't the real problem going to be yes, I want to send my data so we live in a transient world so I can get my healthcare in Florida and I can get my healthcare in New York or whatever and have them have my information. But I want to be able to be selective because I'm very private about some – a patient may feel an incident, a situation they want to keep very private. And it's unnecessary to be shared and be utilized for research and everything else. So, it's like you either get it and you get the whole kitchen sink. And where does the patient have the ability to have a voice and control? And I guess we can do it in the app world in many other ways.

And is it the clunkiness of the systems that we are using today? And should we not be working on tomorrow in these rule makings? I guess that's my concern because, in everything else we do, we can be selective and granular. And are we doing a disservice by not moving in that direction forward? That's just my question in light of the reality of a patient's world.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, what I'm hearing is we need to take the concept of granularity and find an appropriate place for it and make sure that we have consensus around whatever our recommendation is. And we will try to do that. I just saw this change and I was trying to get back to it.

**Arien Malec - Change Healthcare - Co-Chair**

I'd recommend at this point because I think we captured a ton of really good feedback, I recommend at this point, we try to power through and get to the end so that we can take another pass because I'm a little worried about our ability to get to the next HITAC meeting.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yes. We do –

**Cynthia Fisher - WaterRev, LLC - Member**

Arien, can we at least put a place holder for this dialogue?

**Arien Malec - Change Healthcare - Co-Chair**

Yes. That's the recommendation.

**[Crosstalk]**

**Cynthia Fisher - WaterRev, LLC - Member**

I want to get this done but I do think it needs to be written down as a place holder because otherwise, we will have to remember it, which it would be helpful to have a place holder that we work on this to represent a patient's need and future.

**John Kansky - Indiana Health Information Exchange - Co-Chair**
It's captured in a comment.

**[Crosstalk]**

**Noam Arzt - HLN Consulting, LLC - Public Member**
I would just make one additional tiny point just to get it into the notes. We also haven't spoken about the potential to have granularity or coarseness based on exchange purpose. We've only been talking about selectivity based on the type of data in the patient's record. But for some patients, it might not be about the type of data. It might be about the purpose that you're using it for, which more or less I'll say maps to use cases loosely. So, that may actually be a more feasible way to have some implementable granularity. It's not by data site, it's by purpose. And I'm sorry, Arien, when is the next HITAC meeting that this is going to be discussed at? That wasn't clear.

**Arien Malec - Change Healthcare - Co-Chair**
Yeah. We are already somewhat late relative to the comment period. We got an extension to get into the July meeting, which I think is July 14, 15, 16.

**Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead**
The 11th.

**Arien Malec - Change Healthcare - Co-Chair**
Yeah. So, pretty close.

**Noam Arzt - HLN Consulting, LLC - Public Member**
Okay. But it's that meeting?

**Arien Malec - Change Healthcare - Co-Chair**
Yeah.

**John Kansky - Indiana Health Information Exchange - Co-Chair**
Yeah. And we're presenting our recommendations so we've got some work to do, gang.

**Arien Malec - Change Healthcare - Co-Chair**
To get voted on.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yes, to get voted on. Mark, you have your hand up. If you have a quick comment before we go on.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

It is quick. I want to flag Mark Seagal's comment in the chat box about what TEFCA exchange means. I think we're just speaking about it broadly and I think he's got a nuance there that's important.

**David McCallie, Jr. - Individual - Public Member**

The essence of our debate all morning.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Could well be. And maybe a short version.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Could we get back to the letter? And I think we were on Recommendation 13. Hopefully, less controversial. Okay. The idea behind Recommendation 13 is just asking ONC to clarify if when a patient exercises their – am I okay saying exercise their meaningful choice? Is that violating our language?

**Arien Malec - Change Healthcare - Co-Chair**

That's good.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. When they do so, are they exercising that choice with respect to the organization? How far is that choice communicated and enforced across the TEFCA ecosystem? That's, basically, what we're asking ONC to clarify. Noam has his hand raised.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Yeah. My only comment would be would it be more helpful to ONC to take a shot at it? In other words, to propose something rather than sort of ask open ended questions. I'm not sure I know what that was but I'm wondering if that would be more useful.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

It's not entirely open ended. I was just using shorthand. If we read the comment, it says specifically once exercised, their meaningful choice is expected to be communicated up their QHIN branch and shared by their QHIN and with other QHINs, which organizations in the TEFCA ecosystem are expected to be aware of the individual's meaningful choice and respect it. Only the organization with the direct relationship, Choice 1, all participants and participant members under that TEFCA branch where the individual has a direct relationship, Choice 2, or all QHINs, participants, and participant members across the TEFCA ecosystem, Choice 3. To your point, if we wanted to suggest one of those three choices as the right one, we can. They're obviously easier or more difficult to implement. David, you have your hand up.

**David McCallie, Jr. - Individual - Public Member**

Yeah. I think we ought to recommend a specific fairly focused definition of what you're choosing if you choose not to have your data shared. And I would propose that your data is not shared through the technical means of the TEFCA network, which is an enumerable set of data connections operating under these conditions and terms. And that's what you're choosing to turn off. You're not choosing to effect anything else. You don't have the power to effect other routes of exchange because they're not mediated via TEFCA.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right. But I think the first half of your point if I understood it, was you're saying we should recommend the third choice.

**David McCallie, Jr. - Individual - Public Member**

Yes.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Which is if an individual says I do not want my information used or disclosed within TEFCA that message gets communicated to every participant, every QHIN, every participant member and they are expected to honor that.

**David McCallie, Jr. - Individual - Public Member**

Oh, I see what you're saying. Anyone who is implementing a TEFCA authorized transaction would be expected to respect it moving the data through TEFCA, which would not affect, for example, an agreement you might have with your local regional HIE. It would not affect necessarily sharing across a large integrated delivery network, etc.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

No, things outside of TEFCA. So, let me just push on this to make sure we mean it. And then, we'll see. Noam, I see you have your hand raised. Let me get this real quick ahead of you. So, in Cynthia's example earlier, somebody might get healthcare in New York and they might get healthcare in Florida. And so, they – I don't even need to go to geographic differences because I believe that provider organizations in the same town are going to participate in different QHINs. So, we're saying that you get care at Provider A who participates with one participant and then, that participant uses one QHIN. And then, you get care at another place across town, which is a different member, uses a different participant and a different QHIN.

So, if you exercise your meaningful choice at either of those branches that would apply across all branches and to both participant members that you chose to get care at. That's what we're saying.

**David McCallie, Jr. - Individual - Public Member**

With respect to TEFCA transactions.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

With respect to TEFCA transactions only because TEFCA can't go further than that.

**David McCallie, Jr. - Individual - Public Member**

Right. Technically, you could imagine the MPI and record locator that each QHIN has that understands who you are and where your records are within that QHIN. And you choose to opt out, they would broadcast that knowledge to all of the other QHINs so that their MPIs and record locators could set a flag that says do not exchange this person's information.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay.

**David McCallie, Jr. - Individual - Public Member**

It would be a technical implementation.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I get it and I'm not arguing against it by any means because I think this makes perfect sense logically. What I want to point out in the example that I gave is that patient matching is critical because if all you do is communicate it to – no, I guess that might be okay because if it doesn't go through a QHIN, it's not a TEFCA transaction by definition. So, as long as all of the QHINs maintain the individual's choice and respect it then, no matter which branches under a QHIN you're on, it can be implemented theoretically. Okay. So, I'm sorry, Noam, you've been patiently waiting.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Yes. I have two separate comments. First, in what you described, the TEFCA part of the transaction is just the QHIN to QHIN interaction, right. So, shouldn't the QHINs as gatekeepers be the only ones who need to worry about this as opposed to all the way up and down, the participants, members, etc.? The QHINs –

**Arien Malec - Change Healthcare - Co-Chair**

That's an architecture decision or discussion that really is going to depend on the QHIN and their relationship with their member organizations. But I do agree that the key issue is QHIN 1 collects QHIN participant member, has a discussion with the individual. That individual makes a decision relative to their participation in QHIN based or mediated exchange. And then, QHIN 2 does a request to QHIN 3. Does the request between QHIN 2 and QHIN 3 honor the choice that was made by the individual with respect to QHIN 1, which implies some way of sharing that information between the organizations? Or does that individual exercise in decision making only with respect to exchange involving QHIN 1?

And then, it's really a local decision or an architecture and coordination decision as opposed to how the QHIN 2 and QHIN 3 honor that choice, which may involve communicating down to the participant and participant members because they don't actually maintain any of this metadata. Or it may be held at the QHIN level.

**Noam Arzt - HLN Consulting, LLC - Public Member**

And I guess I always assumed in your example that QHIN 2 and QHIN 3 would have to have a way to find out what the participant member told QHIN 1 about their meaningful choice.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, that's the question is are we going to recommend in Recommendation 13 that we're telling ONC that it should apply, I think, Noam, as you're describing.

**David McCallie, Jr. - Individual - Public Member**

One way to cast the choices maybe a little bit in harsh light but there's kind of a global choice where you could go to any one of your providers and say I no longer want TEFCA to move my data around and that would apply to your data at all of your providers as long as they were part of TEFCA. That's the global choice. The edge choice would you would have to enforce that provider by provider by provider. And you'd have to go to each one of your providers and say I don't want you to share my data that you have up through TEFCA. However, the other guys could still do it.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

If everyone is generally in agreement that it should apply across the whole TEFCA ecosystem, is it hard to – does anyone – I think it's going to be really, really hard to do that because any time you have two patients that are the same that don't get matched, there's an opportunity for the filter to fail, if you will.

**[Crosstalk]**

**Noam Arzt - HLN Consulting, LLC - Public Member**

You have to leave the patient matching problem aside really because the whole thing rises – all of this rises and falls on proper matching. So, you can't throw that monkey wrench in.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. And I wasn't attempting to. You're right. I should have kept my mouth shut. So, is there anyone who doesn't think Recommendation 13 should say that meaningful choice should apply across the whole ecosystem?

**Noam Arzt - HLN Consulting, LLC - Public Member**

I agree that it should but my original point was but it's only the QHINs who have to worry about it.

**[Crosstalk]**

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I think that's something like the patient matching is you're right but it doesn't matter.

**David McCallie, Jr. - Individual - Public Member**

But it is right.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

The simplicity of Recommendation 13 is the task force recommends that ONC clarify that meaningful choice applies across the whole ecosystem.

**David McCallie, Jr. - Individual - Public Member**

And it's a tough technical problem to figure out how to do that but it's, I think, feasible. It could be done. Patient matching complexity notwithstanding.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Right.

**David McCallie, Jr. - Individual - Public Member**

And it's the most powerful way to stop the sharing of your data. It is, however, a blunt force tool just like the all or none discussion we had earlier.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

As noted earlier. Okay. So –

**Noam Arzt - HLN Consulting, LLC - Public Member**

I did have one other point as well. Remember, I said I had two points. That was just one of them. The other is I'm concerned that I could envision a world and it has to do with we've talked a lot about this only applies to a TEFCA mediated transaction. My other transactions are unaffected. I could envision a world where, technically, there is no difference between a TEFCA transaction and a non TEFCA transaction technically. But conceptually, a certain transaction may be – the MRTCs may be incumbent upon them and another transaction they may not be. So, my concern is that folks start thinking about this stuff sort of architecturally when it's possible that the architecture will be the same. In other words, to tell what a TEFCA transaction is or isn't may not be because it's using TEFCA infrastructure.

I think a lot of stuff is going to use the same in infrastructure. Certain transactions have certain terms and conditions that apply to them by agreement and certain ones don't. But I think it's important not to conflate that. A TEFCA transaction is one where certain terms and conditions apply, not necessarily one where you are using a certain technical infrastructure because you might use that infrastructure for both.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

If I'm following your point, I think for the foreseeable future, it's not going to be hard to discern TEFCA transactions from non TEFCA transactions because they will be exchange purposes that go through a QHIN.

**David McCallie, Jr. - Individual - Public Member**

But I think Noam's point is governed by the TEFCA contract and flow down language. That's what we're talking about here, not about other things that may or may not use the same

pipes.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. I understand because I've asked similar questions in the context of, for example, the e-health exchange. How do you know when you're on the exchange and how do you know when you're not? That's merely a framework. This is also defining a framework so we have that same challenge. But we will know who the QHINs are and we will know what the exchange purposes are. Is this a dragon we need to slay in this particular set of recommendations is my question?

**Arien Malec - Change Healthcare - Co-Chair**

Yeah.

**Noam Arzt - HLN Consulting, LLC - Public Member**

I don't know. I just heard the language a lot throughout our conversation. Well, that only applies to my TEFCA transaction. My other ones are okay. And I want to make sure that we make some statement about how actually you tell the difference because the difference isn't because I'm using the TEFCA network physically. I think it's always going to be the same for many participants and players.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, if we were to write a recommendation on that, would it be hey, ONC, the task force wants to make sure that you're aware that it might get confusing in the future?

**Arien Malec - Change Healthcare - Co-Chair**

Yeah. I take the perspective as somebody who operates EDI networks that this situation is not as strange or uncommon as people think it is. It's, in fact, fairly usual that there are multiple paths from Point A to Point B and network operators choose paths based on a number of conditions, including technical feasibility, total cost to reach, etc. And I just don't think it's problematic in practice that there are multiple paths to go from Point A to Point B. And the network operators would want to keep track of which path is which.

**David McCallie, Jr. - Individual - Public Member**

But isn't the issue here the authorization to exchange? The path is totally irrelevant. It's the authorization. Under what auspices are you moving this data?

**Arien Malec - Change Healthcare - Co-Chair**

No. The path is not irrelevant. I might get from Point A to Point B through Contract A and I might get from Point A to Point B through Contract B. And I might choose to go through Contract A for any number of reasons, including price, including restrictions, including a number of reasons.

**David McCallie, Jr. - Individual - Public Member**

But I'm talking about legal authorization, not authorization to use a different – to pay a

special rate for a faster pipe. So, TEFCA can only influence TEFCA contracts.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Sorry. We've got 11 recommendations and 40 minutes. So, I'll leave it as if anybody wants to propose a recommendation in that regard, send it to us. Moving on to Section 5.2, disclosures and auditable events. Is there controversy on 14 or 15? Do we need to walk through them? I don't believe there was a lot of action in terms of editing or feedback. Recommendation 15, sorry, not to slow us down, trying to speed us up, if I'm recalling, this is akin to the decision around recommending that things work across the entire network. Should a summary of disclosures apply only to the entity with the direct relationship to the requesting individual or should a summary of disclosures include data that has been pulled – wait a minute? That's not what I thought it said.

Recommendation 15, the MRTC should require a summary of disclosures only from the entity with the direct relationship to the requesting individual and their associated QHIN. Such a summary should include disclosures when data has been pulled from and disclosures when data has been requested by the associated QHIN. So, that's suggesting that a summary of disclosures – I'm borrowing Noam's point earlier that everything goes to the QHIN that since everything goes through the QHIN, the summary of disclosures should be of stuff that went to and through that QHIN if I'm restating that correctly. David, do you have your hand up or is that an old one?

**David McCallie, Jr. - Individual - Public Member**

I'm sorry, I was on mute. No, it's live. One of the things that bothers me about this one and several of the other ones is it kind of makes the assumption that an individual or even a provider and a provider would know who the QHIN is because these things are defined in terms of services provided by the QHIN. If you as an individual wanted an accounting of disclosures, you probably have no idea what a QHIN is much less which QHIN you would want to talk to. So, some of these seem impractical.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Well, let's probe that.

**David McCallie, Jr. - Individual - Public Member**

It's really the network that you would want to ask, right. I want to know where the network exchanged my data.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I think the point here if I'm tracking it, is it's a little bit nuanced but, clearly, it's important in a clear way. It's clear in an important way is that you don't need to know who your QHIN is. You know who you have a direct relationship with. You go to them and you request a summary of disclosures and none of your information could have possibly gone into or out of the TEFCA ecosystem without going through the QHIN that's associated with the organization with which you have a direct relationship. So, being clear and saying that the summary of disclosure should be from that QHIN branch is implying – here's what I think it's saying.

Oh, geez, here we go. If you had activity completely and utterly independent in another QHIN branch that that activity wouldn't show up in your summary of disclosures because the origin of that information was at a completely different participant member or participant in a different QHIN branch. And they wouldn't necessarily know about it. I think that's the only difference here.

**David McCallie, Jr. - Individual - Public Member**

And it's a big difference. It's a little bit like the meaningful choice debate earlier of I want to opt out once and it applies to all of the QHINs. I want an accounting of disclosure of my data and how it flows to the network. I want to as for it once and it should apply to all of the QHINs. Those are similar technical scope problems. This one is cast more narrowly, which I think, in general, is not a bad starting point. This is just your QHIN and you wouldn't know about two and three necessarily.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Correct.

**David McCallie, Jr. - Individual - Public Member**

I think what is the spirit of the request here and the spirit of the request is – whose life are we trying to improve by this requirement? Is it the patient who wants an easy way to find out what's happening to their data or is it the QHINs who want an easy technical solution? Or is it –

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Like many of the things that we've encountered in this discussion, I think this may be a Kansky philosophy. But to me, it's all about trying to balance what we want to see in the world with how much burden it places on society. Sorry to go there. But that's how I think about these things. So, I think Recommendation 15 is reasonable in terms of what it gives the requester of a summary of disclosures without dramatically increasing the burden on society to get back perhaps absolutely no additional information. David, you and I are the only ones talking about this so I think we might be safe moving on to security.

**David McCallie, Jr. - Individual - Public Member**

Sounds good. Okay. So, Section 6, the first recommendation is 16. ONC should focus on the need for risk based security assessment and recommendation for QHIN and not make where the data resides a central criteria for security. I just had one comment that I had made when reading this earlier. What we seem to be saying, and I'm just trying to improve this recommendation and not take issue with it is what we seem to be saying is much like the whole philosophy behind HIPAA security is HIPAA security doesn't tell you exactly how to be secure but it describes sort of a comprehensive security program and expects you to have one. I don't know if that's in any way helpful or if anybody takes issue with Recommendation 16. Seeing no hands, I'm going to keep going. No. 17, I'm reading it.

This is about clarifying the restriction of data center operations and data at risk in the US. We

think that that's reasonable. But we're asking ONC to define the requirements in terms of operations and data at risk and not use the term cloud services, which includes – cloud services are problematic and confusing and we're asking ONC to instead just define differently what we feel is a reasonable request. Again, no hands. Keep going. No. 18 –

**Noam Arzt - HLN Consulting, LLC - Public Member**

I'm sorry. I have a quick hand up. We made comments above about some of the perhaps unintended consequences of this sort of restriction of EHI outside the US. But we didn't really resolve them. The reasonableness of a patient in Mexico or Canada. There isn't the recommendation that's sort of – or is that 16?

**Arien Malec - Change Healthcare - Co-Chair**

That's 18.

**Noam Arzt - HLN Consulting, LLC - Public Member**

I'm sorry, 18. No, it's at 18 or do you mean – I'm sorry. Let me look at that.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

No. 18 is because of the need to have data follow the patient and because of the existence of transnational settings of care, for example, DOD. ONC should not restrict data access and exchange that is transnational.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Okay, sorry. Then, yeah, it's there.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Oh, but you underscored – I'm glad we had that. Thank you. Keep going. Scroll up, please or down. I can never get that right. I'm sorry, go the opposite way of what you just did. Move the content up. Thank you. We just did 18, keep going. Controlled unclassified. So, No. 19 is, I think, straight forward. We recommend removing the section on CUI. I think that was on the basis that – well, let me read 20 and not improvise here. The task force recommends that ONC make it clear that – my screen just blanked out because my laptop timed out. Make it clear that the additional obligations on CUI handling and other specific requirements be borne by the federal partners. Okay.

As federal partners on board to TEFCA administered exchange, ONC should work with federal partners to ensure that additional security requirements do not impede the principle of reciprocity. So, I think I remember this discussion now. And I think what we're saying is yes, CUI is a challenge that the federal partners bring to the table and that we don't think adding requirements to TEFCA is the solution to the problem. We need to ask the federal partners to work with the ONC and RCE to figure out how to get their needs met regarding CUI. Is that pretty close? Nothing in the affirmative and nothing on the contrary. So, I'm going to take the opportunity to keep going. Security tagging, please. Recommendation 21, ONC should defer to the health IT for the care continuum task force recommendation. Somebody who knows what that is should probably help facilitate this because I don't.

**Arien Malec - Change Healthcare - Co-Chair**

I don't think we should. This is a point of order. I don't think we should defer to the task force recommendations though we did make recommendations as the full committee. The key point here is basically to the same effect. The key point here is that we should not have security tagging requirements that are specific to the TEFCA. Instead, we should have common security tagging requirements that are common to certification under the programs and use them in the TEFCA. And then, the second major comment is that every time we've looked at this, the standards actually are reasonable relative to the ability to express tags in exchange data. But the policy requirements are not yet actionable and implementable.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

So, Arien, is this as simple as making sure that we direct the ONC to the correct set of recommendations and ask them to follow those?

**Arien Malec - Change Healthcare - Co-Chair**

Yes. And also just to note that we need to make sure that we're not just talking about standards but also the policy enablement. It's the same discussion that we were just having really about how do I express my choice to not participate and how do I express the right to be forgotten when we don't know how to make it actionable at point of care.

**David McCallie, Jr. - Individual - Public Member**

Point of clarity.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yes, sir.

**David McCallie, Jr. - Individual - Public Member**

David here. Would this not better be put as privacy and security tagging or even just sensitive data tagging? It's not really about security that we're tagging. It's really privacy.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

But is it specifically framed that way in TEF 2?

**David McCallie, Jr. - Individual - Public Member**

I think it's all lumped together. But restrictions on redisclosure is not a security restriction. It's a privacy restriction. Section 6 is just entitled privacy, security, and patient safety. So, it's kind of lumped together.

**Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead**

And security labeling, it's not in the MRTCs. It's actually in the introduction because it was just a request for comment and it looks like it is titled security labeling.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Okay. So, it doesn't really matter what we call it.

**David McCallie, Jr. - Individual - Public Member**

Yeah. It's a minor point but it's much broader than just security.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Thank you. Arien, you may get the job of tweaking that recommendation because you seem to have a hand on it.

**Arien Malec - Change Healthcare - Co-Chair**

Yeah.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

That was my diplomatic version of one, two, three, not it. Okay. I think the 6.4 recommendation, I think there was general agreement on just recommending that we delete that particular provision. Identity proofing and authentication. We have a couple of recommendations. Recommendation 23 for clarity, we recommend that the – oh, yeah. We recommend that the ONC overtly state what we think is intended, which is that participants and participant members under a QHIN branch can rely – I'm sorry, that the QHINs can rely on identity proofing done within the participants and participant members under the QHIN branch on the basis that all **[mumbling reading]**. Yeah.

So, they're all using the same identity proofing standards as a practical matter, have to accept others' identity proofing, and we're just asking that be stated overtly for the sake of clarity. No. 24, we agree with ONC's inclusion of AAL2 and IAL2 but recommend that the industry have appropriate time to implement those standards. Okay. Thank you for helping us dramatically pick up speed and make progress. We now have the opportunity to circle back to some of the – Zoe and Arien, looking for opinions on where we go next. We could go to 8. We could go to 7. That, I guess, would be my –

**Arien Malec - Change Healthcare - Co-Chair**

Can we just do a pass from the top?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Can I pass you the baton for that?

**Arien Malec - Change Healthcare - Co-Chair**

Sure.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

And I just want to flag that there's been a pending question about alignment with the API requirements and ONC's MPRM.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Mark, I think that is literally the first thing that's going to come up.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Okay. Since it's a fresh conversation, I wondered if you wanted to cover it first. But having said it, I'm off.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. Top down, I think it's literally the first thing

**Arien Malec - Change Healthcare - Co-Chair**

Okay. It's literally the first thing. Can we go through Recommendation 1 just so we can look at it and say check? I'm not seeing the screen move. Can we move up a little bit? I think the screen may be frozen. Let's go to the API discussion then.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

I can see No. 1.

**Arien Malec - Change Healthcare - Co-Chair**

Oh, you can see No. 1.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. The only tweak on No. 1 was I think that we softened the bullet that was related to the participation.

**Arien Malec - Change Healthcare - Co-Chair**

Yes, okay. Check. Let's go down. So, let's talk about the API alignment. And Mark, do you want to set the stage for the issue you want to discuss?

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

I'm trying to recall what we've already covered within the task force. I believe there was an early conversation that the TEFCA V2 is set up as document based exchange because ONC wants something out of the box quickly. I think we really should have something where TEFCA is alignment with ONC is saying about API's. And I know that in my own thinking and in comments that we filed, we think a bridge could be that the TEFCA provides for API's on the same timetable that ONC uses in its proposed MPRM. I don't mean to dictate that as a recommendation. But I just think it is possible to try to get some alignment so that API based exchange is also available through TEFCA starting in 2022. Is that fast enough, Arien?

**Arien Malec - Change Healthcare - Co-Chair**

No, that's good. And here's the way I see this and maybe I'm saying this for the purpose of testing to make sure I'm not misunderstanding. So, I don't see the TEFCA as mandating document based exchange. I see that as being properly the area of the QTF. And I think our general recommendations are to defer many of these decisions to the QTF unless the MRTCs

specifically refer to exchange of consolidated CDA formatted data following USCDI. Then, the key decisions relative to API based exchange or document baaed exchange should be deferred to the QTF. And I think we've already made recommendations in that area.

And we made recommendations in the area precisely because the existing QTF has somewhat the function of locking us into world N minus 1 as opposed to world N that we're going towards. I wonder if ONC could clarify if we do have MRTCs that specifically refer to document based exchange.

**Zoe Barber - Office of the National Coordinator for Health Information Technology - Staff Lead**

No, Arien. What you said is exactly right. The MRTCs do not require either document based exchange or APIs on those solutions. It would be referred to the QTF and RCE.

**Arien Malec - Change Healthcare - Co-Chair**

Cool. Thank you. David and then, Noam.

**David McCallie, Jr. - Individual - Public Member**

Yeah. Just to pile on, the exchange that occurs today through some of the networks that TEFCA is mirroring like Common Well and Care Quality is document centric but they actually use APIs. Some of them use older APIs. Some of them are document centric and use newer APIs like Fyre. APIs can exchange documents or discrete data. So, it's a misnomer to equate API with discrete data or documents with non Fyre. So, I think defer all of that to the RCE and stay out of it as we have consistently said.

**Arien Malec - Change Healthcare - Co-Chair**

Noam?

**Noam Arzt - HLN Consulting, LLC - Public Member**

Yeah. I just want to agree with that as well. So, I was going to make that same point that we've already sort of pushed this stuff out. So, we should stick with that.

**Arien Malec - Change Healthcare - Co-Chair**

Okay. Mark, any strong opinions?

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Yeah. I think we ought to recommend that we expect the participants in TEFCA to make available Fyre based API exchange on the timetable that ONC establishes for everybody else. The details of that I agree to leave it to the QTF and RCE to figure out. But I think TEFCA right now is silent about that. I think we should make that recommendation so that we are clear that these two means of exchange are not parallel and never touching but that we actually see them as working together and being able to leverage each other.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

This is John. Maybe I misunderstood but I think we risk giving conflicting recommendations if we say hey, ONC, don't tell us what technology to use, except for this one.

**Noam Arzt - HLN Consulting, LLC - Public Member**

But there's a compromise in there because it's that last point he made that we're not making yet, which is some statement that says hey, whatever sticks out, there ought to be some consistency between this and whatever the final rule ends up being. There it is.

**David McCallie, Jr. - Individual - Public Member**

This is David. I want to raise maybe what Mark is talking about at risk of putting a new complicated thing in front of us but it is not out of the question, for example, that you could imagine apps being able to negotiate direct connections to portal APIs as required in the new rules through TEFCA. So, the portalitis problem that we've all heard so much about of how difficult it is to connect your app to all of your providers' portals could theoretically be mediated somehow through TEFCA. But I look at that as a completely new use case or permitted purpose or whatever we want to call those things because it's not about exchange anymore amongst systems. It's about an individual wielding an app and asking TEFCA to help point it at their portals. But that's a new use case. But maybe that's what Mark is getting at.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Sheryl has her hand up.

**Sheryl Turney - Anthem Blue Cross Blue Shield - Member**

Yeah, this is Sheryl. I don't agree with the new use case because I brought this up in the first round of TEFCA discussions and the clarification I got from ONC is that it is essentially the purpose behind TEFCA was really more for the ability to allow a patient to use an app to come in and only have to go to one place in order to get that data more than it was for all of the systems to talk to one another. So, I don't think this is new. And I do believe that TEFCA should be somewhat technology independent. However, since it does already speak to technology, I do think we should say something to the effect that it should be able to support that. And I was going to bring this up earlier showing my non-technical ability but Apple released their Apple health record yesterday to everyone.

So, now there's going to be a de facto standard for pretty much anyone that has an iPhone. And they're going to want to go to a TEFCA type arrangement to get the data rather than hundreds of thousands of providers. So, at the end of the day, this is, to me, part of what TEFCA was meant to be doing to help the patient. And even some of the things that we were talking about earlier today, I wasn't sure how to weigh in because the patient is not going to know if they're using an Apple health record whether Apple is going directly to the provider or to TEFCA. So, when you're talking about authorizations, it's going to be invisible to them what the means is behind the curtain. And they're not going to now what TEFCA is or any of those types of things when they're trying to interact with it. And we need to make it simpler for them when authorizations occur and also when this type of support is required.

So, I do think we need to say something. And I do think that it should support multiple means of interaction. But I don't think this is a new use case. This is one of the ones that they

discussed and we discussed as a group over a year ago.

**Arien Malec - Change Healthcare - Co-Chair**

Yeah. So, just as a reminder, individual access is one of the key policy requirements and exchange requirements that are written pretty deeply into the MRTCs. So, I don't see anything relative to deferring these decisions to the QTF to be in conflict with that.

**David McCallie, Jr. - Individual - Public Member**

There is a difference between the individual access use case defined in the current TEF 2 document, which is, essentially, read only and connecting an app directly to a provider's portal for purposes of things like paying your bills and other transactions that are not contemplated in anything in the current TEF. It doesn't mean it couldn't be accommodated in the future. And that was my point. It can grow into something more than an aggregator portal.

**[Crosstalk]**

**Arien Malec - Change Healthcare - Co-Chair**

Just a point of order. We have a whole discussion on that coming up. This one is particular to the way I framed the discussion on the table is should we, when we get to the discussions on the QTF, should we stick with our existing recommendations to stay functionally focused and defer the decisions for how to the QTF? Or should we make a statement that says something to the effect of we think APIs are good and the QTF should probably accommodate APIs? And those aren't strictly in conflict but they're directionally in conflict of we think this should be a decision that's deferred. But we kind of want to put a little bit of a thumb on the scale.

**David McCallie, Jr. - Individual - Public Member**

But, Arien, when you say API, what do you mean? It's all APIs, as you know. Are you talking about Fyre discrete data? What are you talking about?

**Arien Malec - Change Healthcare - Co-Chair**

I think that is the intent when people talk about API in this context is –

**David McCallie, Jr. - Individual - Public Member**

Be specific.

**Arien Malec - Change Healthcare - Co-Chair**

Fyre based API access. And I'm trying to be a fair defender of the debate. I think I've already waved my flag, which is let's stick defer these decisions and stay clear on functional requirements. Noam and then, David, you have your hand up but do you still have your hand up?

**Noam Arzt - HLN Consulting, LLC - Public Member**

Sorry. I don't think I had my hand up.

**Arien Malec - Change Healthcare - Co-Chair**

Okay.

**David McCallie, Jr. - Individual - Public Member**

Well, I'll finish just to echo your last sentence there. I think if we want to weigh in here, we should weigh in on a functional capability. So, if we're saying the functional ability of a patient to use TEFCA to navigate transparently to their portals and achieve transactions using portal based APIs then, that's a nice functional requirement. That's okay.

**Arien Malec - Change Healthcare - Co-Chair**

We have that discussion all lined up. Okay.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

Arien, what does that mean? Does that mean it's a discussion to come on something else?

**Arien Malec - Change Healthcare - Co-Chair**

Yes. This is the same as I don't know if it's 8A, B discussion of what functional requirements do we include in IAS. And I believe it's 8A, 8B.

**Mark Savage - UCSF Center for Digital Health Innovation - Public Member**

I don't know if you guys think this is a better functional way to describe it but we need the two bases of exchange to work with each other. So, yes, it's Fyre based, its' whatever the standard is that ONC adopts whether it's two or four and I hope it's four. We can express that as a functional requirement or we can just say ONC's rule. But I think the important thing here is that these two national systems' approaches to interoperability need to be able to work together.

**Arien Malec - Change Healthcare - Co-Chair**

Yes. And, again, I agree with Sheryl that if we roll out the TEFCA and the net result is that I can't use my Apple health app more fluidly than I currently can, I'm not sure that as an individual I would call the TEFCA a success. And that's a little different from functionally logging into all of my portals but it accomplishes the same goal.

**David McCallie, Jr. - Individual - Public Member**

Yeah. But you may encumber a lot of work just for technical cleanliness. I'm not sure that's a win either.

**Arien Malec - Change Healthcare - Co-Chair**

I'm talking about the functional requirement of gosh, it would be nice to, and using Apple Health as an example, log into Apple Health and get access to "all of my data". How that's done, I think, absolutely the decision should be deferred to the QTF. But if the QTF is insufficient to meet that functional requirement and we're not specific enough about the functional requirement, maybe when we get to that piece for IAS we should revisit the

functional requirement there. I'm going to move on. So, 2B, it says discuss further. I'm not sure what the discussion point is. So, the issue at hand is that the information blocking is constrained to all data and all permitted purposes.

The TEFCA is constrained to the USCDI. I know there have been many respondents who have sought to limit the exposure of EHI with respect to the information blocking rule. But this recommendation separate of that is saying it's okay if information blocking has a wider aperture than the TEFCA. The point here is that the TEFCA is somewhat pragmatic and allows access to all of the data in the USCDI. There may be some need for relative to information blocking to go outside of the TEFCA in rare and unusual cases. But it's fine to constrain to the USCDI. So, I'm just going to pause there.

**David McCallie, Jr. - Individual - Public Member**

This is David. I think I may have been the instigator for some of the thinking here. And the other part of it is or the logic is that it's better to put pressure on the HIT community to rapidly expand standards based transfer of data than it is to require arbitrary exchange in a nonstandard way. So, instead of doing it twice, once in a nonstandard way and then, again in a standard way, speed up the use of standards because more and more of these systems will be driven by algorithmic parsing of the data that is only possible when there are some reasonable good standards in place. So, for provider productivity, etc., the faster we expand standards the better. And that's where the energy should be spent. That was the spirit of this one.

**Arien Malec - Change Healthcare - Co-Chair**

Yeah. Is there any dissent? Without dissent, we're moving on. Let's keep going. I'm not seeing the screen move. It may just be an issue on mine. Okay. New recommendation/old recommendation. John, help me.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Yeah. Let me see if I can – I think new recommendation – yeah. I'll take this one. New Recommendation 3A was supposed to be listening to the task force and writing a better version of old Recommendation 3A but we wanted to ask the task force if we got it right or right enough. So, whereas in old Recommendation 3A, we were trying to say hey, align privacy and security obligations under TEFCA with HIPAA, we got a lot of feedback on that. And we're trying to cite specific examples. And I think the proposed new Recommendation 3A and if you guys like it, we can just get rid of the old one. The new one goes something like this.

To add clarity and avoid misinterpretation, we're encouraging ONC to reframe privacy and security obligations as 1) HIPAA obligations that are specifically intended to extend to cover participants and participant members who are not covered entities or business associates. And the other category, which is new privacy and security obligations, which go beyond HIPAA and cover all participants and participant members. So, in discussing old 3A, we got smarter and discovered that what we really think we mean is new 3A.

**Arien Malec - Change Healthcare - Co-Chair**

Yeah.

**David McCallie, Jr. - Individual - Public Member**
I like it.

**Denise Webb - Individual - Member**
I'm good with it.

**Arien Malec - Change Healthcare - Co-Chair**
Let us move on. We've got to make public comment. This is a good way of forcing the issue. We are going to pause for public comment.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Operator, can you open the line for public comment, please.

**Operator**
If you would like to make a public comment, please press star 1 on your telephone keypad. A confirmation tone will indicate your line is in the cue. You may press star 2 if you would like to remove your comment from the cue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Thank you. Is there anybody on the line?

**Operator**
There are no comments at this time.

**Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer**
Thanks. Arien.

**Arien Malec - Change Healthcare - Co-Chair**
Cool. Let's go back to – we agreed on new 3A, which will now henceforth be called 3A. And 3B, okay. John, what is the screen looking like for you?

**John Kansky - Indiana Health Information Exchange - Co-Chair**
Okay. I got it. I'm looking at 3B. And I had to read this one a couple of times. You have to read the pros above for this one to make sense. The paragraph above 3B says the task force understands that Draft 2 creates new rights of individuals regarding access to the health information and calls on specific HIPAA obligations to explain these rights. We understand that existing HIPAA obligations to share information are not supplanted by these new rights. For example, key phrase, information that is required by HIPAA to be shared with public

health authorities is still required to be shared, even after the individual exercises their right of meaningful choice.

I think that's a Noam Arzt memorial example. And in Recommendation 3B, we're basically saying to add clarity and avoid misinterpretation, ONC should offer other examples like that one because we think that one came up in conversation but probably isn't the only one. So, we think that if – go ahead.

**Arien Malec - Change Healthcare - Co-Chair**

Do we need this recommendation? Isn't it restating the point that we just discussed that says that the exercise of meaningful choice and the decisions that are made under that choice are relative only to TEFCA based exchanged? And it's the same point here. The additional obligations are relevant only for TEFCA based exchange, which is not and will not be the only kinds of exchange that are required. Or are we saying instead that there are, I'm not even sure how to frame it because I'm over anchored on meaningful choice, but there are things that the TEFCA says that it really doesn't say because HIPAA overrides them?

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Noam has his hand raised and he'll probably fix this but I think what we were trying to say, and I can't speak for ONC, is that yeah, TEFCA says that anything that's required by law still stands. We're pointing out that it wouldn't be bad to just make sure everybody understands that. But Noam has his hand raised.

**Noam Arzt - HLN Consulting, LLC - Public Member**

All I was going to say is I have no problem getting rid of 3B. I really like the paragraph above it though. So, would a friendly recommendation be to move the paragraph above new 3A, in other words just have that paragraph be part of that introductory section? I think it flows from the paragraph that's now above that. So, we're sort of stating some things and then, we have Recommendation 3.

**Arien Malec - Change Healthcare - Co-Chair**

That works.

**Noam Arzt - HLN Consulting, LLC - Public Member**

I just don't want to lose the thought because I think it's good thought. I don't know that it needs to be memorialized in 3B.

**Arien Malec - Change Healthcare - Co-Chair**

Cool. Done. Recommendation 4, and we have five more minutes left. My connection status is upgraded to merely fair now, which appears to do the trick. Again, just to note, this is the recommendation by which we are seeking to provide additional flexibility and additional tools for mapping MRTCs to existing participation agreements. And in particular, we're recommending that the RCE be allowed to evaluate and approve existing language that is equivalent to MRTCs. We are recommending that certain TEFCA terms and conditions be labeled required versus addressable to take a little page out of HIPAA.

And then, in the areas where there are terms and conditions that are not mappable or addressable that we provide a defined and appropriate time period to revise terms and conditions while still participating in exchange so that we're not gumming up the works.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

And, Arien, if I could add that I think it's important to note that the last three words before these bullets are such means as. So, we're not specifically telling the ONC these are the three things we recommend that you do but we're trying to give them examples so we make our point clearly.

**Arien Malec - Change Healthcare - Co-Chair**

Yes, thank you. Okay. Hearing no discussion on that point, I think we should close out and start back in at Recommendation 5, which takes us thorough the hot zone in the middle of the document for our next meeting.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

Good call in what Arien just said but good call for the last two hours. I appreciate everybody's progress.

**Arien Malec - Change Healthcare - Co-Chair**

Likewise.

**Noam Arzt - HLN Consulting, LLC - Public Member**

And that meeting is tomorrow, right?

**Arien Malec - Change Healthcare - Co-Chair**

I just do what my calendar says but if you say it's tomorrow, it's tomorrow.

**John Kansky - Indiana Health Information Exchange - Co-Chair**

It is, in fact, tomorrow.

**Arien Malec - Change Healthcare - Co-Chair**

It is, in fact, tomorrow. And then, we'll go gloriously off into the barbeque and fireworks.

**Noam Arzt - HLN Consulting, LLC - Public Member**

Oh, I thought this was the barbeque and fireworks.

**Arien Malec - Change Healthcare - Co-Chair**

Definitely the fireworks. We'll get the fireworks started early. All right. Thanks, everybody.