Information Blocking (IB) Workgroup 1

Transcript
April 3, 2019
Virtual Meeting

SPEAKERS

Name	Organization	Title
Michael Adcock	Individual	Co-Chair
Andrew Truscott	Accenture	Co-Chair
Cynthia A. Fisher	WaterRev LLC	Member
Valerie Grey	New York eHealth Collaborative	Member
Anil K. Jain	IBM Watson Health	Member
John Kansky	Indiana Health Information Exchange	Member
Steven Lane	Sutter Health	Member
Arien Malec	Change Healthcare	Member
Denni McColm	Citizens Memorial Healthcare	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Sasha TerMaat	Epic	Member
Lauren Thompson	DoD/VA Interagency Program Office	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Denise Webb	Individual	Member
Mark Knee	Office of the National Coordinator	Staff Lead
Penelope Hughes	Office of the National Coordinator	SME

Operator
All lines are now bridged

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good afternoon, everyone. Welcome to Work Group 1 of the Information Blocking Task Force. A quick roll call and we'll just right into it. Andy Truscott?

Andrew Truscott – Accenture – Co-Chair
Present.

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

Michael Adcock – Individual – Co-Chair
Here.

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

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
Here.

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

John Kansky – Indiana Health Information Exchange - Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And Denni McColm? Cynthia Fisher?

Cynthia Fisher – WaterRev LLC - Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Okay. I will turn it over to Michael to get us started. Are you on mute?

Michael Adcock – Individual – Co-Chair

I was, yes. And I was having a great conversation with myself very much. Good morning. I'm going to say good morning because it's morning where I am. And I hope that everyone is doing well. thank you all for joining. I know it's been a while since we have had a work group call. The purpose of that was so that we could focus on getting some of this work done in the document so that we can get to a point where we have some solid recommendations on our portion of this under Work Group 1. I'm not going to waste a bunch of time with this. We're going to jump right into the work. We're going to try to cover HINs and HIEs today, get to health IT developer of certified health IT and then, move to public comment. So, if we could go ahead, Mark, and pull over the Google Docs. Thank you.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Yeah, can you see it?

Cynthia Fisher – WaterRev LLC - Member

Mike, could I just ask, I thought when we started the call, there was this idea that we were going to work on price transparency today or maybe I'm confused with what the goal was. Or is there another day that we were doing on price transparency –

Michael Adcock – Individual – Co-Chair

No, Cynthia, you were right. I think we didn't get quite as far as we wanted to previously. So, it's up to the group. I was talking to Andy offline about this. I had on the agenda HIN and HIE and developers because I thought that we really need to get through that. But you're right that we do still have the open conversation about price transparency as well.

Andrew Truscott – Accenture – Co-Chair

Okay. So, I'll just try and address that quite quickly now. Yes, we do want to say something about the price transparency. I am working with the presumption that everybody on the call has actually come up with their proposed draftings in a lot of spaces in here. We already have a place holder in the price transparency group. We actually had already discussed some text to go in there. We've already agreed that we thought a HITCC task force should be created specifically around producing recommendations for regulations around price transparency. And we left a place holder there for that input. So, if anyone has got that input, we could push it in very, very, very quickly because we already have a lot of this information and the framework ready for that. Does anybody have drafted recommendations to go in there?

[Crosstalk]

Cynthia Fisher – WaterRev LLC - Member

I guess I just thought today's call was on pricing transparency so I thought that was the discussion. But are we going to schedule that then for another day? Because there were a series of questions in the last call that we were on that the next call would be pricing transparency and we would go by question by question by question and develop a more thoughtful approach. So, that's what I thought we were doing but we can go back to this

order. But I do think it's for the other phone call.

Andrew Truscott – Accenture – Co-Chair

Was that the agreement that was made on the last call, Mark?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I think what happened is, yes, Cynthia is right. We had some homework to by COB, I think it was Monday, I'm losing track of whether it was this week or last week, to post and take a look at the questions and have some thoughtful responses to the bolded questions that ONC asked in their request for comment or request for information. I think what happened was is we got caught up on the auditing issue and EHI and we weren't able to push forward. And we also shortened the last call to an hour. So, we didn't get to price transparency when we wanted to. And I think it got pushed a bit. So, again, I'm okay with whatever approach you all want, if you want to do price transparency today or HIN and HIEs and developers.

Andrew Truscott – Accenture – Co-Chair

Okay. Has anybody on the call done their homework around price transparency and got a series of suggestions that we can walk through together?

Cynthia Fisher – WaterRev LLC - Member

Yes. This is what I'm going to suggest, Andy, is that I think it warrants its own call. And if you want to finish up here on HINs and exchanges and cert, that's fine. But I do think we were going to have a focused call. And I didn't see anybody else's comments on Monday so I didn't know. I have comments that we can add in. But I think it's just worthy. It's meaty, it's doable. I know it's a concern. I disagree with the delay of game because medical records and electronic health records were all started with rate card sharing between providers and payers. And it's been digitized for decades. So, I don't want to say that we need to delay the game because it's all there. It's doable.

Andrew Truscott – Accenture – Co-Chair

I don't anyone is disagreeing that. I actually want to look at the Google document and look where updates have been made. Now, price transparency does feature in those updates. Are those updates coming from you? Cynthia?

Cynthia Fisher – WaterRev LLC - Member

I have updates in from the last call but I also have additional that I can add. But I think as a group, we should just decide when we're going to focus on it and then, we focus on it. I think it's worth focus but it's not here on the agenda today. So, I'm happy to go back to what the agenda is and suggest we have another call for price transparency.

Andrew Truscott – Accenture – Co-Chair

I'm ambivalent either way. We can push items off of the agenda today. I'm happy to stick with it because we do actually have to work through this stuff. But if we want to get transparency out because it seems to be the 10,000 pound gorilla in the room, we're not going to be able to move beyond it until we've got it done, let's get it done.

Michael Adcock – Individual – Co-Chair
What do other members think on this who are on the call?

Andrew Truscott – Accenture – Co-Chair
John?

John Kansky – Indiana Health Information Exchange - Member
This is John. Confessing I did not do detailed homework in terms of going point by point on the preamble questions. I have reviewed them. I have some opinions I'm willing to share whether that be today or non an additional call.

Andrew Truscott – Accenture – Co-Chair
Okay.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
This is Sheryl. I know I verbally shared some of the areas of not objection because we don't object to price transparency. I think from the payer community, we want to be sure it's meaningful and that it's useable and that it's digestible by the user, which I'm not sure rate cards are the way to go. So, we might have a difference of opinion in terms of the approach. But also, I believe I did share and, unfortunately, I don't think the document I have is sharable outside of my company. But there was an opinion, and I have to go back and look at it, but the Department of Justice I believe, on the broad sharing of cost data itself. It's come up in a number of states and the work on the ABCDs because in many areas, especially rural ones, basically, having all of the rates published tends to drive the prices up and not down, unfortunately.

And, again, that wasn't our study. It was something that came out of the Department of Justice analysis. So, I do think we should have that as a reference here as well because, at the end of the day, we want people to know the cost. But we don't want to put them in jeopardy of having to pay higher costs because of the way that we're doing it.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
And maybe this will give you all some time to think about whether we should have the price transparency conversation today or moving forward but I did want to make a point from ONC's perspective on price information and price transparency just to be crystal clear. And I think I've said this a number of times is that we have a request for comment in the rule that ONC is able to implement proposals regarding pricing information and price transparency in the final rule. So, we request comment on how, if you all think we should do that, we should do that. And as we made clear, price information as currently drafted is included in the definition of electronic health information. And there's also a request for information more broadly about what the department should be doing moving forward regarding price transparency.

That's all to say just that I don't know that it needs to be an all or nothing. And what I was getting at in the last call and Cynthia mentioned is going through the questions is just to determine what level of proposals or recommendations the group would want regarding price information and price transparency. And I think that would be a helpful conversation to have.

Michael Adcock – Individual – Co-Chair

This is Michael –

Cynthia Fisher – WaterRev LLC - Member

This is Cynthia. I'll just quickly suggest that why don't we do what is on today's agenda and set aside a separate time to fulfill the request of a task force of HHS to actually work on price transparency and come up with a committee recommendation. Let's be real. This is a moment in time where patients need to see, know, and choose their healthcare based upon having visibility into real prices.

Andrew Truscott – Accenture – Co-Chair

Let's do that tomorrow then. Let's do that tomorrow.

Cynthia Fisher – WaterRev LLC - Member

Let's do our job. That's my goal and I'm happy to do it.

Andrew Truscott – Accenture – Co-Chair

Okay. Let's do it tomorrow because that's when we've got an expert in our meeting.

Michael Adcock – Individual – Co-Chair

Yeah, this is Michael. I was about to say the same thing. Let's follow the agenda and get through HIN and HIE and the other work and then, cover price transparency on the other call.

Andrew Truscott – Accenture – Co-Chair

In the meantime, can people go into the Google document, look at what we already have in the price transparency section and in the implications of the information blocking rule section? Because there are comments on price transparency in there, too. And actually, to Sheryl's point earlier, there are comments around paraphrasing. It's all very well sharing information but it has to be understandable to the patient. And charge masters tend not to be.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Okay. So, can you all see my screen?

Andrew Truscott – Accenture – Co-Chair

Yes, we can see your screen.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Okay.

Michael Adcock – Individual – Co-Chair

Yes.

Andrew Truscott – Accenture – Co-Chair

Over to you.

Michael Adcock – Individual – Co-Chair

Okay. So, let's start with HIN and yes, we can see your screen, Mark. Was there something you wanted to point out there?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

No, I have two monitors and I wanted to make sure that you're able to see the right one.

Michael Adcock – Individual – Co-Chair

Yeah, you've got the right one. So, I'm assuming, and I can't see down far enough to see it, there are recommendations. I see the proposed recommendation. Have others put in – I'm trying to toggle between two documents. Okay. So, who put this in? I can't see the author.

Andrew Truscott – Accenture – Co-Chair

Okay. So, after the last time, we discussed this through, I actually went into 21st Century Cures and put this section in. So, I went through 21st Century Cures and looked at the way that it refers to health information exchange or health information networks. So, you've got basically a couple, maybe three, different ways in which 21st Century Cures talks about it. And I was doing this with the intent of saying whether there was a clear view that 21st Century Cures had because, frankly, working in the industry day in and day out, we use the term HIE at least in several different ways and HIN in a couple of different ways. So, maybe this was an opportunity to bring clarity, especially because of the way the regulations are drafted, the access is used as specific ways of executing sanctions against someone.

So, having clarity I thought would be a good thing. So, we talk about, in this first section, so this is important to provide the language of 21st Century Cures that talks about health information exchange networks and health information exchanges. And that seems to be a specific way of referring to groups of networks that do exchange. So, the idea that, and I've said this before I think, network is a noun and exchange is a verb. And if you scroll down to the next section – oh, no, you've got it there. However, there is a contrasting reference. Oh, no, up. I was getting ahead of myself. So, you've got these three statements here where we actually health information exchange looks like it's considered to be an organization, which, again, is another way that the outside world and the market views the definition of health information exchange.

And then, later on in 4006, we talk about platforms of health information exchanges, which you could read as it being HIE is a technology type or technology that supports exchange of health information. But then, later on in 4006, if you scroll down slightly, there's guidance to be an issue to health information exchanges. So, it's obviously then, the health information exchange is something that can have guidance issued to it. So, there are kind of these, I believe, somewhat confusing uses of the term health information exchange in 21st Century Cures. What do you guys think?

John Kansky – Indiana Health Information Exchange - Member

This is John. I'm waffled between wanting there to be clarity around the definitions but then wondering why mushing the two together doesn't just make it easier for everyone to understand. So, I would argue differently if we were going to say it doesn't really matter if an organization coming to this regulation fits either an HIE or an HIN. They know they're in that group. And the things that they have to do or avoid doing in this regulation are the same. What does it matter? Meaning argument for maybe just mushing them together versus trying to precisely define those organizations. We haven't precisely defined those – by precise, I mean less broad. There has been no attempt thus far in previous calls to make the definitions more precise and less broad.

So, I think you're going to take in some organizations that maybe were not anticipated or intended. But does it matter?

Andrew Truscott – Accenture – Co-Chair

Okay. I actually thought you were agreeing with me. There's certainly my intent there because I want to mush it together. I'm, frankly, sitting here saying all of these types of organizations that are being referred to either as HIEs or HINs, in general, they're all the same thing. So, let's just call them, as an organization genre, HINs. And they perform HIE.

John Kansky – Indiana Health Information Exchange - Member

Yes.

Cynthia Fisher – WaterRev LLC - Member

Well, why even bother? I thought we had talked about earlier – I thought HHS has done a thorough job taking **[audio skip]** Cures Act. It uses networks and exchanges in the broad sense and, in the broad sense, is looking for accountability of handling of patient information.

Andrew Truscott – Accenture – Co-Chair

And that's all in the material together to make it clear.

Cynthia Fisher – WaterRev LLC - Member

If you want to spend all of this effort and time bucketing them in a group then, we have vertical integration of all oligarchies that are doing their PBMs, their pharmacies, their hospitals, their insurance companies, they're coming together. You don't want to have just a sub LLC that is acting as an exchange be the only entity that's accountable when across the vertically integrated, you have a broad use of information. And there are lots of ways that are

being played out. So, I just think why are we bothering doing this? What's the real purpose here?

Andrew Truscott – Accenture – Co-Chair

Cynthia, for exactly the reason you just outlined. To achieve what you've just outlined, this is, I think, the smartest way of doing it because for exactly that reason of oligarchies reaching out and spreading their wings into areas where they haven't done previous. Doing this achieves exactly what you're fearful of.

Cynthia Fisher – WaterRev LLC - Member

Well, why doesn't just a small N and a small E accomplish that rather than letting these organizations define themselves as narrow and precise?

Andrew Truscott – Accenture – Co-Chair

We're not.

Cynthia Fisher – WaterRev LLC - Member

If you have a small N and a small E as is in Cures, it's broad. And then, everybody is in the bucket because they're actually playing with and changing and exchanging patient information.

Andrew Truscott – Accenture – Co-Chair

But Cures isn't consistent. Cures has capitals and lowercase. If you look at the section above where we are right now, I collected together every single reference to these in Cures. And you'll see there is no consistency both in usage and in the way it's capitalized or not. So, to help achieve exactly what you're looking for I said let's just be clear.

John Kansky – Indiana Health Information Exchange - Member

Just trying to give my interpretation. I think Andy's suggestion is aimed at clarity. It does not make the definitions less broad. It makes them more clear and it makes the regulation easier to understand and apply.

Andrew Truscott – Accenture – Co-Chair

Yes. So, Cynthia, you inspired this.

Cynthia Fisher – WaterRev LLC - Member

I'm just confused by it but maybe I just need a little more time to understand what you're saying.

Andrew Truscott – Accenture – Co-Chair

Well, let's discuss it. What's confusing? About what we have on the screen right now, what is confusing about that?

Cynthia Fisher – WaterRev LLC - Member

Because I think you're changing the definition.

Andrew Truscott – Accenture – Co-Chair
But the definition is not consistent in Cures. What do you think the definition is?

Cynthia Fisher – WaterRev LLC - Member
I just have to digest what you've written. I'm sorry, I didn't get a chance to digest it before the call. So, I'm just reading what you have.

Andrew Truscott – Accenture – Co-Chair
Okay.

Cynthia Fisher – WaterRev LLC - Member
So, feel free to open it to discussion but I have to read what you have and see how it compares to the existing language.

Andrew Truscott – Accenture – Co-Chair
Have you got some alternative language already drafted?

Cynthia Fisher – WaterRev LLC - Member
I'm just reading what you have on the screen, Andy.

Andrew Truscott – Accenture – Co-Chair
Oh, okay. No worries.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
So, Andy, this is Sheryl, while that's going on, I agree with the recommendation that you're making here if I understand it correctly so that the term would health information network, which is the entity that's administering the exchange of the data. And the act of exchanging the data is health information exchange.

Andrew Truscott – Accenture – Co-Chair
Yes.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
Yeah, I agree. I think that makes it more clear.

Andrew Truscott – Accenture – Co-Chair
Thank you, ma'am. And I tried to distill all of the discussion we've had into these four points, which are based upon the existing definitions of both exchange and network. I tried to bring it, as John says, mushed into one place.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

That's what actually was very helpful.

Andrew Truscott – Accenture – Co-Chair
John and his mushing?

John Kansky – Indiana Health Information Exchange - Member
Mush is an example of the difference between American and English.

Cynthia Fisher – WaterRev LLC - Member
And the issue that I have with this is that there are other entities, other software providers, not necessarily networks or exchanges as they're defined today. So, again, this is where you go, okay, we don't want the Stage Coach Association of America defining how railroads and airlines need to and –

Andrew Truscott – Accenture – Co-Chair
Cynthia, you're absolutely right, which is why we have this section at the very end of what we want called Parties Affected by the Information Blocking Provision. And that is where we have the opportunity to take into account, effectively, anybody who has processing or handling EHI. And let's just quickly take a deviation, Mike, if that's okay with you.

Cynthia Fisher – WaterRev LLC - Member
I see it as you're narrowing it. But I see a broad network. Anybody who has a network that's networking patient information, anybody who exchanges patient information. Again, I go back to the broader definition. But HHS, Mark, you may have something to weigh in.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Yeah. I just had a thought. Andy, I understand we had that conversation about parties affected but just to be clear, that's not terminology we use in the rule. It's kind of just I think you wanted to have a conversation about who would be affected, which I think is an important conversation to have. But to the point that I think Cynthia was talking about, whether you fall on whichever side, our position is that Congress laid out these four actors, developers, providers, networks, and exchanges. And those are the actors that have been identified as falling under the information blocking provision.

So, if real life entities wanted to determine whether they would be considered an information blocker potentially, they would want to look to the definitions that we provide for those four actors to determine whether they could be considered an information blocker.

Andrew Truscott – Accenture – Co-Chair
Okay. I have to say that I don't find that helpful. I'm sorry. Because the reason I sat down and actually went through the Cures Act by myself is to pick out the different ways in which the act uses the terms. And it is unclear. And I think you'll hear from John's comments, you'll hear from Sheryl's comments, you've heard from my comments it's unclear. And this is the industry we work in. So, by doing what we are trying to do here and the consensus of the

group is not to move forward then, we don't move forward. However, right now, it seems like there is a building consensus is to make it clear. And Cynthia is absolutely correct that there are other actors, which are not considered right now. And we need to keep it broad, which is why the additional drafting – what are we doing?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I'm pulling up the Cures Act because I want to just show you what I'm looking at.

Andrew Truscott – Accenture – Co-Chair

Okay.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I'm not sure which section – you're right. First, to start, you're right that Congress was inconsistent in the use of many terms in Cures. But this language right here to me under information blocking is pretty clear, "If conducted by a health information technology developer, exchange, or network." They're talking about those actors. And then, "If conducted by a healthcare provider."

Andrew Truscott – Accenture – Co-Chair

Okay. So, do we really want to get into grammar and fight this one backwards and forwards? Do you mean a health information technology developer, a health information technology exchange, a health information technology network? Or do you mean an exchange as an entity, a network as an entity, or developer as an entity? You see, I need clarity. And if you look at the usage of network and exchange, which is if you went back to the Google Doc you could see that we've actually drawn out the one, two, three, four, five, six, seven, eight different usages of the term exchange. You can see it's used differently.

Cynthia Fisher – WaterRev LLC - Member

So, Andy, those are written in lowercase in the broad sense. If you go back to Mark's screen, it's just really clear the way it's written to me there by the Cures Act.

Andrew Truscott – Accenture – Co-Chair

Okay. If you guys think –

[Crosstalk]

Cynthia Fisher – WaterRev LLC - Member

It's not defining in that sentence. It's not defining HIE or HIN. It's saying a network, an exchange of type, a developer, a provider. Those are the four buckets.

Andrew Truscott – Accenture – Co-Chair

It's actually saying a health information technology developer, exchange, network, which the

best **[inaudible] [00:28:23]** could be read in several different ways. And if you look at the usage of HIE and HIN elsewhere in Cures, it's not used in that way. It's not used consistently. And Mark said it's not used consistently. I'm not sure I understand why you are resisting bringing clarity.

Michael Adcock – Individual – Co-Chair

This is Michael. I'm going to ask it a different way. So, in the proposal that Andy has, an exchange is an act. A network is an individual or entity. Under network, where are there loopholes or what is left out under those four different points under network that would allow someone to perform this act or to be a part of a group that performs this act that isn't covered? So, what are we missing that would allow somebody – because I understand, Cynthia, what you're saying about future proofing? And I think Andy is agreeing with you. And I think we're all agreeing with you. If you look at those four pieces to say that you have to satisfy one or several of the following, what's missing? Is there something missing there? Because to me, it's not narrowing. It's actually clarifying but without narrowing it. To me, if you are exchanging information, you're going to fall into one of these points or potentially multiple of those points. Is there something we're missing that would be of concern that we could add to it? Because I understand the clarity piece.

And there are lots of definitions. And whether it's capital or lowercase to me is really – we're being asked to defined these terms and they were put in the text in this way. What is missing? I guess that's what I'm asking the group. What is missing from those four bullet points or do we need to add a fifth or do we need to change a fourth or do whatever? What is missing that we need to add to make sure it's broad enough? Honestly, and I know everybody is probably still reading – oh, good, I'm not on mute. I thought I was talking to myself for a little bit. I'm sure everyone is still reading.

But what I read when I saw this in the Google Doc yesterday or early this morning actually was that this was trying to accomplish exactly what we've been discussing, which is attempting to 1) clarify without narrowing but also to be able to make sure that we're covering all of the entities that need to be covered in the future proofing of this because it is difficult to do because we don't know what it will be defined as in the future, but what it is that is there anything that Cynthia or John or Sheryl or Andy or Mark that we're missing in here that would allow a person or a group whether vertically integrated or whatever to escape without being held accountable?

John Kansky – Indiana Health Information Exchange - Member

This is John. I cannot think of an example. I have the same question. And I just want to point out that several calls ago and probably several since I argued that this definition is so broad as to take in a bunch of unintended organizations. But in as much as no one has an appetite for making it more narrow, I have just let that point drop. So, the point I'm trying to make is there's a degree to which we're trying to reach consensus. So, I cannot think of any examples of any organization that would not meet this definition that we think should. I could probably think of a ton that meet this definition that we don't intend to. But that's just the way it is.

Cynthia Fisher – WaterRev LLC - Member

So, the thing that I am concerned about in the narrowness of the definition of the health information networks is it makes it seem that it's a broader based network versus one player into a network or into the pipe. It seems as if it's defined as the administrative controlling policy setting, agreement setting. That it's actually almost protectionism for network as it exists today in some tighter form versus the participants of entities that simply exchange or network patient health information. There are a lot of factors in those four points that appear narrow. So, that's my feedback just as I read it and that's top of mind.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Just a point of clarification about that is that we use the language about unaffiliated individuals or entities in the definition of health information networks because if you think about it, if there's not that aspect or something like that and you're just talking about a one to one exchange of information then, there's nothing to keep provider from being considered a health information network because every time they share data with another provider or with a patient, you could say that they would be a network. And it seems like, again, not to – I'm just trying to say that the intent in reading the legislation is that there are four actors. And a point that will be confusing, again, they're your recommendations, if you make health information exchange the verb, the act of accessing transmitting, we already define exchange within access exchange or us as the terminology used by Congress.

Andrew Truscott – Accenture – Co-Chair

But Mark, this doesn't say that.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

It doesn't say what?

Andrew Truscott – Accenture – Co-Chair

It doesn't make it just the act. It also says or the organization conducting the act. Look at the definition of HIE.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Okay. I see that. But you don't think that would create in the market that you're defining HIE as both an act and an organization?

Andrew Truscott – Accenture – Co-Chair

Well, we put that in purely because of the feedback that I got from Cynthia and John last time we went through this. No more confusion than there is right now, put it that way. But to Cynthia's absolute point there, and you make a very good point, Cynthia, that you're saying that the only people who could exchange are a network well, that doesn't quite make sense. I agree with you. This is why two and four are drafted the way they are. But I would draw your attention to the very, very last piece, which is around the broader definition of the term actor. And the originally drafting of Cures Act, actors regulated by the information blocking

division include healthcare providers, developers, exchanges, and networks.

And, actually, my suggestion there, Cynthia, is to meet absolutely your fear and the future proofing is we just simply say the actors include all of those who create **[inaudible] [00:36:16]** and exchange or otherwise process EHI. And I've put the drafting in there for you to look at at your leisure as well. It's not on the screen right now. It's right down at the bottom if someone wants to look at that. And that was deliberately done, Cynthia, because of your concern. So, we just need to make –

[Crosstalk]

Cynthia Fisher – WaterRev LLC - Member

The real issue here – is the real issue here – let's go up 30,000 feet. Exchanges, networks, developers all come into the bucket on information blocking up to $1 million fine per occurrence as I understand from the rules. Providers have a to be determined penalty with the Inspector General for information blocking. Right now, the challenge is providers – the whole reason why we're here is that Congress will have set up with providers keeping the patient information within their health system and not sharing it. That they have the flexibility as we live in a mobile and transient world and we move across 50 states just trying to take a flight any day and the airlines are full and we move across health payer networks, we move across systems when we go skiing in Colorado and somebody tears an ACL. Everybody needs to go into different systems.

So, we need access to information. It needs to be given to the patient. Is the real issue here and the real concern is where a provider goes into that bucket? And if a provider exchanges information, is it the fear of being held accountable $1 million per occurrence as then, being defined as an exchange or network? Why are we going through these machinations? Is it that we just need to have the most favored nations and hold everybody accountable for up to $1 million per occurrence and then, we don't even have to go through these exercises? But I'm trying to understand the big picture. Patients just need access to their information. And we're entangled in defining these subsets of groups as we see them today. And why not just hold everybody accountable to the same like most favored nations? And then, do we even care?

Andrew Truscott – Accenture – Co-Chair

I think the only reason we are is because Cures calls them out as specific actors. And the regulations that are currently drafted are not as clear as they could be. And I actually genuinely didn't think this would be anything remotely contentious. We'll just go, okay, fine, we need more clarity and move on. I'm kind of surprised we're even having this conversation.

Cynthia Fisher – WaterRev LLC - Member

Well, that's my question. Thirty- thousand reads, why are we going down into the weeds? Is it protectionism for a party? Why don't we just hold anybody who exchanges or networks information accountable for things –

[Crosstalk]

Michael Adcock – Individual – Co-Chair

How does the proposed definition not do exactly that? Is it okay to throw some specific examples up against this definition? For example, I run the Indiana Health Information Exchange. I look at this definition, and I clearly fit in No. 2. Let me find it. We provide a service that enables or facilitates health information exchange. That's what our organization does. We might need some other bullets but we do that. So, then I think about Common Well or Sure Scripts, they all do one, two, three, or four. And then, I get to any provider that runs a private HIE, they fit the definition. And you can just keep going from there, right.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

So, just a point to think about with three or four, Andy, it looks like with what you drafted, you pretty much took our definition of HIN in one and two, and then, you made three and four the same but with affiliated individuals. Is that right?

Andrew Truscott – Accenture – Co-Chair

I was standing on the shoulders of giants, yes.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

So, as far as unintended consequences that I know all of you are concerned about or John especially is concerned about, if you think about, as I said, we were careful to try to not make unaffiliated individuals clear. But really, the goal is that Congress is clear that providers should be treated differently than developers, exchanges, and networks. So, if you think about a hospital system and you're saying that a network would include two or more affiliated individuals that would just mean a few doctors getting together and sharing information would all be potentially a network.

Andrew Truscott – Accenture – Co-Chair

Okay. Mark, before we bury off down that one, something like Common Well, they're all members. So, they count as being affiliated. The terms affiliated and unaffiliated are not defined. And the penalties are maximal. It's not like you're mandating a $1 million penalty. Everyone automatically gets it if they're found guilty. So, I think that's an overread. Frankly –

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Well, we do define unaffiliated in the preamble though. We have an extensive discussion about what we mean by that.

Andrew Truscott – Accenture – Co-Chair

I get that but please don't point to the preamble. We're trying to make it clear in the regulations. That's why we've got everyone in one place. They're in one place. And Cynthia makes a very good point around vertically integrated organizations, which are – let's say a

large retailer who now wants to provide care services. They wouldn't fall underneath this, even though they are spread across the country, have a greater reach than any health information network potentially. A national retailer who wants to provide primary care services wouldn't be encompassed by this. So, that's why I have been drafting at the end of this – we're going somewhere else now.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

No, I was just providing some background here.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

And I agree with that point. I guess I'm sorry, Andy, I didn't notice that you had added the affiliated because I thought we had already discussed this point in a prior meeting and we had all agreed that we needed to keep in the unaffiliated because if you have –

Andrew Truscott – Accenture – Co-Chair

We do. That's why they're all there.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Yeah. Because if you add in the affiliated, which as it does in the preamble, I think that some of the questions that we need to answer based on the use cases are the one that you just mentioned with the hospital and the doctors, is that considered a network? The Blue Cross Blue Shield Association that's got a franchise and licensees, is that a network? What are we really talking about in terms of affiliated versus nonaffiliated? Maybe it's defining that.

Andrew Truscott – Accenture – Co-Chair

Do we think they should be treated in different ways, first of all?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Well, I don't necessarily think from a philosophy perspective they should be treated a certain way but there are concerns. Providers have them because we've heard them and so would the Blue Cross Blue Shield Association where we have multiple licensees in the same area. So, without some sort of protection, what's stopping Blue Shield of California requesting data from Blue Cross Blue Shield of Anthem of California on the same population for someone that is not a covered member? But that's where it becomes an issue. And what does that mean and how does that work? Because it could be an anti-competitive issue.

Andrew Truscott – Accenture – Co-Chair

Why would this impact that one way or the other? I'm confused.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Because if they're affiliated and there becomes a request to share data at that level then, basically, we may be in a position of having to share contracted rates with a competitor that's in our own market with another Blue plan, which today isn't allowed.

Andrew Truscott – Accenture – Co-Chair

Okay. I thought what was getting put in place with these regulations was actually to level that playing field and say that we want price transparency so price information is included in the definition of electronic health information. That's the definition of the scope of the data. What we've done here, we've said whether you're affiliated or unaffiliated, you cannot block that information. We're not going to treat you any differently. You have to allow information to be passed between. I think you're saying hang on, there's actually a concern here with price information being shared. We'll talk about this more tomorrow when you go through price transparency. But the reasoning of EHI is it has to be individual.

So, it wouldn't necessarily – an organization couldn't just get another organization's entire price charge masters or contracts or something. They only can see it in the context of a particular individual disposition. So, I'm a bit confused by why that would be a concern. I'm trying to be really careful about how we partition this.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

The granularity to which the data is available that concerns us if we were sharing episodes of care or some basis of price that's meaningful based on the patient's own experience, that's one thing. But in terms of data sharing, and you know this, what they ask for is all of the detail levels on all of the claims and all of the claim lines, which really gets into more of the reimbursement rates. And, again, I bring up the whole issue that we had brought to us before from the Department of Justice in that, especially when we're playing in the same regional or geographic area, it's done nothing but drive prices up by sharing that with our competitor.

Cynthia Fisher – WaterRev LLC - Member

Well, there are different opinions on that, Sheryl. So, I think the big issue here is that we have to do price transparency. And there are plenty of other arguments in the opposite direction. You can look at the food industry. You can look at the retail industry. You can look at a lot of different industries that show competitiveness of having transparency. Opacity does not serve the consumer well.

Andrew Truscott – Accenture – Co-Chair

Okay. So, we're going to talk about this tomorrow. Price transparency is tomorrow and we are going to address it. We absolutely are. Okay?

Cynthia Fisher – WaterRev LLC - Member

But I think Sheryl raises a good point about looking at the networks affiliated and unaffiliated and why it needs to be broad. I think – oops, we get to see a wake. Was that point just watered down?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Sorry about that. That was my bad.

Andrew Truscott – Accenture – Co-Chair

Why would we differentiate between whether the entities were affiliated or unaffiliated for the purposes of whether that implicates information blocking because I thought what we wanted to achieve was it doesn't matter whether you're affiliated or unaffiliated. We want information to be shared.

Cynthia Fisher – WaterRev LLC - Member

Exactly. I agree with you there, Andy.

Andrew Truscott – Accenture – Co-Chair

Okay. So, this drafting as it currently stands treats them all equally. Now, I know that Sheryl has a concern over that, particularly around price transparency. And I would like us to litigate through that tomorrow so that we could actually say there's an exception maybe for price transparency. Or we decide actually there's no exception. But in general, the sharing information about a patient where the patient wants it to be shared and it's in the best interests of that patient, it doesn't matter whether the end points are affiliated or not.

Cynthia Fisher – WaterRev LLC - Member

Could I have clarity on where providers fit? Because if providers are sharing and exchanging information, aren't they then an exchange as well and network as well? Aren't they then exchanging networking in the broader sense of the word? And so, wouldn't they fall under the similar penalties?

Andrew Truscott – Accenture – Co-Chair

Okay. So, some providers don't provide any kind of exchange activities or operate a network to make that happen. Some providers do. Some providers operate a private network across multiple entities within their organization and between other groups like physician groups, etc., that they are associated with. What we're trying to do here is just simplify that out a little bit. Where I think where you're going is right is that, potentially, a provider who is also a network performing an exchange between affiliated and/or unaffiliated entities could actually be implicated by being an actor in several different ways both as a provider and a network. And that's absolutely true. They could. So, what is kind of my view at the moment?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I just pulled up an example that explains our position to what we're talking about. And I can take it off. But I just wanted to say that we do address these very points in the preamble as for why we proposed it a certain way. And just real quickly, Andy, what we're saying is the provider could be considered a network or exchange but they'd have to be acting functionally as a network or exchange as we defined them. That's the main point.

Andrew Truscott – Accenture – Co-Chair

Yeah. So, that's the same thing. But let's say a provider is operating functionally as a network as well. On what basis would you seek to issue sanctions against them under the current drafting of the regulation, as a network or as a provider or as both?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Are you asking me?

Andrew Truscott – Accenture – Co-Chair

Yeah.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

As we talk about in the example, you'd have to look at – again, I want to emphasize you can fault the Cures Act on many levels, I guess, if you wanted to. But I think Congress is very clear that providers should be treated differently than exchanges, networks, and developers. The language is pretty clear there. So, what we're saying in our preamble that we discussed is that you'd look at what the actions are that are being taken. If the entity is acting as a provider, it would be treated as a provider. If the entity is acting under our definition of network with two unaffiliated entities or individuals and sharing information in that way then, they would be subject to the penalties that would tie to a network or exchange. It's all based on the function regarding networks and exchange.

Andrew Truscott – Accenture – Co-Chair

Okay. So, let's not get too deep into this but there is that slight gray area, I think, where you have a provider who functions as a network between two affiliated entities. So, let's say it's integrated care delivery network with a primary care group and an acute facility. And they're not routinely information between those two across their network within their own provider organization, even though they are two discrete entities, they could potentially be implicated on both fronts. And at some point, you're going to have to decide which of those actions you're going to sanction them under. Does that make sense?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Yeah, sure it does. I can't speak to any examples that are outside of the discussions we have in the preamble but that's more of an enforcement issue. What we're trying to deal with here is creating clear definitions for the four actors Congress identified that can be used for OIG to enforce the regulation. I think you're right. It's very possible that there could be an entity that acts both as a provider, I think is what you're saying, and a network. But if you think about it, the conduct probably would not be the same conduct because you'd be looking at the function of the actor. So, there could be two different conducts by the same actor but they would just be working as different functions from the same entity. Does that make sense?

Andrew Truscott – Accenture – Co-Chair

You're making sense. I understand the words you're saying. I think that it largely doesn't matter for this conversation because this particular organization **[inaudible] [00:54:26]** is covered and implicated. And then, during enforcement, you'll discern of which sort of actor

you're going to enforce it upon. Got it. To Cynthia's point 40 minutes ago, there are vertically integrated organizations who are ever expanding. Are we covered in these definitions that currently stand for those organizations? I'm not sure and my reading was we weren't, which is why if you scroll all the way to the bottom of this document, scroll, Mark, in the section around are these four actors, which are suggested, it's not suggested that those are the only four actors. Next page, Mark. Cynthia, are you there?

Cynthia Fisher – WaterRev LLC - Member

Yes, I'm here.

Andrew Truscott – Accenture – Co-Chair

Can you have a look at this regulatory text recommendation here that Mark has got up on the screen because this was kind of seeking to channel you? And please correct it if it's not.

Cynthia Fisher – WaterRev LLC - Member

Also, I'm only seeing a piece of this. And Mark, is there some way also that you can just send us what you have in the preamble? Because I didn't get to see it before you took it off the screen.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Yeah, sure, Cynthia. Under each section, if you look at the HIN and HIE, I'll scroll back up, but the page numbers from preamble are referenced. And that's where I was. So, you can just look through those pages.

Cynthia Fisher – WaterRev LLC - Member

Okay. I'm on an iPad, sorry, it doesn't work like my computer.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

No problem. I just want to make sure that everyone reads the examples we provided.

Cynthia Fisher – WaterRev LLC - Member

Okay. I'll have to pull that up.

Andrew Truscott – Accenture – Co-Chair

It's in permanent lingo, my browser right now. Okay.

[Crosstalk]

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

And I'll just kill some time, Cynthia, while you're pulling this up just to note that actor is a term that is not used in Cures, I believe. It was just a term that we used to define those four

actors that Congress talked about. So, it's a term of art. So, that's the point I wanted to make there.

Andrew Truscott – Accenture – Co-Chair

A term of art.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Well, maybe not a term of art but it's a term that we use to refer to the entities or individuals that Congress identified in Cures.

Andrew Truscott – Accenture – Co-Chair

It's actually a pretty good term. That's fine. I'm not disagreeing with you about that at all.

Cynthia Fisher – WaterRev LLC - Member

Well, I'm reading this and I guess it says network and exchange information. Again, I would just use the words in the small N and the small E. And I also think that it should be consistent with what HHS says. So, here it has regulatory text, recommendation but it doesn't have what the regulatory text says.

Andrew Truscott – Accenture – Co-Chair

There is none. This is none. This is additional to cover your very real concerns, which I thought as a group we agreed with. So, this is an additional suggestion to ONC that they put in something like this to make it absolutely clear that whilst we do have these entity types defined because that's what we were told to do, the actual intent of congress is for all of these activities to be implicated if you don't do them. I was channeling my inner Cynthia.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Andy, don't get angry. I'm going to pull over just for comparison how we define actor in the rule just so everyone understands.

Andrew Truscott – Accenture – Co-Chair

Yeah. And in our discussions, I think we specifically said tie it down to just the certified health developer. That's in our over narrowing. A healthcare provider has a particular meaning. We want to make it clear that these vertically integrated type organizations, it includes them, too. And that's why rather than talking about organization types, we're saying if you do this stuff with EHI then, you're included. Frankly, if we recommend this, whatever happens at the end game, it gives you actually a level to go and investigate this.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I'm just curious though, Andy, how do you reconcile that with what Congress said in Cures that specifically calls out these four actors?

Andrew Truscott – Accenture – Co-Chair

It's well done to specifically call these out to – I think it actually used the word includes. It doesn't say to be only. And this group in discussion has raised the fact that we have concerns over other organization types who are handling patient information and will be providing patient care services who don't fall under the classic definitions, which have been used hitherto, and we want regulations in place, which stand the test of time.

Michael Adcock – Individual – Co-Chair

This is Michael. The one thing I wanted to say there was I think the intent of Congress was to not narrow it to just these four groups. Someone correct me if I was wrong, it was to make sure that information was being shared freely and not be blocked. And I think that's what we're trying to do is to make sure that if you're a group, an individual, an entity, whatever that is sharing information or has information to exchange, to share, to transmit, to create, whatever that you will not block that information. And I think, in some points, we're trying to narrow it so that we meet Congress's words in the Cures Act. And in other areas, we're trying to make sure it's broad. I think we need to make sure that patients and providers have the information they need to deliver care, to receive care, to pay for care, whatever it might be.

And I think that however we define an HIE and HIN if it's done right, everyone that shares information will fall into a category, which is much better than what we have today whether it's decided that anytime a provider is doing this, they're considered a provider. Fine. If the information blocking whether they're considered a provider or a network or exchange, they're being held accountable, which is what we don't have today. If they're a network and they're doing something they're not supposed to do or they're blocking something they're not supposed to block, they're being held accountable. What I'm trying to decide is is there anything that we've proposed so far that would allow someone to escape accountability? And if so, we need to put in there. If not, we need to come to some type of agreement as to what that looks like.

Cynthia Fisher – WaterRev LLC - Member

Yeah. I think that's a really well said point. And I think that's really the intent here is to say that this is about giving patients and physicians total access. And that's inclusive of the whole record. That means physician notes, that means your MRIs, it means your labs, it means the ability to move across systems. And we have cloud computing today. I even would argue the biggest thing is you get an MRI or you get an x-ray and you can't get access to it and the CD Roms don't work and patients have to leave their homes and go physically try to grab this information, which is ridiculous to have to grab digital information and waste of time and labor and employers losing them for half days off of work chasing down this info. Is the provider held accountable? Help me understand this. So, the biggest thing is the patient gets referred. They get seen, they get tests, they get labs, they get films. And then, they have to go see the specialist or they want to go outside of that hospital network.

And today, it is so difficult for them to get that information to make it relevant for their referral care and get access to that care. So, what we want to make sure is empowerment of the patient that says, look, I can click on here if I can't get access. I can report it and I can

hold somebody really accountable for not giving me access so I can move and be seen by a specialist within the next two days. Real time and digital. So, I think the big thing here is what Mike said is we want to make sure that we don't use however the words are and that the players involved are all held accountable.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Just to chime in really quickly, I'm not going to weigh in on whether you should or shouldn't make that recommendation. My read of Cures and the position we took in our proposed rule was that Congress does not take that very, very broad approach and does identify who they are talking about, which is developers, providers, networks, and exchanges. And just to be clear that it seems to me what Cures says. So, I think it would be very difficult. And you'd also want to make sure you think about who, if you're saying everyone who touches health information should be covered, I don't know how you would define it, but just think about the consequences. I know, John, you've talked about this in the past.

Michael Adcock – Individual – Co-Chair

Right. So, taking that a bit further then, who are we trying to say it's okay for them to information block? If you're following that logic, yes, everyone should be held accountable. There's nobody that whether they're part of a provider group, whether they're part of a health IT developer, whether they're part of a network or exchange, whatever a position is, nobody should be able to allow the blocking of information. Is that not what we're trying to do here? I thought we were trying to prevent information blocking.

Andrew Truscott – Accenture – Co-Chair

That's a good question, Mike. Mark, who is it that we say that it's okay to information block?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Just to be clear, ONC's position is not to say it's ever okay to information block. I'll just restate where we came from. We wrote a report to Congress in 2016 that said information blocking is a huge problem. And we laid out a rationale and potential definition and worked with Congress to come up with the Cures Act. And in Cures, Congress provides a definition of information blocking and identifies four distinct actors, which are developers, providers, networks, and exchanges that would be actors that could fall under the information blocking provision. What ONC has been tasked with is coming up with definitions and identifying clearly how to define those actors and how to define the conduct that would fall under the definition of information blocking.

So, I definitely cannot get into a conversation about that anyone is allowed to information block. What we're doing – and then, also, of course, identifying the exceptions, which Congress asked us to do. So, that's where we're coming from. But I'm just saying as far as legislative interpretation, I understand this group and I think it's great. We agree with you. We want the sharing and flowing of information and we think that's paramount. It's extremely important. But I'm just trying to focus on the fact that we need to work within what Congress actually said in Cures if you want it to be actually implemented, the proposals,

the recommendations.

Michael Adcock – Individual – Co-Chair

Again, this is Michael. What are we proposing that doesn't fall within that? I guess I'm confused. I'm just trying to figure out how we can get to a definition that's somewhat clear because, to be quite honest, the HIN/HIE definitions, when we all of us, in the beginning, were not clear. So, we're trying to provide clarity and make sure that we're holding the groups accountable that need to be held accountable, what are we doing that isn't within the framework that you're talking about other than trying to provide clarity so we can have recommendations?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I'm not sure if you are. I'm not sure what your recommendations will end up being in the end. All I wanted to say was that based on our read of Cures, we needed to identify and define these four categories of actors that would fall under the information blocking provision. And based on the fact that Congress clearly said the providers penalty wise should be treated differently than developers, networks, and exchanges, our read and the way we made our proposals was that there needs to be some distinction between provider definition and the definition of network exchange and developer. That's just our approach and I guess I'm just trying to make that very clear. But your recommendations are your recommendations.

Andrew Truscott – Accenture – Co-Chair

Before we talk **[inaudible] [01:09:07]**, I think, Mark, for where we're all coming from, you've got those definitions because of how you need to do enforcement. And that makes perfect sense to treat a provider differently to how you treat another entity for many, many good reasons. So, if you put the enforcement –

Cynthia Fisher – WaterRev LLC - Member

Can you help me with the reasons? Why would a provider be treated differently? And would the provider be treated differently for less or more of a fine? Why wouldn't they all be treated the same? I guess I'm trying to understand why that's carved out.

Andrew Truscott – Accenture – Co-Chair

Okay. Because I think if we can just park for a moment the fact that a provider might also be an HIN but actually providers come in many, many, many different shapes and sizes. And you may inadvertently be overly punitive on a smaller provider who for whatever reason is unable at the moment and you want to work through things with him. But the big ones that are guilty of information blocking for whatever reason would also fall under the HIN type definitions anyway. And so, you have that much bigger enforcement stake. And I'm not trying to excuse it in any way. Just that I can recognize that 21st Century Cures did actually have a difference in how the intent and how it expressed it for a developer, an exchange, or a network versus a provider. Because with a provider, they said if it's conducted by a provider, the provider knows that the practice is unreasonable and is likely to interfere.

Whereas with a developer, an exchange, or a network it's not that just they know, it's that they should have known. So, there is a difference in how Congress was thinking about providers as opposed to let's just say, other actors. That was my understanding.

Cynthia Fisher – WaterRev LLC - Member

But isn't it up to $1 million per occurrence up to as determined by the Inspector General? So, if it's just one small entity, wouldn't the Inspector General still have the power of that authority? And isn't it mostly the information of – isn't information blocking really mainly taking place by providers not wanting you to go across the street to a competitive hospital?

Andrew Truscott – Accenture – Co-Chair

I think that's certainly an argument that sometimes happens or maybe a lot happens like that. But I think there are also issues from developers, exchanges, and networks absolutely.

Cynthia Fisher – WaterRev LLC - Member

Obviously, it is with the others as well. But my thought is the ambiguity would be – I don't even know if it's clear to me as a consumer, is the penalty supposed to be less than what's defined by the HINs and HIEs? Or is it supposed to be more than what's already defined up to $1 million per person?

Andrew Truscott – Accenture – Co-Chair

That's a good point. But the problem is we have the legislation makes the distinction here between a provider and the others in terms of the intent. However, what we're talking about here is the definitions inside regulation, which is something that is a bit more – well, we can make recommendations to change that. But the regulation is enacted and you can't change that.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

And just to note, we do have a request for information about provider disincentives, which you all are welcome – it's being discussed in Group 2. But, of course, you're welcome to comment on that. And I see where you're coming from, Cynthia, but I will say that, as Andy said, whatever Congress's intent was, I can't speak to that. But they are pretty clear about at least the penalties for developers, networks, and exchanges. And we are still considering the penalties or disincentives for providers. So, whatever their reasoning was, it's kind of outside of ONC's scope right now.

Andrew Truscott – Accenture – Co-Chair

Didn't CMS say something in their rules and regulations around penalties? Was it five percent of Medicare and Medicaid payments or something like that? There are some other penalties around providers working around for sure outside of the fact that these haven't been defined. I have to say, Cynthia, I'd like your input on this one. The 21st Century Cures talks clearly about health information technology developer. And my understanding was that that was meant to – the original intent certainly of some of the congressional members who were involved in drafting was that it was not meant to be restrictive to only those developers of

certified health IT. It was actually meant to be all health IT developers. In the current regulation drafting and, Mark, keep me honest, it seems to be a slight lead casting of health IT developer to only those developers of certified health IT.

And maybe that's tripping over of how enforcement would happen from ONC, etc., as well. And I think the original intent, and it's one that I think I personally agree with, is that we should be looking at anybody who is developing health IT because as technology is moving, the entry level bar to get into selling software, platforms and services, which handle patient information and can control patient information and can restrict patient information has lowered a lot. It's a lot more straight forward to do. And many of those actors have absolutely no intent of becoming certified health IT within the meaning of being part of the certification program at ONC.

And many of them actually don't want to. And we may be inadvertently missing a section of health IT, which is growing because the numbers of health IT developers who are delivering into healthcare organizations to handle patient information that weren't certified three or four years ago was far smaller than it is now and it's going to carry on growing. So, John Kansky, can you hear us? John seems to be pinging and saying he's got a problem.

John Kansky – Indiana Health Information Exchange - Member
No, I think I'm back. Can you hear me?

Andrew Truscott – Accenture – Co-Chair
Oh, yes, we can.

John Kansky – Indiana Health Information Exchange - Member
I was momentarily – I could hear you but you couldn't hear me. But I think the issue was on my end.

Andrew Truscott – Accenture – Co-Chair
So, I have to pay them off to mute you.

John Kansky – Indiana Health Information Exchange - Member
It's a good idea.

Andrew Truscott – Accenture – Co-Chair
But the health IT developer one, I'd welcome everyone's input on this because I kind of think it might be a bit of a blind spot we've got in the current drafting.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
John, can I just give you a little – I want you to talk after but as far as why we tied it to certified health IT that you have to have at least one product certified at the time of the conduct, if you look at Cures, I'm happy to pull that language over, in the Inspector General

authority, which is who is actually enforcing information blocking, the language is pretty clear. It says the health information technology developer of certified health information technology or other entity offering certified health information technology. So, we need to enforce this eventually, and Congress seemed pretty clear about the enforcement authority for OIG. So, go ahead, John.

Andrew Truscott – Accenture – Co-Chair

You're right. It does. And I think that when the legislation was drafted that would have been a largely mutually inclusive group. But things have moved. I'm channeling my inner Cynthia again. Technology is moving. There are people who are going to be engaged in handling patient information, creating patient information, and blocking patient information that we didn't even think of three years ago. And it's kind of beholden on us to raise that so that we can either say okay, it sucks to be us but we can't or oh, yeah, actually, we can do something about this.

John Kansky – Indiana Health Information Exchange - Member

So, Andy, is your concern that there's going to be HIT developers that are important and relevant in interoperability that don't need to be certified for any reason?

Andrew Truscott – Accenture – Co-Chair

Yes. And that I know it will.

John Kansky – Indiana Health Information Exchange - Member

Well, yeah, I immediately thought of –

Andrew Truscott – Accenture – Co-Chair

Don't mention names, don't mention names.

John Kansky – Indiana Health Information Exchange - Member

No, no. I'm not mentioning any names. I thought of a category. And so sincere question, anybody that develops an app for an Android or iOS platform that's designed to be used by consumers, there's no reason currently that that has to be certified technology, right?

Andrew Truscott – Accenture – Co-Chair

Absolutely.

John Kansky – Indiana Health Information Exchange - Member

So, that's especially the way the government is thinking – go ahead.

Andrew Truscott – Accenture – Co-Chair

I'll give you another one. I know of at least two companies who are building fairly sophisticated both ambulatory and in patient EMRs that they want to bring to market but they don't want to sell it. They want to give it away and it's very, very elastic and true based so they can get access to large volumes of patient information and give it away for nothing. It

doesn't need to be certified.

John Kansky – Indiana Health Information Exchange - Member
Right. And the last thing that we want to do is to put the entire industry under very clear but arguably – a regulation that requires data sharing completely and then, leave some important actors with a business opportunity that's created by the regulation.

Andrew Truscott – Accenture – Co-Chair
Yeah.

John Kansky – Indiana Health Information Exchange - Member
I think that's the most important thing said on any one of these calls.

Andrew Truscott – Accenture – Co-Chair
I told you. It was my inner Cynthia, it wasn't me.

Cynthia Fisher – WaterRev LLC - Member
Could you repeat it? I missed it. I'm sorry. I stepped out. I just came back. I heard something, oh, I missed it.

Andrew Truscott – Accenture – Co-Chair
Okay, John, do you want to repeat it to just channel it?

John Kansky – Indiana Health Information Exchange - Member
Sure. I'll take a shot at it.

Andrew Truscott – Accenture – Co-Chair
Both classes as well.

John Kansky – Indiana Health Information Exchange - Member
Both what?

Andrew Truscott – Accenture – Co-Chair
Both classes of actors that we just thought of.

John Kansky – Indiana Health Information Exchange - Member
Oh, the two examples?

Andrew Truscott – Accenture – Co-Chair
Yeah.

John Kansky – Indiana Health Information Exchange - Member

Sure. So, it's important, and you can fix it after I say it, Andy, it's important that we don't have a limited definition of developer that is limited only to those that develop certified technology because if we do that, there are important developers, I'm air quoting because we're talking about definitions here, there will be important developers that would not have any reason that their technology would need to be certified. For example, anybody developing a mobile app for an iOS or Android platform designed to be used by the consumer for their healthcare data would not need to be certified. And Andy offered an example of organizations developing EHRs that are not expected to be sold but expected to be given away.

So, the problem is that if everybody in the industry except those developers is subject to this regulation, the regulation actually amplifies their business opportunity of not sharing data.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

This is Mark. I think it's a really good point. I guess just in your recommendations, you might want to think about if you want to move forward with that recommendation because like we talked about, the language in Cures seems pretty clear. So, you might want to recommend a statutory amendment or something like that, which I think is potentially possible.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

This is Sheryl. I have a question. Would it be an option to go another way to say that if you're going to provide any type of system that utilizes PHI that the system has to be certified? Wouldn't that be another option? That would take care of those two situations and many others.

Andrew Truscott – Accenture – Co-Chair

Potentially.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Because I think that's a better way to handle this situation because it's going to continue to grow. And at the end of the day, if that's the issue then, any system that utilizes personal health information would really need to be certified. And then, it will be covered by this rule and they won't be allowed to do information blocking.

Andrew Truscott – Accenture – Co-Chair

Okay. So, we're actually saying that any information technology that processes electronic health information has to be certified.

John Kansky – Indiana Health Information Exchange - Member

No. Wait a minute. Doesn't that require –

Andrew Truscott – Accenture – Co-Chair

I'm not saying I agree.

John Kansky – Indiana Health Information Exchange - Member

Doesn't that require a whole bunch of certification guidelines that don't exist?

Andrew Truscott – Accenture – Co-Chair

Yeah. I was just channeling it first, I wasn't saying I agree.

John Kansky – Indiana Health Information Exchange - Member

No, no, I think that's a problem.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Right. And then, every client system out there would have to be certified, which is going to add more millions of dollars onto the cost of this. That's not what I was getting at. I was saying any system that exchanges data that basically would be used to exchange data for personal health information, which is different based on what we just did today.

John Kansky – Indiana Health Information Exchange - Member

Okay. Sheryl, you just said that every system that every health information exchange in the country uses has to be certified. They're not today and those guidelines don't exist.

Cynthia Fisher – WaterRev LLC - Member

There are certain patients that have chosen to utilize applications and services where they have the terms and conditions. And they believe they're far superior to today's existing EHR software developed. And so, they're basically catapulting saying what I get from my hospital and my provider is unacceptable and unusable. And I'm going to go over here to this new player that is very clear about their terms and conditions of my use. And I'm going to choose to select them and the doctors and the accessibility to get access to nurses, care, PTs, whatever. So, they get full comprehensive care today outside of the certification program.

And the patient makes the decision to make that choice. I think the fact of the matter, again, it goes back to Stage Coach of America, is what we're trying to do is trying to get Congress and HHS fed up with patients not getting their information in today's systems released to them. And in the same sense, we're having new, novel, innovative, superior products and services delivered to the millennials, for instance, that aren't going to put up with what they're getting today. So, I just think we also could drastically hurt innovation.

Andrew Truscott – Accenture – Co-Chair

And that's kind of why I was saying rather than mandating certification, mandate that you don't information block. Then, we're not placing additional hoops to jump through. We're just saying you can't information block.

John Kansky – Indiana Health Information Exchange - Member

Right.

Cynthia Fisher – WaterRev LLC - Member
Agreed.

John Kansky – Indiana Health Information Exchange - Member
To Mark's point within the constraints that were given in terms of the legislation, how do we make that recommendation?

Andrew Truscott – Accenture – Co-Chair
I think we make the recommendation that ONC work out how to make it and take it forward. I think in our discussion if you look in the notes, I tried to capture it because this isn't the first time we've talked about this. The technology has moved substantially in the last three years. And this legislation was kind of enacted at the end of 2016. So, the playing field is a slightly different level of muddiness than it was then. And so, it's fairly reasonable to go back and – Mark just raised it and said there would be a statutory amendment that just makes this a bit clearer. And if this group recommends it, it gives ONC a basis to say we can receive the recommendation. And it also allows us to, I think, address some of the issues around self-developers, which we've got in other regulations here.

And to Cynthia's point, the larger organizations who are looking to vertically and horizontally integrate and spread and grow where they're actually saying we're not going to go and buy some platform and do this. We'll just build our own. And we don't need to care – to Sheryl's point, it's not about exchange necessarily because they have no intention of exchanging information. Information is power. Well, that's precisely the mindset we want to not allow to get in a place because we want to promote information sharing by preventing information blocking. I'll try and capture all of these discussions in here. Will people have a look at it in private? John, Cynthia, Sheryl?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
I'm thinking.

Andrew Truscott – Accenture – Co-Chair
Thank you. Mike, are you still there to lead us through to the next section?

Michael Adcock – Individual – Co-Chair
I'm still here but I don't have access to the documents so I don't know – and I can't see part of the agenda either.

Andrew Truscott – Accenture – Co-Chair
Where did we get to on HIE and HIN definitions? I thought I heard that we were kind of okay. But if the consensus is we actually don't want to go forward with the recommendation I've outlined there then, we can go back to our original definition that we were advised to.

John Kansky – Indiana Health Information Exchange - Member
Andy, if you're waiting for somebody to say something, I'll help you out there. I'm not sure if

what I have to say is super helpful. 1) I feel, to be honest, a little bit beaten into submission on debating that one any longer. I feel like the original definitions were incredibly broad and would take in all of the organizations that we want to take in and then some. But there will be some complexity in terms of people trying to interpret. I think mushing them together into one is just as broad and only clearer in the sense that there's one fuzzy definition to interpret instead of two. For that reason, I'm slightly in favor of the latter.

Andrew Truscott – Accenture – Co-Chair

Genuinely, John, I don't want to brow beat you on this one because you come from one of these organizations. And you understand it probably better than the majority of other people on the committee let alone on this call. Can you have a go at changing this and tying it down a bit more?

John Kansky – Indiana Health Information Exchange - Member

Well, so let me speak to it from that perspective since you're sort of inviting me to. On the one hand, we take off our hats when we come onto these task forces. I'm trying to speak from my experience as a guy that runs a health information exchange but not speak as a health information exchange. But if I put that hat back on, part of me says I meet this definition for about 16 different reasons. So, clearly, our organization is going to be regulated by this. If the definition is overly broad and ends up taking in not only whatever the heck an HIN is and whatever the heck an HIE is but anybody that looks at data, thinks about data, or moves it from here to there then, I guess, great. Misery loves company. We're all going to be regulated by the same rule. So, for selfish reasons, the intent of the rule is to define as an HIE. I'm the poster child.

Our organization is the poster child for an HIE. I'm not sure what the poster child for an HIN is. And without starting to name names, we can't really sort that out. But to the point that we've talked about – and that's what I meant by beating it into submission. That's not you, Andy, it's that we've gone around in circles so many times on this. It's that I'm not sure what the relevance is of one fuzzy definition of an HIE and one fuzzy broad definition of an HIN. Debating those things separately seems pointless. So, where you started this is could I, for example, look at those definitions and try to make them narrower to describe what I know to be John Kansky's definition of an HIE and John Kansky's definition of an HIN. I'm sure I could do that but I doubt that those would be well received because they would be narrower because I would be attempting to define two more specific classes of organizations.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

And just to note that the proposed changes, Andy, that you made for John's reference, that is making it broader than what we currently have if I'm reading it correctly because it's saying –

Andrew Truscott – Accenture – Co-Chair

Does it make it broader? I don't think it made it broader. I thought it made it exactly the same scope just clearer.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff

Lead

Well, at least for HIN, we have the limiting factor of unaffiliated. But what you're saying is that you would want HIN to include unaffiliated and affiliated individuals. So, really, you wouldn't even need that distinction. You would just say two or more individuals or entities really.

Andrew Truscott – Accenture – Co-Chair

Pretty much, actually. I was actually just looking at it to say unaffiliated or affiliated because in the current drafting in the proposed regulation, affiliated versus unaffiliated is exchange versus network, which doesn't make sense in the industry perception.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

I don't think that's totally how we characterize it and I would just refer you all to the preamble discussion.

Andrew Truscott – Accenture – Co-Chair

Let's go back into the existing version. Hang on. HIN is about unaffiliated. And then, HIE talks about a particular class of individuals or entities for limited set of purposes, which, personally, I think is really kind of – yeah.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

All I'm saying is that the distinction you made wasn't totally accurate. But still, we recommendations on how to clarify these definitions, of course.

Andrew Truscott – Accenture – Co-Chair

Okay. You're right. I was less accurate than I could have been on that one by accident rather than intent.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

No harm, no foul.

Andrew Truscott – Accenture – Co-Chair

This is heavy work. Frankly, John, if it makes things easier, we just remove the term unaffiliated or affiliated full stop from the HIN definition.

John Kansky – Indiana Health Information Exchange - Member

I think that's helpful. I have to – do what you're saying and then, I'll re-read it.

Andrew Truscott – Accenture – Co-Chair

Yeah. You can't answer it now.

John Kansky – Indiana Health Information Exchange - Member

So, three and four are gone?

Andrew Truscott – Accenture – Co-Chair

Yeah, three and four are gone because there's no distinction between affiliated and unaffiliated and that was the only delta.

John Kansky – Indiana Health Information Exchange - Member

Got it.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

And just to put a finer point on I think what you're proposing, Andy, is really I think this is just our definition of HIN and you just took out unaffiliated the word.

Andrew Truscott – Accenture – Co-Chair

Yes.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Okay.

Andrew Truscott – Accenture – Co-Chair

It goes something like we keep saying Common Well and we'll pick on poor old Common Well again. They're an HIN but they're affiliated. Well, you could argue, I suppose. But it just makes it clearer.

John Kansky – Indiana Health Information Exchange - Member

You're taunting me into the space that I've resisted going and asking questions like what's an organization that substantially influences technology but doesn't do any of those other things. Is that a health information network? So, is HINS a health information network because they substantially influence technology?

Andrew Truscott – Accenture – Co-Chair

I think this would be where you've got an operating organization, which uses technology but doesn't actually define the interface agreements. So, where you –

John Kansky – Indiana Health Information Exchange - Member

Sorry, go ahead.

Andrew Truscott – Accenture – Co-Chair

I could pick on Common Well again where you've got Common Well that pulls into one, however the actual technology decision is being run by MASS at the moment. Where you've

got these slightly more complicated arrangements, especially in the state HIE space as well.

John Kansky – Indiana Health Information Exchange - Member

And this is where the Kansky concept here is is that wow, good point. And if that's brought out in a preamble clearly then, great. But if you're HIMS and you read this, they're going to go oh, my gosh, am I a health information network because I think I substantially influence technology and now, I need to call my lawyer.

Andrew Truscott – Accenture – Co-Chair

We could argue the use of the word substantial there but that's a good point.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

And just a point there, John, there would still have to be an interference with access exchange or use. Just because you fall under one of the definitions of the actors, there still has to be that underlying conduct that's problematic.

John Kansky – Indiana Health Information Exchange - Member

Right, Mark, but if you run an organization that just found out you're defined as an actor in a major federal regulation, you now have a compliance task and three ring binders and six digit legal bills.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Yeah. You're right. I agree with you. I was just saying that there's still whether whatever entity you're talking about, whether they are doing the types of things that would interfere with access exchange or use of electronic health information.

Andrew Truscott – Accenture – Co-Chair

Honestly, I think John has got a very good point here. It's the term substantially influenced, I think, John, that you're tripping over. Providers, managers, and control I think you're fine with, right?

John Kansky – Indiana Health Information Exchange - Member

I believe that's true, yeah.

Andrew Truscott – Accenture – Co-Chair

And hey, I can see that. That definition probably works better for you, right?

John Kansky – Indiana Health Information Exchange - Member

I wouldn't know how it applies in the top one. Determines, oversees, administers, controls, or substantially influences policies. This one is even more – policies or agreements. Determines, oversees, administers. Yeah, I think substantially influences is problematic, to be honest. Determines, oversees, administers, controls, or defines policies or agreements. Are

you familiar with the terms framework versus network?

Andrew Truscott – Accenture – Co-Chair
Yeah.

John Kansky – Indiana Health Information Exchange - Member
So, No. 1 is a framework and No. 2 is a network?

Andrew Truscott – Accenture – Co-Chair
Yeah.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
And just to clarify, I was wrong in what I stated earlier. It looks like if there's any way to bring a redline version next time that would be helpful because you did change quite a bit of the other language from our definition.

Andrew Truscott – Accenture – Co-Chair
Oh, did I? I must be feeling really enthused. Why did I do that?

John Kansky – Indiana Health Information Exchange - Member
Nice try, Andy.

Andrew Truscott – Accenture – Co-Chair
Let's go back and look at the definition.

Cynthia Fisher – WaterRev LLC - Member
It's really hard to see and compare without a redline. I agree with that. If we can please have red lines compared to the original text.

Andrew Truscott – Accenture – Co-Chair
Okay. And when ONC provides me with technology that allows me to do that, I absolutely will. But the next version, I will personally redline. So, there's the original version.

John Kansky – Indiana Health Information Exchange - Member
Andy, quick comment. I just wanted to weigh in that definitely like where this is headed better than where we started. It's got a lot fewer words. It's a lot less subject to interpretation and it's a lot easier to understand. And I don't think, trying to channel my inner Cynthia, I don't think it leaves anybody out.

Andrew Truscott – Accenture – Co-Chair
Thank you, John. And if you look on the screen right now, what's in red is the original version. It doesn't look that dissimilar, Mark, from what you had.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

No, I just wanted to be precise that there were changes to the original definition.

John Kansky – Indiana Health Information Exchange - Member

Mark, do you have anything that you want to receive back on the substantial influences, the possibility of deleting those words, does that give you heartburn?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

On that one, I'd have to look back. I'll read what we have in the preamble, and I encourage you all to do the same. Maybe we talked about it some. So, let me get back to you about that. I appreciate you asking.

Cynthia Fisher – WaterRev LLC - Member

This is Cynthia, just on redlining, classically, a redline basically would be used in the new text. And you either scratch through a red line or have new red words that show the differences versus having –

Andrew Truscott – Accenture – Co-Chair

I know. I will take my time and I will extract everything from these documents, do a proper compare on them and then, provide everyone back with the mark up, okay?

Cynthia Fisher – WaterRev LLC - Member

Thanks. I know it's not built into the software so sorry, Andy, on that one.

Andrew Truscott – Accenture – Co-Chair

It's a really efficient use of my time. No problems at all. Look, we have to pull together a combined set of recommendations. So, it needs to be going across all of them. So, I'll do it in one place across them all. Okay? Mark?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Yes.

Andrew Truscott – Accenture – Co-Chair

Can you get the combination Google document for whoever is going to create it and send me the link for it, please?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead

Oh, you mean for the final recommendations document.

Andrew Truscott – Accenture – Co-Chair

The first draft of the final ones, yes, please.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Yeah.

Andrew Truscott – Accenture – Co-Chair
And let's go to public comment at this point.

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

Operator
If you'd 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'd 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 start keys.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
And let's leave the phone number up for a few minutes just because we didn't have a lot of time to get into that. And it's a pretty heavy discussion.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I'll stop sharing.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Operator, do we have anyone in the cue at this time?

Operator
There is no one in the cue.

Andrew Truscott – Accenture – Co-Chair
I can't believe that the public doesn't have anything to say given the conversation they just heard.

John Kansky – Indiana Health Information Exchange - Member
My father's will.

Cynthia Fisher – WaterRev LLC - Member

Andy and team?

Andrew Truscott – Accenture – Co-Chair

Yes, ma'am.

Cynthia Fisher – WaterRev LLC - Member

I just think that, frankly, HHS's definition and ONC's definition is fitting. And I feel that using the capital sense of those terminologies of exchange in network is more narrowing. But that's just how I read it because you're narrowing it into existing entities that are described as exchanges and networks in today's world. So, I thought that the purpose of to prevent information blocking is as described as they had for the ONC. But I basically feel, right now, it's been a bit of a swirly. So, where it landed is simpler, yes, but at least at first look to me, it's narrower to a defined entity or two defined entities.

Andrew Truscott – Accenture – Co-Chair

Okay. Thanks for that. I think part of what you're seeing as well is myself, definitely John, and I think others who these terms are used in very many different ways and are imbued with a sense of meaning in different places, in different context, in different ways. And we're seeking to normalize that meaning to a single definition whilst we can because we recognize the turn it could well cause if we don't. John, is that a fair point?

John Kansky – Indiana Health Information Exchange - Member

It is. And I just want to point out to Cynthia that it's in my organization's selfish best interest to have these definitions be extremely broad because no matter what happens, we're going to be covered by this. So, in just the interest of what Andy said trying to make them clear without leaving anybody out.

Cynthia Fisher – WaterRev LLC - Member

Okay. So, just one thing. On this, is the change that you have, does it only applies to exchange? And in what was previously there, it also had for access and use.

Andrew Truscott – Accenture – Co-Chair

Yeah, because the definition of health information exchange would get updated to accessing, transmitting, processing, handling, or other such use over the health information. And then, the definition around HIN is talking about capital H health information exchange. So, the definition of HIN is by inclusion, including the revised definition of HIE. So, you've got access, transmit, process, handling, or other such use.

John Kansky – Indiana Health Information Exchange - Member

Thank you for explaining that. So, access, exchange, and use are all part of the definition of HIE, got it.

Andrew Truscott – Accenture – Co-Chair

Yeah. Well, access, transmit, processing, handling, use.

Cynthia Fisher – WaterRev LLC - Member

Okay. I have a broad question, which we could address tomorrow when we do the pricing.

Andrew Truscott – Accenture – Co-Chair

It's price transparency tomorrow. I'm excited.

Cynthia Fisher – WaterRev LLC - Member

I know. But just kind of where pricing information for services and payment information would be exchanged and networked.

Andrew Truscott – Accenture – Co-Chair

Actually, this **[inaudible][01:50:02]**

[Crosstalk]

Cynthia Fisher – WaterRev LLC - Member

I don't think it's part of HIEs and HINs today.

Andrew Truscott – Accenture – Co-Chair

I'm sorry, just say that again from the top.

Cynthia Fisher – WaterRev LLC - Member

So, if I'm a patient and I need to know the price of something and I need to know that my bill and my claims data past, present, and future payment information, if I want to have that digitally and comprehensively as a patient after I've eaten my dinner at a restaurant, I get the bill and it matches the price on the menu and I get it all comprehensively. So, HIEs and HINs in today's world explaining to the public or the consumer, are HIEs and HINs as they are described as entities today also considered pricing exchanges and networking of pricing and claims data, payment data?

Andrew Truscott – Accenture – Co-Chair

My understanding is that, in general, price information is not routinely shared. Is that a fair – is that where you're going, Cynthia.

Cynthia Fisher – WaterRev LLC - Member

Well, it is shared today between the contract negotiations, between the rate charts, between the insurers and the payers.

Andrew Truscott – Accenture – Co-Chair

Okay. Not in an open way then.

Cynthia Fisher – WaterRev LLC - Member

My question to you is that sharing of that data as it's provider to payer and it's patient information specific and it's patient specific that the entities that are sharing that information today, are they considered HIEs or HINs and developers? We have providers in that cue as well. So, could you please clarify?

Andrew Truscott – Accenture – Co-Chair

Would they be considered HINs? I believe so because where we currently got to, they are involved in the exchange, access, transmit, use, whatever, of electronic health information. And electronic health information by inclusion includes price information, not cost but price.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I think to try to help explain, Cynthia, I want to make sure I understand what you're saying. So, if you are working for an employer group and that employer group has contracted with a vendor for a vendor transparency tool that makes supposedly all of their pricing data available to the patient and then, that consumer transparency vendor would be considered a health information network. Is that what you're asking?

Cynthia Fisher – WaterRev LLC - Member

Well, would that include the vendor and the payer and the provider as an HIN?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Well, that's the difficulty. So, the employer group is the payer in this case. The health plan contracted with the providers, they make the data available to the employer group based on the benefit plans the employer group chooses. And then, the employer group hires the vendor for consumer transparency. So, today, it's all handled through providing data to the employer group. And then, the employer group works with the vendor to decide what they make available. So, I'm not clear either based on what we're saying here if that consumer transparency vendor would then be considered a health information network. They're going to be receiving data from the employer group because that's the way it's handled today in order to provide that data and the consumer transparency to the member.

Andrew Truscott – Accenture – Co-Chair

So, I think they would.

Cynthia Fisher – WaterRev LLC - Member

If the provider or the payer doesn't provide the information to the transparency and then, price, who is accountable or not providing information on pricing if it doesn't come from the provider/payer posting?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Right. But it's more than just provider/payer. That's my point. In this situation, you have a provider. You have a payer and then, you have the health plan. They're all separate entities that are all working together. The health plan contracts with the provider based on a certain network. And the employer group gets to choose what networks are going to make available, what they don't make available, and then, what benefits they're going to make available. So,

even though the health plan may have created a product, for most large employer groups, those are all modified. So, it's the payer itself, which in this case is the employer group that decides what benefits are going to be provided to the employee and what isn't. What formularies are going to be covered and what isn't, what services are going to be in network versus what's not.

So, in this case, who is a health information network? I think we have to start there for our next meeting on price transparency because it's now not clear to me because it's more than just what you're saying. There are a lot more players involved in it. And that's what makes this complex. It's not like going to a restaurant. Essentially, the health plan is the one who is pricing out the cost of all of the food in the restaurant. But there's an intermediary between the waiter and the patron who is basically saying no, this table can't order that because, in this employer group, we're not providing those products that way. We're providing it a different way. So, it's not quite as simple as the uberization or ordering in a restaurant scenario. And all I want to get to is if this is the goal then, we need a real life use case that we can use to say how it would work. Otherwise, it's not implementable. And that's what I'm trying to make sure that whatever it is we do, we can do it.

Andrew Truscott – Accenture – Co-Chair

I agree with that one. Sorry, I got cut off there, guys. In some of the comments I've made in the Google doc, and you can read these at your leisure hopefully before tomorrow, I have a concern over how we could actually make this happen given the healthcare system as it stands because there's a difference between the price that Andy gets charged for service and the price that John gets charged for a service for a whole variety of factors. And to enable price transparency in the whole, broad what could this mean for me if I chose to go and receive care somewhere else or go to or chose to have another provider could actually be a massive burden. I'm not arguing against it. I'm just saying we need to have that use case to work through what it could actually mean.

Cynthia Fisher – WaterRev LLC - Member

And who allows for rationalization when somebody gets charged 23 times the Medicare rate for a service that they could have gotten three blocks away near the Medicare rate. So, having that transparency is critical. And it can be done. It's the will to be done. Of course, there's going to be a lot of objections about it because of the protections and that's built into opacity. So, that's a topic for tomorrow. But I just was looking for, at this moment, a clarification on accountability of the HINs when prices aren't transparent and aren't posted. We had enough challenges just even trying to get the charge masters' prices displayed. So, I just throw that out into the cue. So, who is accountable and how are they accountable in the definitions as defined by Congress?

Andrew Truscott – Accenture – Co-Chair

And those are good points. We are going to talk about it tomorrow. Please can everybody, when we're thinking about this stuff over the rest of today and tomorrow, try and come up with how we want this to work so that when we get together, we can prevent unintended consequences and debate the intended consequences because I'm sure we have a difference of opinion on that as well?

Cynthia Fisher – WaterRev LLC - Member

I have a 2:00 call so, I'm sorry, I'm going to have to sign off.

Andrew Truscott – Accenture – Co-Chair

That's okay. See you all tomorrow. Take care. Thank you, guys. Take care.