Trusted Exchange Framework and Common Agreement Task Force

Transcript
June 24, 2019
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
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Kathryn Marchesini	Office of the National Coordinator	Chief Privacy Officer

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning everybody. Happy Monday welcome to the TEFCA task force call. Of the members, we have Arien Malec, Sheryl Tourney, Sasha TerMaat, Cynthia Fisher, Anil Jain, Denise Webb, David McCallie, Mark Savage, and Noam Arzt. Are there any members on the phone or on the Adobe who have not announced themselves? And I know John Kansky, our other chair, will be joining us here a couple minutes late. So, at this point, I will turn it over to Arien Malec to get us started.

Arien Malec – Change Healthcare – Co-Chair
Hello. Since the last meeting, we did some turns of the recommendations letter. We had some work over the weekend to get to a formatted document that has recommendations in numerical order. And as part of that process, I think we've highlighted several issues. We've done the first pass through all the recommendations. There's a fair amount of clean up that is fairly unobjectionable, and then there are several items where we have yet to get to a consensus as a task force. So, we're going to spend the time today covering all of the hard bits and trying to make sure that we have a sense of whether there is a consensus as a task force. Whether there is a strong minority opinion that we need to reflect in the transmittal letter.

We will spend the time today covering all the hard bits and trying to make sure we have a sense of whether there is a consensus as a task force. Whether there is a strong consensus for strong minority opinion that we need to reflect in the transmittal letter, or whether or not we cannot get to consensus and there is some level of a split decision where we cannot determine the recommendations. To the national coordinator. So, we're not going to go through all of the recommendations. Particularly go through all the recommendations where there was the appropriate consensus. We've sent out a version of the document so people could review that offline and go through the recommendations that we didn't have a chance to cover today. And make sure that the revisions and wordsmithing, that kind of thing, accurately reflects the sense of the task force.

As I said, today we're really going to focus on the areas as fun. John's going to be a little bit late, but as soon as he's there, he's going to do most of the hard work. But maybe I'll just kick us off with the first area of discussion. And I believe that is on recommendation 1-A on assenting adoption of TEFCA.

And we have one recommendation that says we should not use TEFCA participation as a condition of participation. And another recommendation that provides the notion of carrots and sticks for TEFCA adoption and recommends that CMS require TEFCA participation as a condition of participation in Medicare and Medicaid.

So, we flagged this one as to discuss as a group. So, we did note that federal agencies might require TEFCA participation as a condition of contracting with federal agencies. That seems to be clearly within if you're DOD or you're VHA, and you're doing contracting for services, or you're ISH, or you're SSA relative to the disability determination, it does seem like a reasonable requirement to use the nationwide, congressionally mandated trusted exchange framework to exchange data.

Concerning CMS requiring participation as a condition of participation, maybe just to frame up this topic, there's a hard version of this. Which is it should be literally a condition of participation for

Medicare and Medicaid, you don't get paid if you don't use the TEFCA? It could be a programmatic requirement, that is rolled into ACO programs, like MSSPs, medical home programs, and whatever MIPS is called these days. I lost the plot on all the acronyms there. And then we could just remove this recommendation entirely.

So, framing up maybe the Goldilocks options. I will now see who's raised their hand. I don't see any hands raised.

David McCallie – Individual – Public Member
I'll verbally raise my hand.

Arien Malec – Change Healthcare – Co-Chair
David is up.

David McCallie – Individual – Public Member
I think the way we have this worded here, calling attention to this decision, categorizing it as carrot and sticks, make sense. As you point out, there's a lot of complexity under the covers, so it is unlikely that we could, in the time we have and the expertise and symbols here anyway, make a super fine-grained recommendation.

So, I like the way it is worded. It's considered both carrots and sticks. Here is a range of choices. It might make sense to expand the choices the way you did, Arien, in your prologue to include some poor examples, particularly on the CMS condition of participation. You could, as you said, put that as part of the definition of a medical home or an MMSP participant.

The other thought I have is, and I think it sort of goes without saying, but these things would only work once TEFCA is a functioning network. So, there's a chicken and egg problem. It has to be in a staged and graded fashion if you make something like a condition of participation. So, it's not at an all or none thing. Maybe it comes in a stepwise fashion. But again, those are details maybe that we shouldn't speculate on.

Arien Malec – Change Healthcare – Co-Chair
Yes. So just to be really clear, the meaning of condition of participation relative to, for example, Medicare, is that you are not eligible for reimbursement if you don't meet the conditions of participation. So, to me, that's the biggest stick that CMS has to wield. So maybe we want to soft-pedal this and say consider a range of options for CMS to incorporate TEFCA into Medicare and Medicaid programs, including value-based payment programs, including relevant contracting, and then, as the maximal, as TEFCA adoption is broadly supported, including as a condition of participation. Would that be an appropriate way of framing this discussion point?

David McCallie – Individual – Public Member
David here, yes. That captures what I was thinking.

Arien Malec – Change Healthcare – Co-Chair
Okay. Sasha.

Sasha TarMaat – Epic – Member

Thanks. I appreciate the different options that are outlined here. I have, I think, a background with the meaningful use now called promoting interoperability program that makes me a bit hesitant about using some of the types of sticks that we're outlining.

There have been standards and initiatives and projects, which were generally conceived be good, useful to the industry, advantageous and so forth, that were rolled out in various stages of meaningful use, and then through that rollout, folks realized that there were elements of them that were not ready for primetime. That did not apply to all different use cases and settings that might participate in the program that had unintended side effects.

And that causes me to I think to be hesitant about using that in a case with something that we don't really know all the details of that yet. I think that's a high risk. My feeling would be that if TEFCA succeeds in the aims that we have for it, then it will be market driven that people want to join it. If joining it is the fastest, easiest, most effective, most comprehensive way to exchange information with people who you're not already in another network with, the demand should drive adoption into that.

And I have significant concerns that including something like promoting interoperability or a condition of participation in Medicare or Medicaid, when we still don't even have the full framework or agreement from an RCE and all of that, is ripe for the kinds of unintended consequences we've seen in past stages of meaningful use.

Arien Malec – Change Healthcare – Co-Chair
Absolutely. Fair comment. Denise?

Denise Webb – Individual – Member
Yes. Good morning. I was going to chime in that the suggested amendment you were making to that bullet concerning conditions of participation I think is absolutely necessary. Because I know, having worked in Medicaid, it's hard to get providers to take Medicaid covered patients. And so, I wouldn't want some blanket statement here about using participation as a condition of participation in Medicare and Medicaid without clarifying that we're talking about some program where it would make sense.

Because it's hard enough to get providers. You know what they end up doing? Like I have a brother-in-law, he's a family practice provider. He just won't take Medicaid patients. So, I mean, you can have unintended consequences by having a heavy stick that ultimately is a downside for the patients who are trying to get access and get care.

Arien Malec – Change Healthcare – Co-Chair
Yes. I'm really mindful of Sasha's comments that maybe the appropriate condition of participation stick is relative to information blocking. And that TEFCA should be the most natural, easiest path to achieve requirements as it's successful. And maybe information blocking provides all the relevant sticks that are necessary, and we're kind of misapplying the sticks here. Noam and then David wants to get back in the queue.

Noam Arzt – HLN Consulting, LLC – Public Member
I just wanted to agree that I also share some caution here in being too brazen about these suggestions. Including that sort of recognition of David's chicken and egg problem. That's all.

Arien Malec – Change Healthcare – Co-Chair
Okay. David? Round two.

David McCallie – Individual – Public Member
Yes. I'm certainly sympathetic to the unintended consequence problem. We certainly have plenty of examples of that. But I also believe that the potential participants in TEFCA at the RCE level and the QHIN level have enough experience to understand those and have enough experience to put in appropriate incentives that minimize the chance of those unintended consequences.

But I don't think that we should forget that this whole thing came about because they will have Congress to nearly unanimously create a new law that authorized the creation of this network. To address a problem that market forces had not solved and had certainly not solved adequately. So, this is not just a random thing we're doing for the heck of it. It's something that's being done because a law was passed. And so, I think there's a lot of power behind it.

Arien Malec – Change Healthcare – Co-Chair
I hear from you. Again, the kind of laugh that I just had is information blocking seems like the bigger and more powerful stick.

David McCallie – Individual – Public Member
But we neutered that stick in our own recommendations unless we go and modify them further down in this document. It's pretty watered down.

Arien Malec – Change Healthcare – Co-Chair
Yes. In the information blocking task force recommendations, we recommended conditions of participation for – information blocking had a station as conditions of participation. So again, I just feel like that's the appropriate place to put the stick.

What I would suggest wording here is something to the effect of as TEFCA is implemented and real-world tested and participation increases, consider trying to programmatic such as value-based purchasing and condition of participation. So, really gradate the inclusion to broadscale adoption. Is there a sense of the task force there?

David McCallie – Individual – Public Member
I think we'll need to see the words.

Arien Malec – Change Healthcare – Co-Chair
Okay. John, you have your hand up.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. First of all, I'm here. Sorry for being late. I've been listening for about five minutes. So, I'll weigh in on that question that you just posted. I certainly would be more comfortable with that language than what we currently have. My comment that I was going to make is that these five bulleted lists were an attempt at giving ONC some suggested examples of things that could be considered to insistent participation in TEFCA. My sense was just that the fifth bullet went just one step too far.

So, your language, I believe, again, to David's point, people need to read it. I think helps with the concern I was feeling.

Arien Malec – Change Healthcare – Co-Chair
Okay. So, it sounds like we have a way forward. We'll propose some language and then submit for the workgroup's response. And then, John, I'm going to hand the reins over to you gracefully and have you taken on the rest of the coordination. I think you weren't here when I was framing up kind of how we're going to do this. But I propose that we focus really on the areas of controversy today, as opposed to going through the full recommendations, just so that we make sure we cover all of the things that require substantial discussion as a group.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. So that was my strategy all along, was let you deal with conditions of participation, and then I would swoop in after that.

Arien Malec – Change Healthcare – Co-Chair
Perfect.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, I'm hoping, not repeating. Arien and I made a pass through the document, and the ONC team has done a great job or calling out those remaining issues in the comment area. So as Arien just suggested, we're going to go from comment to comment.

So, in recommendation No. 2-A, this is under the general idea that we're encouraging ONC how to align with the information blocking rule. And one of the misalignments that we're calling out is that information blocking says that if you have any EHI, as defined, that's what you need to share. And the TEFCA, too, as drafted, suggests that one needs to include in transactions EHI that you have available that's in the subset of USCDI.

So, in the prior discussion, I sense that some folks say, well, this is easy to fix. Just align it with info blocking and go with all EHI. Others of us feel that using the USCDI subset as drafted aligns with some other things as well as maybe making this easier to implement. So, with that, let's throw it open for discussion to see if we can either find a compromised position on that or if we're truly split. David McCallie?

David McCallie – Individual – Public Member
Yes, I think the big flaw here is on the side of the information blocking MPRM that I think made a big mistake in defining EHIs and information blocking separate from USCDI, but that's not a flaw that we can address with our requirement. We can't fix that. That door is closed. Hopefully, they'll straighten some of that out before the final rule.

But in this case, you want national scale interchange, it has to be standards-based, and therefore, it has to be based on some definition of data. I think the best thing we have is USCDI, and I would put the burden on ONC to make USCDI expand at a rapid pace, rather than suggesting that we take a nonstandard approach of just throwing random data out there because it's EHI, and ending up with the unintended consequence of a lot of data being shared that's not usable because nobody knows how to read it or parse it or understand its context.

So, I favor the couple at the USCDI and put the pressure on ONC to more rapidly expand the progress of increasing the scope of USCDI. And let TEFCA stay in sync with that. That may not be exactly the question you asked.

John Kansky – Indiana Health Information Exchange – Co-Chair
That is a version of a compromised response. I appreciate that. Arien?

Arien Malec – Change Healthcare – Co-Chair
David said what I was going to say so well that I withdraw my hand raising. I have exactly the same perspective. I guess I would add too that it is unlikely – I think we have already acknowledged that the TEFCA will not address every information blocking need. It is really designed to address a super majority of needs, an 80% solution, where information is requested across networks.

And there may be cases where a requester needs more data that can be retrieved through the TEFCA. That request may be required to address information blocking requirements. And I think it is okay and just fine that the TEFCA doesn't solve for every problem in the universe.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
John, it's Mark. Could you add me to the queue at the appropriate time, please? I'm having browser difficulties.

John Kansky – Indiana Health Information Exchange – Co-Chair
Oh, it is the appropriate time now, Mark. Go ahead.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
Okay. To David's point, I agree that it's the other NPRM that will address the issue of how much we are exchanging electronic health information, and how much it is a core data for interoperability. There are comments in there, I know UCSS is one of them, that says exchange should be broad, all the using APIs for example. And I think I would prefer to see that possibility here, not just illuminating to the US core data for operability. I can expand further if you want.

David McCallie – Individual – Public Member
Mark, this is exactly the question that we are trying to resolve. Are you concerned at all, admitting it's a leading question from a guy that we dragged through some of the much of the definitions on the TEFCA task force?

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
I'm familiar with leading questions.

David McCallie – Individual – Public Member
At least I'm admitting to it. That EHI, picking up the kind of on one of David's references, is EHI is going to be fuzzy in its definition. And having people try to know what to send when there isn't something as precise as USCDI to answer the question. I'm just very concerned that we are going to make a lot of, in the case of information blocking, adjudication through the courts versus in this setting. Whether it falls to the RCE or saying, well you can't be a QHIN yet because you're not transacting the right stuff. And they're like, well what is the right stuff? We thought we were doing all EHI. Well, it's not in there. So that's the kind of balancing concern that I have ongoing beyond USCDI.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
I'm going to hope that the ONC provides the appropriate level of definition in the NPRM. I don't think that is necessarily tasked for us on the TEFCA task force. I think it's a question of alignment. I think the rule should be aligned. I think it should be EHI. And I will turn this around and say conversely, the coordinator for interoperability as the floor or ceiling depending on one's perspective, for exchange is just not enough.

David McCallie – Individual – Public Member
Would you be accepting of the compromise position that went something like the following, the task force understands that something broader than USCDI may be desirable, while we recommend staying with USCDI as drafted, unless and until the EHI definition is cast more clearly. Those words weren't particularly well crafted. But the idea is that we're recommending USCDI but going beyond that is clearly desirable. What we need is a clear definition of EHI, and then you can implement that.

Arien Malec – Change Healthcare – Co-Chair
Yes. As an amendment to that. I think the task force senses that the TEFCA should ultimately be responsive to the needs that Congress articulated. We believe the appropriate fix is on the USCDI, EHI definition, not in the TEFCA.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
I like the idea of alignment with the EHI provisions of the other NPR> I was going to answer to your question, the HIPPA itself talks about a designated record set, which is also far broader than core data for interoperability. So, it's another reason to be thinking more broadly.

John Kansky – Indiana Health Information Exchange – Co-Chair
David McCallie, you have your hand up. And then if we're reaching some potential compromise, we'll try and move on. But David, what have you got?

David McCallie – Individual – Public Member
Sorry about that, I was muted. I want to make this clear when I say this is tied to USCDI, I'm also saying expand USCDI at a faster pace than is currently promised. So, I'm certainly not saying that we share less information. I'm saying that we should share information, at least the things that are mediated through APIs, which is a requirement of the NCRM, those things should be shared in a standard based way. And expand the standard faster than requiring everybody to dump unparcelled records on to a network that would both be performance wise, completely unattainable, and useless or near useless to the receiver.

So, expand USCDI is part of the pitch here. It's not a fallback, it's just put the energy of the developers on implementing standards-based exchange rather than dumping out data that fewer people will find useful. So, I like the spirit of where we're trying to go, as much data as possible, just do it through USCDI expansion.

John Kansky – Indiana Health Information Exchange – Co-Chair
That's much better than what I said, thank you.

Okay, with that, if we could scroll up to recommendation 3-A and 3-B. Or scroll down, I guess. Sorry. So, shifting gears to the applicable law section, what we need here is some specific examples that we can offer to ONC. I've had several conversations last week and over the weekend about why is there a

need to align with HIPPA? Where is their misalignment or potential misalignment with HIPPA? And so, in order for us to communicate, let's start with recommendation 3-A, where we're saying align TEFCA privacy and security obligations with HIPAA privacy and security obligations, what one, two, or three examples can we offer ONC to make our point?

Arien Malec – Change Healthcare – Co-Chair
John, I have my hand raised.

John Kansky – Indiana Health Information Exchange – Co-Chair
Oh, please.

David McCallie – Individual – Public Member
This is David, too.

Arien Malec – Change Healthcare – Co-Chair
I was involved in some of the same twitter mediated discussion as you, and I think it helped clarify the key point.

So, point number one is in areas where the TEFCA intentionally repeats several HIPAA obligations to address the needs of non-covered entity, non-VAA participants in TEFCA. And in those areas where the TEFCA repeats elements or obligations are already existing in HIPAA, then I think we recommend that we want to ensure, and we make this comment. Otherwise, we want to make the supply only to the participants that to whom these obligations don't already apply.

Because otherwise, you are basically doing all the hard work twice, once for HIPAA obligations and your VAA obligations. And then a second time for the TEFCA obligations and addressing MRTCs. And that seems redundant and a waste.

And there are a set of obligations that go beyond HIPAA. And we enumerated some of them. The requirement for meaningful choice, for example, goes above and beyond HIPAA obligations. There are some specific obligations relative to the placement of data centers in the United States that go above and beyond the risk-based framework that is established for security under HIPPA.

And those are the examples where we wish the MRTCs to be very clear that these are extra HIPAA obligations that apply to exist covered entities or BAs, and our new and novel obligations for those actors.

John Kansky – Indiana Health Information Exchange – Co-Chair
We will go on to David and Noam next, but let me make sure we captured, Arien, your comments. You are suggesting that there are repeated obligations we want to be clear should apply, but should apply to noncovered entities and nonbusiness associates, and that's a good thing.

But also, calling out examples of obligations such as meaningful choice and no data outside the U.S., that apply to both covered entities, business associates, and none of the above. And we are just calling those out as having the alignment. Is that what you're saying?

Arien Malec – Change Healthcare – Co-Chair

That's right. And one more to that, which is it's a good thing that we applied HIPAA obligations to non-HIPAA actors. We also want to ensure that the obligations are not duplicatable placed on existing HIPAA actors because they're already applying.

John Kansky – Indiana Health Information Exchange – Co-Chair
They're already there.

Arien Malec – Change Healthcare – Co-Chair
Yes, they're already there.

John Kansky – Indiana Health Information Exchange – Co-Chair
Okay, thank you. David, you're next, and then Noam.

David McCallie – Individual – Public Member
Yes, I agree completely with what Arien said eloquently. I think part of the problem that we ran into or are running into is the way that recommendation 3-A is phrased. We're saying they should align it with HIPPA. I think what we're really saying is clarify how it's aligned with HIPPA and clarify where there appears to be redundancy.

So clearly HIPPA is still the law of the land. It hasn't changed, and TEFCA doesn't change it. So, clarify how participation in TEFCA aligns with HIPPA. And then in those places where new entities not covered by HIPPA are pulled into TEFCA, clarify what their obligations are independent of HIPPA since they're too covered by HIPPA. So, it's clarified how it's aligned, rather than realign it, in my opinion.

John Kansky – Indiana Health Information Exchange – Co-Chair
Thank you. Noam?

Noam Arzt – HLN Consulting, LLC – Public Member
I would support what David just said. The only point that I would make is that I think it's important also not to allow affirmative exclusions that are in HIPAA to somehow get lost. So, there is a public health exclusion for public health activity, and not for public health acting as a healthcare provider. Then public health agents would be a healthcare provider.

But there are public health inclusions, I think it's important that nothing herein why or worse states, that's affirmative exclusions are somehow to be lost.

Zoe Barber – Office of the National Coordinator for Health Information Technology – Staff Lead
This is Zoe, and I just wanted to clarify one thing about what Noam said. So, throughout the TEFCA document where we refer to applicable law, I think that is the intention, with all those references, is to ensure that nothing does get lost such as those public health exclusions. So, I wonder, is there a way, are you guys suggesting that we just sort of being clearer about that? And build that out in some sort of guidance more?

Noam Arzt – HLN Consulting, LLC – Public Member
My only point is that as I read this, TEFCA is appropriately invoking applicable law, which is fine, and which is right. But then suggesting to, for instance, in the area of consumer access applications, push beyond existing law by making new entities subject to HIPPA where they otherwise aren't. So, I just don't want there to be any ambiguity that in pushing HIPPA security provisions beyond current law,

those other things aren't pushed beyond current law as well. Or there is no indication that current law is being changed somehow, right? Because one could interpret pushing HIPPA on consumer access participants as going beyond current law.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, I guess one might say we are asking that doubt be removed.

Noam Arzt – HLN Consulting, LLC – Public Member
Yes.

David McCallie – Individual – Public Member
This is David. A footnote on that, the places where entities are participating in TEFCA that are not currently covered entities, we have to be clear about what HIPAA requirements are placed on them. You cannot just say, do what HIPAA does because that is too broad. If you are an IAS QHIN and you are not a covered entity, therefore what exactly are the obligations that are analogous to HIPAA, and which parts of HIPPA are irrelevant to you. Does that make sense?

Noam Arzt – HLN Consulting, LLC – Public Member
Yes, and I think this likely applies more to flow down terms to participants, right? At least that as it stands now, a QUIN, because it has to do sort of everything, likely would at least be a BAA of covered entities, just as a byproduct of the stuff it's got to do, right?

Arien Malec – Change Healthcare – Co-Chair
One additional point here, just as another example because I think we're going to discuss the consumer access provisions. Is that meaningful choice, under current law, regardless of meaningful choice, there is an obligation to push data to public health. Under these provisions, there would be, in fact, an obligation not to.

Sasha TarMaat – Epic – Member
But was that the intent?

Arien Malec – Change Healthcare – Co-Chair
Right. And that's the area where think we need clarity as to which provisions do and don't apply.

John Kansky – Indiana Health Information Exchange – Co-Chair
Before we leave this one, I heard some great comments and new nuance that I think will probably reshape our framing of both recommendation 3-A and 3-B, since 3-A basically said, hey, ONC, harmonize with HIPPA whenever you can. And by the way, 3-B says, when you can't, please hit us over the head. Well, I think the discussion we just had had some new points and some nuance. And it also had a couple of examples that we specifically asked for. One being meaningful choice and ways it goes above and beyond HIPPA. And then the data in the U.S. only. Before we go on, are there any other favorite examples that we should add to that list for the ONC? And I see Arien has his hand raised.

Arien Malec – Change Healthcare – Co-Chair
No, that's duplicative.

John Kansky – Indiana Health Information Exchange – Co-Chair
Oh, that's left over.

David McCallie – Individual – Public Member
There was the example of prohibitions about offshore data. I don't think that's in HIPPA so that might be an example.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. We have that one. Meaningful choice and no data outside the U.S. Are there anything else in the security provision that gave people heartburn as wow, that's new. And not only am I going to have to figure out how to do that, but put it in all my flow downs that are based on HIPPA, for example?

David McCallie – Individual – Public Member
What about the authentication, authorization, IL-2A. That goes beyond HIPPA, I believe. Maybe it's addressable.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. I think those are a couple. Identity proofing and authentication.

Arien Malec – Change Healthcare – Co-Chair
Yes, I think not correct to say it goes beyond HIPAA, but it is a more specific requirement.

John Kansky – Indiana Health Information Exchange – Co-Chairxyz
Yes. It's doesn't just defer to HIPPA. It starts saying things that are different than HIPPA. And maybe that's a much better way to capture it. This is what we need to capture in our comment. Is that it's not so much we're suggesting that the TEFCA draft says to go beyond HIPPA, it's that when it doesn't say if you're HIPPA compliant you're good, creates doubt that people need to figure out how to comply with.

All right. Moving on. I'm sorry, Denise has her hand up.

Denise Webb – Individual – Member
Yes. I want to reinforce I think on the meaningful choice we need to be crystal clear about the fact that while an individual might have meaningful choice, it does not include data flowing to public health. We need to come right out and say that, that is not intended to override the law that's in HIPAA regarding public health.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, it's a specific example. Yes, I think that's extremely helpful.

Denise Webb – Individual – Member
Yes, because for instance, in daric surveillance data, or a report on communicable disease, those kinds of things, it doesn't matter what the patient thinks about whether they want to share that information or not. That information has to flow to public health.

John Kansky – Indiana Health Information Exchange – Co-Chair
Thank you. That enhances the quality of our recommendations.

David McCallie – Individual – Public Member

I will put a footnote, just I'm jumping in here. But that data has to flow. It's the law, the law is not be changed, but may not have to flow through TEFCA. Those are separate concerns. It may turn out TEFCA is a great way for that data to flow. But all of it flows today without TEFCA.

John Kansky – Indiana Health Information Exchange – Co-Chair
Good point. But it doesn't detract anything from our recommendation that it should be clear if an individual exercises meaningful choice, what is that supposed to turn on or off? I cannot literally hear Zoe, but I can hear the Zoe that's in my head suggesting what you said that the law says it's supposed to flow. It's should flow, we're not changing that. So again, we're just asking to remove doubt.

Arien Malec – Change Healthcare – Co-Chair
I'm going to do time cop because I think we have an appropriate set of recommendations here and we have a lot of controversial items to go through.

John Kansky – Indiana Health Information Exchange – Co-Chair
Fair point. Noam, do you have a quick comment you could sneak in there?

Noam Arzt – HLN Consulting, LLC – Public Member
Yes, I guess a question. In listing out these issues, you have sort of used meaningful choice sort of as one of the items where. Are you using that as a euphemism for consumer access?

Arien Malec – Change Healthcare – Co-Chair
No.

John Kansky – Indiana Health Information Exchange – Co-Chair
No, the meaningful choice is a defined term in TEFCA II.

Noam Arzt – HLN Consulting, LLC – Public Member
Okay, but as I read on Page 16, where it talks about the common agreement and HIPPA, in that third paragraph, it is talking much broadly about applying HIPPA to entities who are to be part of the exchange. And they specifically mention exactly Smartphone app developers. So, it's sort of being consumer access app developers. It's talking out extending HIPPA to them. Well, that's not a meaningful choice. I mean, that's a much broader thing. I don't hear us talking about that.

Arien Malec – Change Healthcare – Co-Chair
Noam, just to be clear, there are two issues. 1.) Is as you know, the application of HIPPA to noncovered entities, and to the extent that there are unintended consequences about that application or specific actors to whom the HIPPA obligations don't apply. That needs to be clear. The second is that there are a set of extra HIPPA obligations, including meaningful choice, that also would apply to all actors. And again, there may be cases where, and we've talked about public health. There may be cases where those obligations aren't appropriate, and the discussion of applicable law doesn't really cover or clarify the concerning those extra HIPPA obligations as well.

That clarifies the conundrum. There are two issues, HIPAA application to noncovered entities which may be appropriate for many noncovered entities. But in the case of public health, or research, other examples, may not be appropriate. The second is extra HIPPA obligations that are applied to all parties. And there may be some parties to whom those obligations are also not appropriate.

Noam Arzt – HLN Consulting, LLC – Public Member
So, is the first one of those supposed to be covered in 3-A and the second one of those in 3-B?

John Kansky – Indiana Health Information Exchange – Co-Chair
No. We will redraft those based on the conversation. I think you can essentially throw out 3-A and 3-B as too simplistic. And we will reframe this discussion around Arien's reframing.

Denise Webb – Individual – Member
Arien, you're also confusing the term extra HIPPA obligations. I think that muddies the water. Aren't they really extra privacy and security obligations that go beyond HIPPA.

Arien Malec – Change Healthcare – Co-Chair
Yes. That's what I mean as extra HIPPA. I mean outside of. I'm using extra in a technical sense as outside of HIPPA or beyond HIPPA.

Denise Webb – Individual – Member
Okay. But it doesn't come across that way.

Arien Malec – Change Healthcare – Co-Chair
Okay. I apologize for that use of language.

Denise Webb – Individual – Member
Because other people that hear that are thinking, oh, so those are things that have been added to HIPPA.

Arien Malec – Change Healthcare – Co-Chair
No, thank you for that.

Noam Arzt – HLN Consulting, LLC – Public Member
If it is not related to HIPAA, t shouldn't refer to HIPAA. It's just other stuff.

John Kansky – Indiana Health Information Exchange – Co-Chair
Correct.

Denise Webb – Individual – Member
Above and beyond.

John Kansky – Indiana Health Information Exchange – Co-Chair
But we will be careful with our language, and if we're not careful enough, you guys will tell us next time.

Arien Malec – Change Healthcare – Co-Chair
Absolutely. Again, I think Mark wants to get a comment in, but I also am feeling the time slipping.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
So, it's not on this particular topic, it may be going back. It's something I wrote in the comment box, and so I said bring it up. Want me to go forward?

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes, go.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
So, before the presentation of the HITAC meeting, we flagged a question to discuss alignment between TEFCA and the API provisions of the interoperability rule. And I was searching and didn't find them. Zoe says that's been taken out as being out of scope or at least in the very broad articulation of it in the comment box. And I just wanted to check in on that. It doesn't seem out of scope to me the way we were originally discussing it. Maybe there was a conversation at the meeting I missed on Thursday for which I apologize.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, Mark, I see what you mean about going back. Let's put that on the list of as soon as we get done with the stuff that's called out in the comments, that if not this call, then in the one, we will address that specifically. And as a matter of fact, it's your, and my dialog in the comments is where we're going next on scrolling up to recommendation four.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
Okay, thank you.

John Kansky – Indiana Health Information Exchange – Co-Chair
Scrolling down again. I have to get my ups and downs right. Okay. So, recommendation four is we are offering some suggestions, again, trying to be specific to help ONC understand what we are trying to relate. We're offering tactics in which they could consider to offer the latitude they could offer the RCE to avoid or minimize disruption with existing health information network and health information exchange participation agreements.

And the third, I believe this is the David McCallie memorial tactic, which is giving the RCE latitude concerning QHINs and QHINs concerning participants, to agree to a bootstrapping period. So, this would be a, okay, I understand you have some difficult changes to make to your participation agreements, and it will take you a while. Let's agree that under the following – I'm giving you Kansky's vision of what this would feel like, and others might not be thinking about this the same way.

But the way I was thinking about this was, so the RCE would agree with a QHIN candidate, hey, you've got 300 participants that need to sign your amended agreement, and we know it will take a while. So, for now, you are in. We have agreed to what specifically what terms you need to get changed in your agreement. And we've agreed to a period under which you will do that.

So, no one has deemed that to be irrational. However, and putting Mark on the spot and myself on the spot, we're having a common dialogue. I believe Mark you can speak to your questions, but one of them was let's be clear, does that mean that while the new contracts are being signed, the terms that are going to be in that agreement applies. That's number one.

And then, number two is why don't we specify a period for this period. And I feel more strongly about the latter than the former. My opinion on the latter was part of what I liked about the suggestion was giving the RCE the latitude to be able to say, it's not that hard. Your network is not that big. You get six months. That guy over there will get 12 because he has more terms. It's giving them the ability to agree

to that period, I thought it was an asset. But that's just Kansky's opinion. All right. With that, we have Denise and then David.

Denise Webb – Individual – Member
Actually, I don't have my hand up.

John Kansky – Indiana Health Information Exchange – Co-Chair
Okay, it's almost over. Thank you. David is that an actual hand?

David McCallie – Individual – Public Member
Yes, it is. Although, that doesn't necessarily mean my brain is engaged in having a coherent thought. But I'll give it a shot. I think the bootstrap notion needs to be paired with some kind of lowest common denominator notion. Which is to say, that TEFCA in its evolving birthing, and as it starts to grow, could conceivably allow existing networks to meet some minimum standards, a lowest common denominator of exchange, as it ratchets up the bar up over time.

You might have, for example, just to pick out of the air, something like a common well or care quality, which has robust exchange underway today but do not have any kind of widespread consumer access. I think they have to use cases that allow for that, but it is not actually happening at many scales. You wouldn't tell them you cannot join us until you prove you have widespread consumer access. Let them join, start the process of building a TEFCA while you set a timetable for the additional requirement. It's the lowest common denominator and a bootstrap. Any exchange that is happening is following the law. So, they are all HIPAA compliant exchanges. That doesn't change. So, it's really, how can you bootstrap TEFCA starting with what is already happening in a way that doesn't spook the potential QHIN to saying we don't want to join basically.

John Kansky – Indiana Health Information Exchange – Co-Chair
It's helpful. If I understand, I think you are mixing two things together, both of which are good points. One is contractual terms that need to be changed to participation agreements or amended to participation agreements. And the other is actual capabilities that may or may not be ready. That latter point I think will come up, and I forget the actual recommendation number, but where we are entering specialized QHINS, there is also a new comment about specialized participants, which I think gets to your example of IAS. So, I would encourage us to keep those things distinct.

David McCallie – Individual – Public Member
Yes. That's a great point. I think they will get tied together because the terms that get added will typically be requirements around supplying those kinds of additional services. So, they pretty cohere together, but they are separate technically. The terms and the agreements, and then the new functions.

John Kansky – Indiana Health Information Exchange – Co-Chair
I'm cheating a little bit, because I formed a new stronger opinion over the weekend, that I think one of the best things that ONC could do to encourage participation in TEFCA is in specialized participants, allowing participants not to do all exchange purposes at least not immediately. But I'm cheating and getting that in the head. Denise, can someone lower her hand unless that's a real hand raise? I think Mark Savage is next.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member

The one thing I would add to what I hadn't put in the comment box, is that a pretty broadly worded bullet point. And I think what we would be willing to do, what kind of discussion we would be willing to extend to the RCI probably varies with what the terms are. So, if it were, for example, an applicable law term or a HIPPA requirement or something like that, I don't think we would want the RCE to be giving somebody a period for a pass on things like that.

So, I just want to flag that we are working this is an all-inclusive recommendation, but even for those who want this recommendation, it may depend on the particular terms is. I will now sort of repeat my original understanding, which maybe it was wrong. We were talking about providing the attorneys some time to get the contract amended, and which will be separate from the capability question. And so, the comment I put is what happens while we are going through the process of just getting the contract amended? And I pointed out that in the interoperability rule, for the information blocking requirements there, the term applies even while you're amending the contract, and I was suggesting the same here.

John Kansky – Indiana Health Information Exchange – Co-Chair
Thank you. Noam has his hand raised. Let me sneak in a quick comment because I think it's relevant. But I want to point out the last three words above the colon, ahead of these three bullet points are such means as. Which is to say that I think we're implying to ONC, hey we know it's unhelpful just to tell you, hey, don't disrupt contracts without offering some ideas on what would be less disruptive.

So, we're trying, in my view, we're giving them examples of, hey, we don't know what it's like to be ONC only you guys do. But here's three things we thought of. Why don't you put that in your consideration in a way those that seem the most practical?

So not the intention to say here are three things we're telling you we believe you should do. We're trying to offer specific, concrete tactics that they could employ. And we should obviously make those as accurate and complete as we can. With that, Noam?

Noam Arzt – HLN Consulting, LLC – Public Member
Yes. I'm a little puzzled by part of this conversation, the TEFCA draft that we are looking at introduces the notion of a provisional QHIN. I'm curious why that has not entered into this recommendation? We are talking about this weird period, a provisional QHIN has signed the common agreement, but has not gotten all the ducks in order. Why doesn't that concept apply?

John Kansky – Indiana Health Information Exchange – Co-Chair
I think it does. My again, I'm not the authority, but my reading of provisional was you send in the application, everything seems to be in order, you sign the common agreement, everything seems to be in order, now you're in the provisional period, we will see. As opposed to hearing some tactics.

Again, I don't pretend to know what, in the cooperative agreement that the ONC will enter into with the RCE, how much latitude will be afforded the RCE on topics like this. So, I think what we're trying to do is to back up our recommendation that they should strive to be not disruptive of existing participation agreements. We are trying to offer some tactical suggestions.

As to your point, they may be exactly the kind of, they may be exactly the kind of tactics that they will employ during that provisional period. We are just trying to be specific.

Arien Malec – Change Healthcare – Co-Chair
My reading of the provisional concept is that you are not exchanging data under the TEFCA while you are a provisional QHIN. And I think we are suggesting may be a time where you are testing and using TEFCA and exchanging data before you have mapped all of your existing terms to the MRTCs.

Noam Arzt – HLN Consulting, LLC – Public Member
And I guess, my feeling is as mature as a participant might be, you are either complying, or you are not. If it takes you six months or 12 months to get your agreement in shape, to me, you are still provisional. But you're saying provisional would be nonparticipating. I would have to go back and read that and see if that is really the case.

John Kansky – Indiana Health Information Exchange – Co-Chair
And I think we're – I'm sorry, is someone trying to get in there? I think there is something even perhaps more liberal that we are suggesting here. Because in the last bullet if you read it as QHINs for participants, there is no such thing as a provisional participant, at least not defined in TEFCA 2. So, we are suggesting that to make TEFCA a more adaptable thing and to optimize your participation sooner, we suggest that this latitude is a good thing towards that end.

Now, we have found a way where we say that and where there is an agreement of the task force. If we think about the example which is arguably a little harder for those who want things to be binary and crisp, we are suggesting giving QHINs the latitude with their participants to agree to bootstrap as well. And David McCallie has his hand raised.

David McCallie – Individual – Public Member
Yes. When I'm talking about bootstrapping, it would be really more about which of the minimum required terms and conditions you have actually to meet. Or maybe put in a better way, which uses cases of exchange are you required to support? I would suggest that the network be allowed to come alive supporting a limited subset of use cases and a limited subset of the minimum required terms and conditions, if that makes sense, as a way to pull in existing networks. So, it's a step-by-step set of requirements before you get to the full, everybody does everything completely compliant with the MRTCs.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. I was thinking about that the same way you were suggesting, David. And now we're pushing together contract terms with capabilities. And I am bringing capability potentially into this recommendation, that does not speak to that nuance as it is written. So, let me ask the task force what the reaction to that is because I hear some voices that are saying, you are not a QHIN until you check all the boxes legal and capability wise. And you're not a participant until you do the same. And what I think we are trying to suggest is, is there a way, in the interest of gaining more participation sooner, to use tactics to allow participants, as well as QHINs, to spin up? Whether that be related to contract terms and getting a participant agreement signed, or whether it is somebody is saying, hey, Man, I could do everything on this list except IAS it needs some time. Or I can do IAS and everything else on this list, but I cannot do message delivery. I need some time. Are we going to tell them sorry until you cannot be in? Or are we going to give the RCE and the QHIN some latitude? Okay, I have Noam and then Sasha.

Noam Arzt – HLN Consulting, LLC – Public Member

Look, I appreciate all of it, it's just a really slippery slope. Isn't it? You have a responsibility to be transparent, I'm sorry. The RCE has a responsibility to be transparent. Has a responsibility to be fair. And yet, somehow perhaps that has to be balanced with some bootstrapping of attitude. But it's just a real slippery slope. If it gets perceived that the big boys are being given a lot more latitude than the little boys, that can be problematic from a fairness standpoint.

Maybe it's unrealistic from the start, that we only have not it QHIN, QHIN. Maybe we need to look at this notion of provisional QHIN, and maybe it should crossover the line, and if you are provisional, you are allowed to start up. I mean that is the whole point.

John Kansky – Indiana Health Information Exchange – Co-Chair
We are adding it inclined to the slope, and with her become slippery or not, I acknowledge that we are tempting that possibility by suggesting a tactic that could increase participation. Sasha?

Sasha TarMaat – Epic – Member
So, I certainly strongly favor making participation in alignment with existing networks, and not interrupting exchange networks as they join TEFCA. But I'm trying to understand, and maybe in the pursuit of that goal, what happens if they are not able to do it? So, a health information network becomes a TEFCA participant with an agreement that within 12 months, they would enforce new terms on the participants. Then they have 10 healthcare organizations that want to participate. One of their healthcare organizations doesn't want to sign the terms. Is the whole QHIN then out because the one org would not sign? Or with the health information network have to eject that member from their own participation because they wouldn't adopt the new terms?

I don't want to, in the goal of allowing additional time for contracting, which I support as being time-consuming and a barrier if the MRTCs have to be incorporated into flow down participant agreements. But I also don't want to put networks and their existing participants into an untenable position that way.

John Kansky – Indiana Health Information Exchange – Co-Chair
You make a good point. My response and I'm not going to be running the RCE, nor am I going to be working at ONC, my response would be you're right. That's a problem. And I think it could be managed, by, for example, the QHIN saying, okay, participant, you did not meet your goals, so you are out until you do. Come back when you are ready. That does put some folks in a bad position. But let's face it, implementing this whole TEFCA thing is going to be hard any way you slice it, but your point is well made.

Arien Malec – Change Healthcare – Co-Chair
Just on that topic. I would assume that that participant or participant member could still participate in the HIN but would not be able to participate via TEFCA mediated exchange.

David McCallie – Individual – Public Member
Right. This is David. That's how I would see that. TEFCA is voluntary, and it's not going to be the only way exchange occurs. If someone doesn't want to participate in TEFCA, they have to find other ways to do the exchange, nothing stops them from doing that.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member

But that might put a pretty big burden on the HINs to sort of now sift out and figure out who's communication is TEFCA approved and who's isn't.

David McCallie – Individual – Public Member
And they may choose not to do that. They may not and kick somebody out. That person would then have to go find another HIN since it's not mandatory.

John Kansky – Indiana Health Information Exchange – Co-Chair
In the interest of trying to find a solution to this conundrum, let me turn things to a significantly different angle. Who would object to the deletion of the third tactical suggestion given we have two others that no one is upset about? Or who can suggest a less controversial reframing? For example, I think Mark Savage might be happier if it says if it was specifically limited to contract terms, and they were in place while documents are being signed. And Kansky would be slightly happier if we didn't specify the period, which it doesn't, or we could delete the whole thing. Mark Savage.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
Yes, there's another option, which is to keep the issue flagged and just add the point that ONC should provide guidance in the final rule. You don't have to delete that instead of call that out and says, this decision needs to be addressed.

John Kansky – Indiana Health Information Exchange – Co-Chair
Thank you.

Arien Malec – Change Healthcare – Co-Chair
Punt the hard work to ONC.

John Kansky – Indiana Health Information Exchange – Co-Chair
Say again, Arien?

Arien Malec – Change Healthcare – Co-Chair
Punt the hard work to ONC.

John Kansky – Indiana Health Information Exchange – Co-Chair
Well, and admittedly, we are trying to give them suggestions. So, we can leave this in some form as is and they can choose to ignore it because they don't like it and it's hard. David and then Noam.

David McCallie – Individual – Public Member
It does raise these kinds of questions and the notion of bootstrapping and timetables or bootstrapping and anointing to be qualified or not qualified, provisional, and not provisional. It raises a whole bunch of questions that have not seen addressed in any detail about RCE governance. To what degree is the RCE empowered to make these decisions, and what is the governance process to make those decisions? If you gave the RCE of bootstrapping capability and said, you can set a set of terms and conditions and use cases that are not the full suite envisions use cases. But you can decide when to how to escalate those, is that allowed under the current structure of how the RCE works?

I know that may be way off topic, but in some cases, this is where this is going to devolve to is arguments within the governing process of the RCE.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, in the interest of moving on, where is taking notes for the ONC, please suggest maybe softening this tactic and making reference to RCE governance as a check and balance. But I think the easiest thing might be to depilate a little bit this particular suggested tactic, which is all it is. ONC with the RCE can take it or leave it and then rip on it as they would choose.

We have about five minutes until public comment, and so if we could move down to recommendation five. And the nice thing here is, again, we are just looking for an example or examples to back up our recommendation. This we have called out that there is a misalignment between the diagram or diagrams in the QTF and the MRTCs. But there is some mystery about exactly what we mean. And so, anyone who has observed this misalignment, can we get specific and offer at least one example. I believe there are three figures and seven tables in the QTF. And I didn't know which one we could or shouldn't view as misalignment.

I'm leaving some time because I assume you are all furiously leafing through your QTF.

David McCallie – Individual – Public Member
I think our general recommendation is that technical details should not be in the minimum terms and conditions, and therefore, alignment should be less of an issue. It's not an issue.

John Kansky – Indiana Health Information Exchange – Co-Chair
And we do make that general comment consistent with that theme in a couple of places throughout. Again, having read this so many times now, I have come to appreciate the need for our recommendations to be meaningful and achieve the desired goal. If we say, ONC, don't put so much specific stuff here, or in the QTS, they are not going to know what we mean by that.

So, there is a comment coming up later on in the document that calls the question, so are we recommending that there should be no QTF draft? Let's wait until we get to that one. But the theme is definitively here, and it's the very next thing we need to discuss in recommendation seven.

So, let me do this. I'm trying to be somewhat aggressive n getting through this. Should we delete recommendation five? Because it really refers specifically to descriptions and diagrams and misalignment that I don't know we can point to. We will take up the issue of how specific the QTF should be in the very next recommendation.

David McCallie – Individual – Public Member
I think that's a great idea. I like that.

John Kansky – Indiana Health Information Exchange – Co-Chair
Okay, one vote in favor.

Mark Savage – UCSF Center for Digital Health Innovation – Public Member
John, it's Mark. It's an obvious point, you do want it aligned. Should we just leave that in the narrative and not call that out as a separate recommendation? It reflects that we've seen some misalignment, even if we don't want to take the time to point to examples. But I don't feel strongly about it.

John Kansky – Indiana Health Information Exchange – Co-Chair

Okay. We will consider that possibility. The thing I'm getting stuck on is the fact that that recommendation five refers to diagrams in the QTF that misalign. And if we cannot point to an example, I don't think that we should have it in there.

Noam Arzt – HLN Consulting, LLC – Public Member
So, whatever you do with recommendation five, consider at least the sentence right above it. That is the lead into it.

John Kansky – Indiana Health Information Exchange – Co-Chair
Correct.

Noam Arzt – HLN Consulting, LLC – Public Member
So, in fact, one compromise between smoothing this is to actually leave the recommendation, whether as a recommendation or just as intro material. But strike the sentence above. I mean it's the sentence above that's a little more pointed at begging examples. The recommendation is not so much, begging for examples.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes. The specific diagram is figure 1 sequence diagram for the query, on Page 81.

David McCallie – Individual – Public Member
Yes. And what about it is inconsistent with the MRTCs?

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes, I guess you could actually read it. In alignment it's the combination for XCA and XCPD are generally deployed. That may be created confusion in some of our heads.

David McCallie – Individual – Public Member
I think something like that would be a perfectly fine way to communicate a functional requirement, but it should not be taken as a technical sequence diagram. Maybe that is where some of the confusion comes from.

Arien Malec – Change Healthcare – Co-Chair
Right. It sort of Implies the queries are passed on to the first-degree entity. As opposed to noting that the functional requirement is that the QHIN can figure out which members may or may not have the data and may not pass on the query to those participant members because they may have a document repository. So, there is a lot of assumptions in terms of the deployment model and configuration model that are embedded in figure one.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, Arien, are you lobbying for saving, salvaging the recommendation five?

Arien Malec – Change Healthcare – Co-Chair
I think combing the two recommendations, and I like the suggestion of using our narrative and finding a section to convey some of the nuances here as opposed to putting them in the recommendations themselves.

John Kansky – Indiana Health Information Exchange – Co-Chair

And with witnesses can I put you on the spot to bring in your explanation of the problems with the diagram and the bullets underneath it?

Arien Malec – Change Healthcare – Co-Chair
Yes.

John Kansky – Indiana Health Information Exchange – Co-Chair
Okay. With that, we are 90 seconds late for public comment. If we could go there now, please?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Thanks, John. Operator, can we open the line?

Operator
If you would like to make a public comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star two if you would like to move your comment from the queue. 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
Then you, operator. Do we have any comments?

Operator
Not at this time.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay, John back to you with eight minutes.

John Kansky – Indiana Health Information Exchange – Co-Chair
Thank you. Let's make good use of time. So, we believe we are going to combine recommendation five with six, and we are now on six. Here was my reading and again, having had time to reread and rethink, we seem to be saying that we don't like some of the things in the QTF, and they should not be so specific. But ONC has been clear and clarified on previous calls that the QTF was supposed to be an attempt at giving the RCE a starting point.

So, with that view in mind, are we still saying, to be slightly provocative, my version was should the recommendation be ONC, take the QTF out entirely if that's your intent, and let the RCE start with a blank sheet of paper. And if not, should we be removing the recommendation. My reading of the recommendation as written as it seems like either it is not worth making or are, we suggesting that this should allow the RCE to start with a blank sheet?

David McCallie – Individual – Public Member
I favor taking it out. Translating the important policies and/or functional constraints into a nontechnical language such that you can remove the QTF. And if you mess those policies to clear success regardless of the technical means, by which the industry met the requirements and policy goals. I think it adds confusion to have very specific stuff in there that in some cases is incomplete and

wrong and maybe out of sync where the industry is. Just define what the thing has to do and what the policy goals are that are driving that, and then let the RCE figure that out.

If the goal is to have networks up and to run fast, that could be a clear policy goal. Obviously, they will reuse existing network technology and have some evolution over time to expand that. That should be the determination by the RCE. I say, take it out.

John Kansky – Indiana Health Information Exchange – Co-Chair
So, when you say take it out, you mean the QTF, not the recommendation six?

David McCallie – Individual – Public Member
Yes, well, I would say our recommendation should be that QTF should not be a part of this document, the TEFCA approach. The requirements that are captured should be translated into functional requirements in the context of the policy goals. That should be the endpoint of what is handed off to the RCE.

John Kansky – Indiana Health Information Exchange – Co-Chair
You are saying the QTF should be a QFF. And other than that, stay away from the technical specs or at least take them out of TEFT. And the ONC and now I'm just going a bit too far to make the point. If the ONC wants to take the QTF and still give it to the selected RCE and say, here's what we were thinking if this helps you get started, that's perfectly okay. Why does it need to be in TEFT?

David McCallie – Individual – Public Member
Yes, agreed.

Arien Malec – Change Healthcare – Co-Chair
And this is Arien, I would just add to David's excellent point, that the RCI and the initial perspective QHINs are presumed to be already doing this work in practice. So, we will not be starting, as it were, from a blank slate.

I think as we discovered, the QTF, though it biases the discussion, an important discussion about how to harmonize between old and new ways of doing things and harmonizing between ways that people have already enabled exchange. And it confuses the issues in some cases because of the specificity of the implementation guides.

So, I actually really like the idea of an OFF. And the world does need one more acronym in the TEFCA, so I really endorse that notion.

John Kansky – Indiana Health Information Exchange – Co-Chair
Since we're taking one out, it's a conservation of acronyms.

Arien Malec – Change Healthcare – Co-Chair
Exactly.

John Kansky – Indiana Health Information Exchange – Co-Chair
We have 90 seconds left. We have left off, the next thing for the next call would be picking up at recommendation 8-A and B. Are there any final comments, notes we need on next steps, or suggestions from the ONC? Lauren, Zoe, are we good? Go ahead, David.

David McCallie – Individual – Public Member
If we get an agreement on all these things, we can be BFFs.

John Kansky – Indiana Health Information Exchange – Co-Chair
You mean we're not already.

Noam Arzt – HLN Consulting, LLC – Public Member
Sorry, just one quick comment. Where we're ending on recommendation six was actually a pretty powerful change. Can we perhaps begin the next call just reviewing this one more time to make sure we're clear on what we all think on maybe we agreed to? Because it's pretty fundamental to this.

David McCallie – Individual – Public Member
Agreed.

John Kansky – Indiana Health Information Exchange – Co-Chair
Yes, I think that's a good suggestion. And whether we want it to be or not, this will not be our last pass through these recommendations. But I think restarting with that 5/6 is a good idea. Thank you. Lauren, Zoe?

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Yes, our next call is Wednesday from 1:00 Eastern to 2:30. So we will start off where we are leaving off today, and yeah, I think that's everything.

John Kansky – Indiana Health Information Exchange – Co-Chair
All right. Thanks, everyone for their time and engagement that was great. Appreciate it.