Information Blocking (IB) Workgroup 2

Transcript
March 8, 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
Cassandra Hadley	Office of the National Coordinator	Acting Designated Federal Officer
Mark Knee	Office of the National Coordinator	Staff Lead
Lauren Wu	Office of the National Coordinator	SME
Penelope Hughes	Office of the National Coordinator	Back Up/ Support

Operator

Thank you. All lines are now bridged.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Thank you very much. Good afternoon everyone and welcome to the Information Blocking NPRM workgroup number two on exceptions. Thank you for joining us this afternoon. I am Cassandra Hadley. I am your acting DFO for today. We will officially call the meeting to order starting with rollcall. Andrew Truscott?

Andrew Truscott – Accenture –Co-Chair

Present.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Michael Adcock? Not here yet. Valerie Grey?

Valerie Grey – New York eHealth Collaborative – Member

Here.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Anil Jain? Anil's not here. Arien Malec? Arien is not here. And Steven Lane?

Steven Lane – Sutter Health – Member

Here.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Thank you and I will turn it over to your chair now, Andrew Truscott.

Andrew Truscott – Accenture –Co-Chair

Thank you Cassandra. Hey guys, I think Arien is on his way in. I can see you are intact for the call. Operator, is he dialing in?

Operator

I can double check. Standby. Now joining – Arien Malec.

Andrew Truscott – Accenture –Co-Chair

There we go. Arien joined in.

Arien Malec – Change Healthcare – Member

Hello. Sorry about that.

Andrew Truscott – Accenture –Co-Chair

Hi guys. How are you doing? Okay we are now **[inaudible] [00:01:46]**. I think Anil is here, Arien, Steven and Valerie. Yes?

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Check who we have.

Anil K. Jain – IBM Watson Health – Member

Yes.

Arien Malec – Change Healthcare – Member

Yep, yep.

Andrew Truscott – Accenture –Co-Chair

Okay cool. Okay so I am assuming you have all got the Google document open again looking at the number of people in there. So, we have got two topics to go through today. The first one being recovering costs reasonably incurred.

Arien Malec – Change Healthcare – Member

This one will be easy.

Andrew Truscott – Accenture –Co-Chair

There are copious notes from Arien so maybe Arien needs to start off with **[inaudible] [00:05:25].**

Arien Malec – Change Healthcare – Member

Sure.

Mark Knee – Office of the National Coordinator – Staff Lead

Before we start. I think we have not touched on the security exception. It was on the agenda for the first meeting but I don't think we – did we get through that one?

Andrew Truscott – Accenture –Co-Chair

We will be coming back to that. I am addressing everything that was in the scheduled agendas and then we are going to mop up at the end.

Mark Knee – Office of the National Coordinator – Staff Lead

Okay.

Andrew Truscott – Accenture –Co-Chair

Okay, thanks Mark. Arien.

Arien Malec – Change Healthcare – Member

Sure, so let me pull up – I can't obviously remember all of the comments that I did. I did finally figure out that I am probably blocked at work, and so I am able to do all the work from home. So, I have got some limitations in terms of when I can do some of this work. A lot of these comments will make more sense when we go through all the detail, but the highest level commentary is that my impression of the pricing, the net of the pricing exceptions, 204 and 206, is that they are really tuned towards cases where there is some rent seeking behavior that is secondary to installed use, for example, of any HR. And I can remember, that being a provider, for example Results Transmission Services, where I was both an actor providing result information services and then dependent on EHRs opening up their interfaces and in many cases the total cost to open up interfaces might be $25,000 an interface across a broad community. The total cost of opening up interfaces might be significantly more than the cost of providing orders and results exchange services broadly.

The point being that I definitely acknowledged the case of rent seeking behavior, but also I am concerned that the pricing restrictions that are tuned to price limitations for rent seeking behavior will have significant unintended consequences for providers of innovation oriented services, other kinds of services and I enumerate a number of those details through the text. So that is the meta-comment.

The more detailed comments relating to recovering costs reasonably incurred are – sorry this was all set pursuant to the previous conversation we had to today, which is especially problematic for that 204 and 206 is when coupled with the broad definition of both EHI and HIN creates a broad applicability of pricing restrictions that I think were intended to mitigate rent seeking behavior.

So the commentary text and I have got somewhere in my Twitter threads the exact reference to the commentary text, but there is a comment to the effect that reasonable profits are allowed but the reg text speaks in terms of recovering costs. And this may just be my too much reading of PNL statements but to me there are costs, and then there is revenue and costs are costs and revenue is revenue. Cost recovery to me implies that you are recovering expense. That is the difference between revenue and expense should be zero. This is an area where I think when you read the reg text and then you understand it one way and when you read the commentary, perhaps there was a different interpretation that was intended but it is hard for me to get to that interpretation reading the strict reg text.

Third comment is that the 204 explicitly prohibits both value-based pricing and pricing tiered on revenue, profit, expense, etc. I think the intent of that section was to prevent price gouging from actors who may be dependent on data, but the notion that you would value-base price or the notion that you would tier pricing based on objective metrics that often are revenue or expense based is a pretty common practice. So as an example, not referring to my own pricing or to business pricing services that I have been involved in, I looked at the pricing tiers for Commonwell, the pricing tiers for Manifest Medex, you see the notion of revenue tiering or operating expense tiering as a very common price tiering mechanism that is very commonly used in pricing practices. And so I think you'd see with adoption of 204 significant disruptions to existing pricing services.

The third point, or fourth point, is that there are cases of very business reasonable pricing flexibility or pricing tiering that are commonly used, and again I'll give examples outside of healthcare, so you might have entry-level pricing, there's a freemium model that's commonly in play for API-based connectivity. You often see negotiated discounts, so you might have a price sheet and then some negotiation off that price sheet. You might have volume discount tiering where the price may go down based on commitments to specified volume. All of these are usual pricing practices that to my knowledge no one has ever objected to but would all be prohibited through 204. So, as an example, if I offer a freemium model then I'm not providing uniform pricing mechanisms that are tiered towards cost reasonably incurred or if I incur, you know one of the reasons I do volume-based discounting is because my cost structure goes down the more commitment there is but the cost structure goes down to all of the parties. I am rewarding the organizations who are making volume commitments and again I think that is reasonable pricing mechanism but one that I would read as being outlawed and subject to a million-dollar penalty and perhaps other penalties, through section 204.

So, the fifth comment here is that if I think about the accounting mechanisms that would be required to be in place to comply with 204 it may come as a surprise to people, but most accounting systems are driven by financial reporting to the market or to investors or to other actors for example for not-for-profit. They often don't have the level of detail and specificity that's required to do cost accounting all the way to the product and the customer level. It is a desirable thing to get to. Many businesses try to get to cost accounting or activity-based costing that allow you to do cost accounting all the way to the customer level but is not a usual practice and it would be required in order to comply with 204. And so the net of 204 would be to add I believe significant substantive burdens to organizations seeking to comply with 204.

Those are the main level of concerns with section 204. In terms of more positive framing my recommendation would be, and maybe this would be even more dramatic than ONC was looking for, but my recommendation would number one be to distinguish rent-seeking or pricing where rent-seeking behavior is problematic versus pricing where there's no outward appearance of rent-seeking behavior, and in particular interoperability that is subject to a purchase that's already been made. It is a different category of pricing and price discrimination than interoperability that is subject to or that is independently purchased. The second recommendation –

Andrew Truscott – Accenture –Co-Chair

Could you just amplify that, Arien? What do you mean?

Arien Malec – Change Healthcare – Member

Sure, the very concrete example is that if I purchased an EHR and I have installed that EHR and I am running my business on that EHR, then the only reasonable alternative that I have, the only reasonable method that I have, for example opening a results interface in order to get results from a lab into that EHR is to purchase it from the EHR or to do some level of forced integration which is incredibly expensive in practice. So, that's an example where there is really a monopsony. There's a single seller and, maybe that's a monopoly, but anyway there's a single seller for that, so it is a monopoly case. There's a single seller for that case and that seller has relative to price elasticity, significant incentive to raise prices over and above what's reasonable for opening those interfaces.

In other examples, and I'll give some examples that I have been involved with in the past, operating, ordering, and resulting services. This is an intermediary service in between labs and physicians or EHRs. There's a range of choices that one could select. There's not a single seller for those services. The choice of price for the service is competitive. There's a range of alternatives and so you don't have the same level of pricing concerns. So, I think in conjunction with FTC I believe that ONC could come up with a mechanism for finally targeting these pricing restrictions towards areas where anti-competitive behavior is manifest and then stay away from areas where there is no outward appearance concern of anticompetitive behavior or rent-seeking. That is the general positive comment.

I might even go farther than 204 with respect to opening up interoperability services. I think that there are cases where interoperability services are reasonably required to operate the capability as purchased. And again I'll go back to my resulting example. If I have an HER where charting and viewing clinical lab results is a reasonable capability having the interface available is a zero cost burden to the provider. Now there are cases and I'm sure if Sasha were on this call, there's a ton of cases where there's additional work that's required to configure the interface but actually buying the interface is a zero additive expense activity. And I believe in those cases where interoperability is reasonable and is reasonably required in order to fulfill the function that the price for that interface should be included with the overall pricing [**Inaudible] [15:34]**

Andrew Truscott – Accenture –Co-Chair

[Inaudible] and opportunity costs. **[Inaudible]** an opportunity cost **[inaudible].**

Arien Malec – Change Healthcare – Member

Exactly. Again there are legitimate costs that probably should be done on a pure cost recovery basis for configuring an interface, but really the thrust of this is let's configure – let's recommend that the pricing rules be targeted towards those examples where there is

suspicion of anticompetitive behavior and make sure that they are simple to implement in practice and drive the desired result which is driving down the cost of interoperability. There's a couple of **[inaudible] [00:16:14]** that I have relative to use of nonstandard and acquisition costs that I think we can get down to as we need to but those big items are really the major items that I'm pointing to.

Andrew Truscott – Accenture –Co-Chair

I think the challenge with this one is possibly that it's intended to cover all actors but all actors are not created equal when it comes to the types of costs and the actions that could incur costs.

Arien Malec – Change Healthcare – Member

Yep.

Andrew Truscott – Accenture –Co-Chair

Steven, I thought I heard you clearing your throat.

Anil K. Jain – IBM Watson Health – Member

No, it's Anil. I wasn't sure if you were looking at the hand – I was raising my hand but I wasn't sure if whether we were paying attention to that flag –

Andrew Truscott – Accenture –Co-Chair

Sorry, I was looking at the **[inaudible] {00:16:53]**

Anil K. Jain – IBM Watson Health – Member

Oh no, that's okay. No, it's all right. So, I would say that I generally except when it comes to sort of thinking about what we are trying to do in terms of preventing information blocking. You know one of the things that we hear, at least from my vantage point we see a lot of this, where the revenue models, for example, or that there is an undue expectation that the pricing that someone might put to get data, that's really not their IP, right? I mean it makes sense if you have a revenue model pricing structure when you're licensing your IP but we're talking about health information that's not theirs. And so, to say to someone that you're going to start pricing it in a tier based on revenue it doesn't really make sense. And I think when you talk about recovering reasonable costs we have to start thinking about that if folks start to get priced in a way that starts to look at their revenue model or what they might end up doing with that data downstream I think you could end up in a situation where it would be, for all practical purposes, unnecessary burden and it wouldn't make any sense. It's not their IP. So, it's one thing for a company to say I'm going to give you these – and we do this – at IBM we have groupers. We have risk models. And the more that you might do the price might be better. The higher volume of revenue you might make with some of our models maybe the pricing would change. But to say that I'm going to move data from one place to another that's already been paid for, if you will, through the healthcare transactions I'm

going to start pricing it differently. So, I'm not suggesting that it's **[inaudible][18:41]** but, anyway, I'm sorry. Go ahead.

Arien Malec – Change Healthcare – Member

Sorry, no I apologize for interrupting but I think you're confusing maybe two or three different issues. So one is –

Anil K. Jain – IBM Watson Health – Member

Perhaps I am.

Arien Malec – Change Healthcare – Member

So one is, and I pointed to Manifest Medex as an example, it's a California-based not-for-profit HIE and it does membership tiers based on revenue. And in those cases revenue is a proxy for organizational size. It's a reasonable proxy and it's a pretty common practice. My point was just to say that as a pricing practice it's pretty common and, as far as I know, nobody's jumped up and down and says well you know my price as, I don't know, Sutter or Sutter organizationally to join Manifest Medex should be the same price as a single family practice clinic. So I think everyone agrees and acknowledges that Sutter's a very large organization and the family practice is a small organization and revenues are a reasonable proxy for capturing the size and with objective and hard to game.

Also, relative to the notion that you already paid for it or you already got the data, and again I think you're implicitly putting this into context of opening up an EHR and I'm talking about cases where there are intermediary services that cost money to run and maintain that may have capabilities associated with them that you could freely buy or not buy. And the notion that you would have a right to purchase services to transmit from point A to point B seems to be somewhat strange unless we make all exchange activities truly a public utility and It's not clear to me that, I mean it is clear to me actually, that the states have not been terribly successful at the public utility model to date because if they were, we would spend a lot of money on it and we would have all of the interoperability we need. So, that's really the thrust of the conversations.

I absolutely acknowledge there are cases where there is an EHR you purchased, your data's in that EHR and unless the EHR provides the capability for opening that data you can't do anything with it. A very different case from I got a service I could procure, there are competitors for that service, the market works and I think there's an argument that the pricing discussion should be very different for each of those cases.

Anil K. Jain – IBM Watson Health – Member

Well I would agree but I think if revenue is being used as a proxy for size which is a proxy for what operating expense I might consume in having to deliver those services, that's fine. But what I sometimes see out there, and I think we see models of this, is where they will sometimes use revenue as a proxy for how much they want to start monetizing

interoperability. So, if I make this data available I would like to share and enjoy whatever business models might arise from it. I think that is what they are trying to prevent in this language, I think. And there's a bunch of that out there. And I'm not suggesting that we're all equipped to handle the kind of pricing recovery models that are being depicted here. Maybe the answer is a little bit of both where we need to help ONC understand what's out there today and what's being "acceptable" today versus what I think is going to be less and less acceptable because at the end of the day those prices will need to be transmitted down to the consumer. It's not like anyone is going to be able to say that yes I will accept a revenue model even though it has nothing to do with the costs being incurred. When we start to really look at what's going to happen to the consumer or to the stakeholder, they're not going to be willing to pay those kinds of fees without a very specific reason as to why they are. Why should one group make money off of someone else's innovation? I just don't understand. Isn't that the reason why this language is in here?

Arien Malec – Change Healthcare – Member

Well so, my interpretation of why the language is in here is based on the rent-seeking behavior that I think is legitimately an issue. My point is that if you cater your price regulation around cases of rent-seeking behavior and seek to constrain pricing in ways that are tune to that behavior, the inadvertent effect is that, I gave an example of the start-up that doesn't even know what it's cost model is, what it's full scale cost model is. How is it expected to price its services? You end up in cases where you drive very onerous restrictions on providers of services and capabilities paradoxically driving up the cost of exchange. By the way, I agree with you that riders for data use or price tiering for how valuable the data is are problematic. Price tiering for how valuable the service is, to me, seems to be non-problematic. Does that make sense to you?

Anil K. Jain – IBM Watson Health – Member

I've got to think about that some in terms of differentiating between the service – this is way beyond what we're talking about here but often, not often, occasionally just the simple act of inserting something into the data – some curation or standardization of some kind or some translation – could be perceived as an additional service.

Arien Malec – Change Healthcare – Member

Yeah, it is.

Anil K. Jain – IBM Watson Health – Member

And so, well – it depends. If you're doing it to hide behind the fact that you're creating new IP that you can now charge more for versus that there is intrinsic value in that particular thing and not every consumer or customer is able to discern that. So, I think I would agree that service is different than just raw data, if there's a true service being available, but if you're going to provide those additional services for a different price then there ought to be an ability to get at the actual data that's not been enhanced in any way without having to incur additional fees above and beyond what's reasonably –

Arien Malec – Change Healthcare – Member

So, that's exactly the point that I was trying to make. In terms of pricing for raw data is extraordinarily problematic and price tiering for raw data is problematic. It's the price tiering for value-added services and tiering for value-added services where I think you get into the unintended consequences. And I'm sure you've got examples from your own businesses where I think if you examined pricing practices you'd say "oh, I'm pretty clearly an information blocker" and you kind of wander down the thicket of what would I need to do in order to meet these things. At least in my example in services that I run and operate I would look at that and go "Boy, everything about the pricing needs a change and guess what? Pricing's not going down." When it gets to the reality of it.

Andrew Truscott – Accenture –Co-Chair

We do need to step away a little bit from our own businesses but…**[inaudible] [00:27:07]**

Arien Malec – Change Healthcare – Member

It's just an example of –

Andrew Truscott – Accenture –Co-Chair

It's a good example. I'll be straight with you. I actually have intellectual problems with thinking through some of this stuff in this particular area because the fact is that not all actors of the same type are created equal. So, not all providers are equal. Not all HIE's are equal. Not all HINs are equal. Not all payers are equal. And some of them out there are going to take substantive amounts of investment to enable them not to be an information blocker. And some of them are going to sit there and look at whether the cost of doing so is something which is worth doing given the level of the penalties they might necessarily accrue. So, I think we all know on this call those questions are already being asked by organizations who are aware of the nature of the rules and have gone through and worked out what this impact could be to them.

Arien Malec – Change Healthcare – Member

Can I comment that out of this discussion I think there are some really interesting categorizations that I think could be at least part of a solution or at least be helpful for framing up the discussion. So, one is some relatively objective quantification, again, I believe that FTC could help out with this, situations where there is at least a risk of anticompetitive behavior or a risk of monopoly based or rent-seeking based pricing. Number two is a principle that I think we all agree with on this call, and maybe we should pause and see if we do, which is that there are very different considerations relative to pricing and availability for raw data relative to value-added services. And maybe part of the intent is that the value-added services go into 206 and we really should consider 204 and 206 as a whole but that maybe there's a way to frame this out in terms of free or very low cost access to the underlying data as distinguished from value-added services.

[Inaudible] [00:29:49]

Andrew Truscott – Accenture –Co-Chair

Yes, I agree with you and I agree there is a difference in the nature of access to all data versus access to value-added services. I agree completely. The point I was trying to get to was that for some actors to provide access to data that they curate, for want of a better word, is going to be a much heavier lift than others. And it's not just the case that everybody is on a level playing field, it'll just flip a switch and the pipes are magically on. Some actors are going to take substantive amounts of organizational change and certainly technology implementation and configuration. Would you concur on that?

Arien Malec – Change Healthcare – Member

Sure.

Andrew Truscott – Accenture –Co-Chair

Steve Lane has actually asked a question in the public box. "Arien, can you just define what you mean by rent-seeking behavior please?"

Arien Malec – Change Healthcare – Member

Sure, so this is a term of art in economics relative to monopoly-based pricing but it's the notion that if I control – the analogy is based on if I control the plot of land and you've got to come to my plot of land then I can charge pricing that may be decoupled from the actual value that I'm providing. So, in the case of – again let's go to the case of an EHR that you've purchased. You may have spent multiple millions of dollars on purchase and implementation and then you come to time to open up a lab interface. There may be no material cost to opening up that lab interface besides flipping the proverbial switch but the vendor can charge pretty much whatever price they want to for opening up that switch. So, those are cases of monopolistic or rent-seeking pricing behavior.

Andrew Truscott – Accenture –Co-Chair

Isn't it more likely you will see an HIE that egregiously charges for use of the pipes that it provides?

Arien Malec – Change Healthcare – Member

Those are examples where it's hard for me to figure out – if there's only a single HIE – so if we have an example where the state has mandated that all exchange needs to go through an HIE then I think clearly you have a monopoly situation or a potential rent-seeking situation. But if you have a choice of multiple actors who can reasonably provide similar services you really just don't have the same level of considerations, which is why I am not suggesting tuning it to monopoly situations or potentially any competitive situations.

Steven Lane – Sutter Health – Member

So, I would like to just ask. This has been a fascinating discussion that clearly goes into areas that are not my training or expertise which is totally fine. But what exactly is our charge with regard to this exception? I mean we can debate kind of the policy issues, etc. but I think we should bring it back down to what feedback are we going to provide and what direction are we planning to encourage here.

Andrew Truscott – Accenture –Co-Chair

Yeah, I think that's what we're getting to Steve, which is like we are looking at this exception and just at the very highest level, is this effectively identifying where costs have been reasonably incurred and allowing access to recover them and is this the most appropriate way of doing it and is this effective? And I'm sure the ONC drafters have considered many, many different approaches to this and this is the final one that they thought was the best balance and the most implementable. And I think we are debating kind of whether we agree.

Mark Knee – Office of the National Coordinator – Staff Lead

To that point, can I weigh in Andy, just for a minute?

Andrew Truscott – Accenture –Co-Chair

Can I stop you?

Mark Knee – Office of the National Coordinator – Staff Lead

Sure, yeah.

Andrew Truscott – Accenture –Co-Chair

No don't. Please, please go. Go, go, go, go.

Mark Knee – Office of the National Coordinator – Staff Lead

I was like, "Yeah, sure. You can stop me." Just a few points and I think this is a really interesting discourse and I'm not going to weigh in – I think from my perspective what I'm hoping to get is if our goal, I think like Arien laid out, was to create and exception that still promotes innovation, addresses anticompetitive behavior and bad actors and rent-seeking and creates a reasonable framework for addressing costs. And to Arien's point, we worked closely with OIG and FTC on this and we did toss around different ideas and the one we came up with. It's not **[inaudible] [00:34:56]** but we think it provides flexibility similar to that and we're looking at the methodology that's involved, which from our perspective provided flexibility that looking at something like direct and indirect costs might not or some structure like that.

However, you all have great experience with all this and I'd be interested to see if you think, you know we didn't strike the right balance with addressing anticompetitive behavior, rent-

seeking and promoting innovation, what suggestions you might have for improving on this exception to get to that and addresses folks who are not acting the right way but also allowing profits. And, to your point Arien, if you don't think that a reasonable profit being allowed is clear enough I see your point. Definitely that's something you are welcome to provide comments on because our intention is to allow reasonable profits.

Arien Malec – Change Healthcare – Member

Thank you, yes.

Anil K. Jain – IBM Watson Health – Member

This is Anil. I guess, I think it's important to allow reasonable profits. Obviously I'm in big favor of reasonable profits. But the profits should be made off of additional services or enhanced services as opposed to – I think maybe we are all saying the same thing – as opposed to simply giving or allowing to be shared what has already is not theirs or is not yours or is the patient's if you will. I guess I want to discern between what we're allowing them to make a profit on or allowing folks to make a profit on versus not making a profit at all. I think that's not what we're trying to do here, right? Is that clear in here?

Mark Knee – Office of the National Coordinator – Staff Lead

That's our intention but again if it's not clear – There is some language in preamble where we talk about how we don't view EHI as a commodity that should be bought and sold the same way that other commodities are. And that as far as the ownership the patients have a real stake in that data that's already been paid for. But again, I think if it's not clear then – I think we're on the same page but I encourage comments on that.

Arien Malec – Change Healthcare – Member

Yep. And then one other point here is that it was confusing to me as a reader of the reg text when 206 is applicable and when 204 is applicable and when both may be applicable. So, again just for people who haven't read that far 204 deals with cost recovery and 206 deals with licensing of interoperable elements. And it's I think maybe better guidance in terms of what goes in what bucket, where the buckets are applicable might also help address some of this issue so if pure cost recovery were confined to the conversation Anil and I were just having – so the problem of providing access to the raw data, that might be a solution to the dilemma that we're posing but it was really hard for me to figure out between 204 and 206 what provisions I use when and then how those provisions get flowed down to the operating controls that are required to produce and operate a service.

[Inaudible] [38:37]

Steven Lane – Sutter Health – Member

Sorry, I was just going to say I think the way you separated that Arien was very helpful. The notion that 204 and cost recovery applies to, as we were saying, sort of letting people move data down the pipes, right? I mean this is, as we've said, this data has been collected and it's really the property of the patient if you will and we are simply providing access to it and

there are certain costs and they should be recovered and that's really different than the value-added services that are going to be referred to in 206. So I think that, at a very high level, that's the simple way for me to understand the difference.

Mark Knee – Office of the National Coordinator – Staff Lead

And just a note, that even though I think that it's very important that there is a clear differentiation between the conditions in both, you do only have to meet one exception to be covered under an exception. So, just to say that you could be one or the other, as long as you are covered by one or the other, you wouldn't be subject to the penalties.

Andrew Truscott – Accenture –Co-Chair

No, okay, but okay. I've got that, yeah. The curious thing to me is certainly when it comes to 206 the definition of interoperability elements. Kind of where Arien was coming from – the overlap between 204 and 206. I'm trying to find or at least have a clear definition of what would fall into one and what would fall into the other.

Arien Malec – Change Healthcare – Member

One of the examples that I've used in the past is let's say I take an open source component and I deploy it on a cloud-based service. I run and operate that cloud-based service so clearly anybody could do the same thing that I'm doing. I don't have IP that I'm licensing so it's hard for me to figure out whether I'm licensing something under 206 or not but I'm clearly offering a valuable service relative to 204 that goes above and beyond making data cleanly available. So, those are kind of the test cases that I have, that I try to apply to see whether it's easy to apply 206 versus 204 in practice.

Andrew Truscott – Accenture –Co-Chair

So, for that particular one the APIs just hang on that cloud service. What I think, in the conditions and maintenance stuff come under the definition of essential and interoperability elements so that would be a 206 exemption.

Arien Malec – Change Healthcare – Member

Maybe. We'll find out when we get to 206.

Andrew Truscott – Accenture –Co-Chair

I tried to remove the use of the word maybe in all of this stuff right now.

Arien Malec – Change Healthcare – Member

And again, I think people jump to a frame where I'm opening up an API into an EHR and maybe part of the issue here is I've got a frame or I'm a service provider and this is just my experience versus other people's experience. I've got a frame where I'm a service provider and interfacing with one or multiple EHRs and I'm just as impeded by the lack of data flowing

but it's not clear that my service is essential to open up data. It's a service but it sits in between in the example that I'm given. You could apply the same thing for a direct HISP. There are many direct HISPs that just take the open source stack out of the box and run and operate it and run a service based on it. I think you can enumerate a whole bunch of examples where you're not essential to making data flow in the sense that you're not a pipe into the EHR or to the source record but you are a utility or service or capability that facilitates information flow and that's where I sort of get stuck in between these definitions.

Andrew Truscott – Accenture –Co-Chair

So, just to pick up on one of your points which is around the tiering piece. Many organizations price in terms of **[inaudible] [00:43:17]** expense revenue while it's tiering. I get that. Was that particularly angled B5?

Arien Malec – Change Healthcare – Member

That was angled – sorry let me get my – I have not yet memorized all of the sub-clauses but –

Andrew Truscott – Accenture –Co-Chair

Okay, B5 is "must not be based on the sales profit revenue or other value that **[inaudible] [00:43:41].**

Arien Malec – Change Healthcare – Member

Correct. So, yes that's exactly right. And it might be that the key clause here is – the problematic bid is access, exchange of, or use of electronic health information. Surmising ONC intent, the intent may be around the information itself but I'm looking at, for example, exchange as relative to some of the services that are provided that may have independent value.

Andrew Truscott – Accenture –Co-Chair

Are you peering inside my mind right now? That's exactly what I'm thinking. Picking up from what Mark Knee just said around – this is all around making sure that people don't – aren't making egregious profits from the data itself I'm kind of thinking that B5 shouldn't say access to, exchange of , or use of. That's kind of the general term we're using for information blocking. It should be "from the use of electronic health information."

Mark Knee – Office of the National Coordinator – Staff Lead

Yep.

Andrew Truscott – Accenture –Co-Chair

Mark, how does that sort of sit with you?

Mark Knee – Office of the National Coordinator – Staff Lead

It's your recommendation. I'll just say it's background from a legal standpoint using this terminology "access, exchange, or use" which is the same terminology used in Cures, it ties everything together within the information blocking section. And so, if you're going to, just from my perspective, if you're going to stray from that foundational kind of text you'd want to have a good reason to do so. It sounds like you all believe that there is a good reason to do so and it's your recommendation so feel free.

Andrew Truscott – Accenture –Co-Chair

Yeah, because I think you and I have commented before that a couple of places where we do deviate from that for good reason and I'm wondering that this would be another one of those reasons so yeah. Arien agrees. Anil, Steven, Valerie, what do you think?

Arien Malec – Change Healthcare – Member

If you compared 4 to 5 you will actually see a significant different where 4 is entirely about using the electronic health information and I think actually copying 4 relative to 5

Andrew Truscott – Accenture –Co-Chair

I have no idea what you mean.

Arien Malec – Change Healthcare – Member

Sorry. Look at the definition under 4 – B4 and B5 – and compared B4 to B5.

Andrew Truscott – Accenture –Co-Chair

You mean using it – got it. Yep.

Mark Knee – Office of the National Coordinator – Staff Lead

The only change I would make to what I think you guys are saying is maybe it's access and use as opposed to just leaving the word exchange out because I'm not sure how you could use it without having access to it.

Andrew Truscott – Accenture –Co-Chair

It's the basis for the sales profit revenue or other value. You're going to have to exchange it but you can't sell it profit revenue or other value based on the use of it.

Mark Knee – Office of the National Coordinator – Staff Lead

Okay, now I'm really – Oh, I see what you're saying. You're saying that we should allow innovators to make money on the exchange of it but not on the access and use of it.

Andrew Truscott – Accenture –Co-Chair

Access you could argue – you should be able to but not use.

Anil K. Jain – IBM Watson Health – Member

I think in theory I'm okay with that. I need to think about this a little bit more.

Steven Lane – Sutter Health – Member

Yeah, I'm still stuck where Anil is.

Anil K. Jain – IBM Watson Health – Member

I think if we're saying that access is an important part of the free flow of information how would be carve out and let people make, I don't know, make money –

Andrew Truscott – Accenture –Co-Chair

Ok, the point is that this clause is supposed to be around, well Arien and my interpretation – Arien, correct me if I'm wrong – is preventing persons from making profits upon the nature of the data itself not upon access to or the exchange of it. Because that has to happen otherwise we are going to end up with –-

Anil K. Jain – IBM Watson Health – Member

But that's already covered – okay, I hear what you're saying. You're saying that that would not be covered under reasonable costs because you do want to encourage innovators to make money off of companies or solutions that facilitate access and exchange.

Andrew Truscott – Accenture –Co-Chair

Yes.

Anil K. Jain – IBM Watson Health – Member

Okay, well then, I mean I guess it could be – I've got to think about this some more guys because I'm bugged by the distinctions between access, exchange and use. I know there are distinctions but the simple exchange of information using standards –- if that's a company's business model then that's great but I'm not sure that that's a very good way to be making money. It would be what you would do with that and the services you might provide on top. So, I don't know whether we're making this more complicated than it needs to be or whether that's the way that you guys are right now.

Andrew Truscott – Accenture –Co-Chair

That's kind of why I just want to simplify it but I think, Steven, you said the other day this is a document where you've got lots of nots and negatives and double negatives, etc.

Steven Lane – Sutter Health – Member

It's tricky, right?

Mark Knee – Office of the National Coordinator – Staff Lead

I was just going to suggest – I'm not saying you need to move on but if you look at the RAND licensing exception that Arien was referencing, which I know we're going to get to, it might kind of address some of these issues that you're talking about here in that exception but just…

Arien Malec – Change Healthcare – Member

Can I ask you maybe in particular in my comment on C2, this is an area where it's super in the weeds and we could just decide I will defer if Andy thinks we should just move on from this one, but I've read that language multiple times and I always get hung up on the words. So, when I think acquisition I think – in the frame of mind that I am in when I think acquisition and tangible assets I'm thinking about acquiring a company and amortizing goodwill or depreciating goodwill. And, I don't know when I read the commentary for C2 the intent seemed to be you cannot use as part of the cost basis IP or IP considerations because that really belongs under 206. But it's the use of very precise accounting terminologies – like intangible asset – and use of words like acquisition that just trip me up every single time. So, I wonder whether you can provide in ways that are explanatory and interpretive and are reasonable? If you can just help me decipher that language.

Andrew Truscott – Accenture –Co-Chair

Arien, just so you know when I read this I went back to the preamble and I've clearly said this is not merger and acquisitions in my mind. It's product purchase.

Arien Malec – Change Healthcare – Member

But the language, again this is where I'm like well there's the reg text and there's the commentary –

Andrew Truscott – Accenture –Co-Chair

That text is horrible. It's horrible and clunky and yucky.

Mark Knee – Office of the National Coordinator – Staff Lead

So this might be one, Arien, that I will follow up on just because I want to make sure. You're right, there are complex ideas here. And, I think with the reg text what we're getting at is the second part is pretty clear. That other than actual development or acquisition costs. So, development and stuff like that are okay and if there is, again, I'll just say that if there's a discrepancy between how the reg text is read and the preamble is read that's something that

we want to know about. But I definitely want to make sure I address that comment fully so maybe I'll get back to you on that one is what I'll say.

Arien Malec – Change Healthcare – Member

Just to give you the gloss in what's tripping me over – when you say it's really clear on the second part of that's really clear, that's actually the part that I have a hard time with because, again, from an accounting and finance perspective if I acquire a company – so I acquire IBM, let's say, for I don't know $100 bucks and then the assessor says the cost basis of IBM is $10 bucks – so just the actual physical plant and stuff is worth $10 bucks. The $90 bucks that I paid over and above the book value for IBM – that $90 bucks is amortized as goodwill? That's an intangible asset? But the total cost that I paid for acquiring IBM is $100 bucks. I think to Andy's point they're actually talking about purchasing a product or purchasing a capability?

Anil K. Jain – IBM Watson Health – Member

At least in my world when I deal with language like this we use intangible assets to represent our patents so if there is a cost associated with – a value associated with a patent – what I think they're trying to saying here is you can't try to take the cost of the patent as a cost of doing this kind of exchange. And I think the word acquisition is exactly right. Sometimes in our development world we'll acquire a set of tools to do something. But I think that's what they're trying to say here.

Arien Malec – Change Healthcare – Member

I agree. That's what's consistent with the commentary and I just think we need to provide maybe some alternative wording relative to the reg text.

Andrew Truscott – Accenture –Co-Chair

[Inaudible] [00:54:27] If he changed the word intangible to product assets this would all make sense.

Anil K. Jain – IBM Watson Health – Member

Well, no, but I mean the word intangible assets, or the phrase, has its very specific meaning and I think what they're saying is you can't throw your copyrights and your brand and your patents all these other things into this to try to increase the costs and therefore charge more to a potential client.

Arien Malec – Change Healthcare – Member

Yeah, this will get weedy very quickly but intangible asset doesn't have the sole meaning that you're implying so in some cases product development costs will be accounted for as an intangible asset. If, for example, I am building products for sale as opposed to building product for internal use it will be an intangible cost in the first case.

Anil K. Jain – IBM Watson Health – Member

Yes, right, which is why they said other than the actual development.

Arien Malec – Change Healthcare – Member

Yeah, exactly. And then it gets super weedy. I just think we need to help our friends at ONC maybe more precisely tune this language relative to the commentary.

Mark Knee – Office of the National Coordinator – Staff Lead

Yeah, and I'd say that I'm not necessarily weighing in. It sounds like we're on the same page generally and these are very complex issues and you all have really good experience in real life dealing with types of things like acquisitions so if you have suggestions I'll definitely try to follow up but based on kind of the intent that we're talking about if you're able to provide some suggestions, sure, that's helpful.

Arien Malec – Change Healthcare – Member

Cool. Thank you.

Andrew Truscott – Accenture –Co-Chair

Yeah, I didn't think we were going to **[inaudible] [00:56:05]** Okay, anything else inside this one at this juncture? Valerie, you've been very quiet.

Valerie Grey – New York eHealth Collaborative – Member

I have been. I have been listening and you know definitely trying to follow. I did for this section, there were a couple of things. The discussion that you just had on I think 5 where there's a suggestion to remove access to and exchange of I guess I'm just trying to follow – my current role is that we work on health information exchange. There is a cost to sort of doing the patient matching, having the pipes, the platform, etc. And what I was trying to figure out from your conversation did that somehow remove an HIE's ability to just try to obtain sort of reasonable reimbursement for those costs. And then I did have something more specific – a question on C6 and 7. I'm not sure if we're there yet but –

Andrew Truscott – Accenture –Co-Chair

Let's just pick up on B5 while I've got it in your mind. The proposed change is because it's an exception that must not be based by removing exchange from it, it means that an HIE can recover its costs whereas –

Valerie Grey – New York eHealth Collaborative – Member

Got it.

Andrew Truscott – Accenture –Co-Chair

Whereas is currently drafted it seems to say you can't recover costs so it's based upon exchange.

Valerie Grey – New York eHealth Collaborative – Member

Got it. Thank you. That works for me. So, are we going to move to C and do that?

Andrew Truscott – Accenture –Co-Chair

Sure. We're in C. We were just on C2 so C6 and 7 are within –

Arien Malec – Change Healthcare – Member

We haven't talked about C1 or I did have a comment there but I've talked so much I'm going to shut up.

Valerie Grey – New York eHealth Collaborative – Member

No, it probably makes sense to go in order. That's probably more orderly.

Andrew Truscott – Accenture –Co-Chair

I was going to let you have the floor but okay. Let's go to C1 then. Go on.

Mark Knee – Office of the National Coordinator – Staff Lead

Are you all able to see the screen by the way on my computer?

[Inaudible][00:58:35]

Arien Malec – Change Healthcare – Member

Mine's stuck on the agenda slide.

Andrew Truscott – Accenture –Co-Chair

I'm looking at the Google document online. If Accel can put it online that would be great.

Mark Knee – Office of the National Coordinator – Staff Lead

Let me try to work on that. You can carry on.

Andrew Truscott – Accenture –Co-Chair

Let's move on to C1.

Arien Malec – Change Healthcare – Member

So I went back to cures. I actually read the cures legislative text and this came almost straight out of the legislative text. It may be hard to refute. When I read the commentary, the commentary makes sense. I get tripped up over the word non-standard. So the intent here both in the cures legislation and then when you read the commentary is if you design your IT solution in ways that makes it hard to get access to the data. And so, the examples of this is I've got an EHR, the database tables aren't documented, I don't offer an interface to get at those database tables and so I've got to go hire a contractor or consultants to go get access to that data then that's a burden and I cannot charge the costs due to my own dumb design. That's my interpretation of what this is intended. The non-standard ways, to me, makes it hard for me to interpret and I know this came straight out of the cures legislation. But to me.

Andrew Truscott – Accenture –Co-Chair

Actually Arien, you don't need it in there. It doesn't add to the sentence.

Arien Malec – Change Healthcare – Member

I agree, it doesn't add to the sentence. I think a lot of the burden that this is pointing at is not burden associated with standards implementation its burden with obfuscated or hard to understand implementations or ways where it's difficult to get access to the data. And I think we should restrict this language or we should make this language clearer and actually open it up more to cover those cases where there's a burden to get access to the data that I've implemented. I can't charge you the costs that are relative to that burden to get access to the data.

Andrew Truscott – Accenture –Co-Chair

I think you and I see eye to eye certainly in the way you just expressed it. Due to the help IT being designed or implemented in ways there are necessary increase in complexity not your non-standard. Unless you're trying to increase the complexity. But where I struggle with is, hold on a second. The example you gave was clearly around an EHR being constructed. Well what about if I'm an organization that's implemented the aforementioned EHR and most EHR pullouts are highly configurable so actually all of a sudden I've got a cost as an organization that I need to bear. As I provide an organization. Is that a yes?

Arien Malec – Change Healthcare – Member

Yes.

Andrew Truscott – Accenture –Co-Chair

Okay, that's my reading of it too. It doesn't matter who you are. If you have imprinted it there's a cost and you cannot pass that cost on anywhere.

Anil K. Jain – IBM Watson Health – Member

This is Anil. I'm getting hung up on two things. Why is the word certified not before health IT. If it's not certified health IT, what is the expectation that it would be standard anyway, right?

So, maybe what this should be is that due to the certified health IT not being implanted in a standard way. Because that is the real problem, right? You have a certified piece of technology that doesn't get implemented in a standard way and that does increase the cost of health IT or HIN department or a group paying unnecessarily or costing unnecessarily. The point is there will be a cost.

[Inaudible] [1:03:11]

Arien Malec – Change Healthcare – Member

Health IT is defined in 42USC300JJ subsection 5. I would assume that if ONC used the term health information technology and not developer of certified health information technology they're referring back to 42USC which is defined as "hardware, software, integrated technology or related licenses, intellectual property, upgrades, package solutions, sold as services that are designed for or support the use by health care entities or patients through electronic creation, maintenance, access, or exchange of health information. "

Mike, do you want to comment? Is that interpretation that I have when I read that language and go back to that definition, is that a reasonable interpretation?

Mark Knee – Office of the National Coordinator – Staff Lead

I'm sorry, Mark? Are you talking to me?

Arien Malec – Change Healthcare – Member

Mark, sorry. I apologize.

Mark Knee – Office of the National Coordinator – Staff Lead

It's okay. Sorry, I was trying to figure out the screen sharing thing. Can you just repeat that one more time?

Arien Malec – Change Healthcare – Member

Yeah, so the term in C1 refers to health IT and health IT is not a defined term as far as I can tell in the information blocking section. But health IT developer of certified health IT technology refers to health information technology which then refers back to the 42USC300JJ subsection 5 definition and then I read out subsection 5. The term health information technology means "hardware, software, integrated technology or related licenses, intellectual property, upgrades, package solutions, sold as services that are designed for or support the use by health care entities or patients through electronic creation, maintenance, access, or exchange of health information. " So the question is am I following those breadcrumbs correctly when I look at C1 and get back to the Public Health Service Act definition for health information technology or was there a different interpretation that I should have followed?

Mark Knee – Office of the National Coordinator – Staff Lead

Sorry, that's a lot. So health IT, I think you're right. That's a term that we use throughout the document in the same way. I guess to the other point about why it's not specified certified health IT it's because while in the context of a health IT developer of certified health IT we clarify "of certified health IT" because in that definition the developer would have had to have one certified product certified when the conduct occurred. Within information blocking we are looking broader than the product. It's not at the product level. We're looking at the developer had to have a certified product but it could be they could get in trouble for conduct that is different than conduct related to that product. So, that's why we don't specific certified product because with information blocking the scope is much broader. It goes to the conduct and not to the product. I guess maybe to your question – you're asking about what the definition of health IT is here then? Is that right?

Andrew Truscott – Accenture –Co-Chair

I think you've kind of answered it. You don't mean certified health IT because that's too narrow of an interpretation. You mean all health information technology.

Mark Knee – Office of the National Coordinator – Staff Lead

Exactly. When we say health IT we're referring to the same kind of broad scope – not the same but with EHI – it's a broad term that we're using.

Lauren Wu – Office of the National Coordinator – SME

So Mark, this is Lauren. Could this also refer to the fact that if you look at the language we're talking about an actor here and in the context of information blocking an actor could be more than just a health IT developer. It could also be a provider or an HIE. And so it could be due to decisions upstairs to implement technology in a nonstandard way that may be outside of the control of the developer or not a decision made by them that also could implicate this.

Mark Knee – Office of the National Coordinator – Staff Lead

I think that's exactly right. And I think that it applies throughout as well. As to Andy's point – Andy you think it's a problematic kind of aspect of all of this but

Andrew Truscott – Accenture –Co-Chair

No, I don't. I think we have to read it with the lens of each actor and realize actually yes, we actually do mean this very broadly across all those actors but it manifests in different ways to those actors.

Mark Knee – Office of the National Coordinator – Staff Lead

Yep, yep. So, Lauren I think you're exactly right. That's a really good point.

Andrew Truscott – Accenture –Co-Chair

It is suggested we move into words **[inaudible] [01:08:08]** health IT as well so it's not so specific because that insinuates specific when it's not – it's general. Steve, are you feeling more comfortable?

Steven Lane – Sutter Health – Member

You're speaking to me? Steven Lane?

Andrew Truscott – Accenture –Co-Chair

Yeah well, Steve's your name.

Steven Lane – Sutter Health – Member

No, no that's fine. I just wanted to make sure. Yeah, I am following this and **[inaudible] [01:08:40]** in a good direction. I do want to warn you that I am probably going to drop in 15 minutes – at 5 minutes before the hour.

Andrew Truscott – Accenture –Co-Chair

Ok, that's fine.

Steven Lane – Sutter Health – Member

I'll just acknowledge that you guys – my expertise is not the same as yours in some of these areas and I'm enjoying and listening and looking for opportunities to provide valuable input but if I'm quiet that's why.

Arien Malec – Change Healthcare – Member

We definitely want the clinical experience as well and I think your point, Steven, of highlighting areas where there are activities that people point to as information blocking that are actually clinically reasonable and appropriate – As we get into the regulatory weeds we probably need you to pull us out every so often.

Andrew Truscott – Accenture –Co-Chair

Okay, let's move to C3. It's another one of these we're using specifically the term "forward looking cost." That means something.

Arien Malec – Change Healthcare – Member

As everyone whose done an NPV knows it all really depends on what your discount rate is.

Andrew Truscott – Accenture –Co-Chair

Steven is about to go "what are you guys talking about now?" Then Steve actually will say "Yeah, yeah, I do it all the time." Okay.

Arien Malec – Change Healthcare – Member

I understood the interpretation of this. Why are we doing this? I think that the concern that ONC had is that I could say "well, if I've got to go – " Let me give an example of an EHR developer. "If I've got to go build you a goddam interface to open up orders and results then I can't go build this really very valuable feature that I need to go build that you're going to pay me money for. So, I'm going to attribute part of the cost of building your interface – your stupid, little interface – to the profit that I'm foregoing for this other, more productive use of my capital." If you read the preamble that was the intent is I cannot attribute to the costs of providing an interface, other, more productive uses of capital that I might do. Then as an allowance then there's this thing of reasonable forward looking cost capital. So, if my cost capital is 10 percent then I can attribute 10 percent to my cost capital.

Anil K. Jain – IBM Watson Health – Member

The actual cost of the capital that you invested as opposed to what you might have done with that capital. That makes sense.

Andrew Truscott – Accenture –Co-Chair

Everything you're saying makes absolutely perfect sense and I love the fact that the caption doesn't pick up on goddam or stupid. I thought that was amusing. But do we mean forward looking or do we just mean except for the reasonable cost of capital?

Arien Malec – Change Healthcare – Member

I think we mean cost of capital. I agree. Forward looking is a red herring in that context.

Andrew Truscott – Accenture –Co-Chair

I think so. Because what you guys just described as a use case is actually backwards looking because it's incurred costs. I'm just marking up the document that all of these – what we might do.

Mark Knee – Office of the National Coordinator – Staff Lead

Just a note, I think that Arien's description of what our intent was is accurate for that one – for opportunity costs.

Arien Malec – Change Healthcare – Member

[Inaudible] [01:12:22] of the word stupid.

Anil K. Jain – IBM Watson Health – Member

This is why we keep him around.

Mark Knee – Office of the National Coordinator – Staff Lead

Minus the stupid and not weighing in on whether forward looking makes sense or not but generally the example you provided was accurate.

Andrew Truscott – Accenture –Co-Chair

In which case, in our particular learned opinion forward looking probably doesn't make sense. It's just the general cost of capital which does make sense. Although it's obviously some of Arien's personal experience in developing interfaces that he calls them stupid and teeny. 45CFR164, 524C4.

Arien Malec – Change Healthcare – Member

This is the cost of patient access so there are additional fee restrictions on patient access that are over and more restrictive than this section.

[Inaudible] [01:13:24] I'm pretty sure I looked it up and that's what it was but yes.

Andrew Truscott – Accenture –Co-Chair

It's HIPAA permits the entity to charge a reasonable cost based fee that covers only certain limited labor, supply and the postage costs that may apply in providing an individual with a copy of the PHI in the form or format requested or agreed to by the individual.

Arien Malec – Change Healthcare – Member

Correct.

Andrew Truscott – Accenture –Co-Chair

Ok, so we're good with that. I love the way that this is a negative to a negative within an exception so it's a triple negative. Actually, yes, okay. So it's a negative to a negative over negative within a negative. It's a quadruple negative. Thanks Steven. So, basically we're saying that fee is permitted. No, that fee is not permitted.

Arien Malec – Change Healthcare – Member

No, it's the other way around. It's the other way around. It excludes any fees that are prohibited.

Andrew Truscott – Accenture –Co-Chair

Yes, it excludes. The exception does not apply to a fee that's prohibited that way. There we go. Got it. Yes. Moving on.

Steven Lane – Sutter Health – Member

Meaning it's still prohibited?

Arien Malec – Change Healthcare – Member

Still prohibited.

Andrew Truscott – Accenture –Co-Chair

Yes.

Steven Lane – Sutter Health – Member

Okay.

Andrew Truscott – Accenture –Co-Chair

A fee based in any part on the electronic access by an individual or their personal representative, agent or designated individuals electronic health information.

Arien Malec – Change Healthcare – Member

What's fascinating about this one is that it seems to override HIPAA but then Cures actually in some sense is an amendment to the fee section of patient access for HIPAA.

Andrew Truscott – Accenture –Co-Chair

Well a member is different versus override.

Mark Knee – Office of the National Coordinator – Staff Lead

So, I just want to be clear. We were real careful.

Arien Malec – Change Healthcare – Member

I'm sure you were.

Mark Knee – Office of the National Coordinator – Staff Lead

Our intent is in no way to override or conflict with HIPAA and I believe we actually – I know we talked about how the HIPAA fees for printing and all of that are allowable. So I don't this conflicts but again if you think it does let us know.

Andrew Truscott – Accenture –Co-Chair

So, you're saying that some fees are allowable because we just read out the one above. I'm getting my negatives all confused again.

Arien Malec – Change Healthcare – Member

Yeah, this prohibits – this exception does not apply – what is not applied to. But it's also cost specifically excluded so it's really hard to figure out. Can I charge postage?

Andrew Truscott – Accenture –Co-Chair

I'm going to go into actual C and look at it – provisions of access.

Arien Malec – Change Healthcare – Member

This is electronic health information exchange so I can't charge postage.

Andrew Truscott – Accenture –Co-Chair

HIPAA says I can include the cost of it to be mailed.

Arien Malec – Change Healthcare – Member

But this is electronic – yeah so this is electronic information.

Andrew Truscott – Accenture –Co-Chair

Supplies for creating a paper copy or electronic media.

Arien Malec – Change Healthcare – Member

Yeah.

Andrew Truscott – Accenture –Co-Chair

And I can do labor when it was in electronic form. This is HIPAA I'm reading. This is –

Arien Malec – Change Healthcare – Member

That's right.

Andrew Truscott – Accenture –Co-Chair

This is 174524. I can impose a reasonable cost based fee.

Arien Malec – Change Healthcare – Member

But then how does that line up with C5?

Mark Knee – Office of the National Coordinator – Staff Lead

If we want to come back to this one – I'm looking. I know we have a language to address this but you guys can keep talking. It's a big rule so, you know, finding it.

Andrew Truscott – Accenture –Co-Chair

I think it lines up. In C5 we're saying – the electronic access may incur a cost and we earned it lined up in 164524 C 4 1 does cover the labor for the electronic form.

Arien Malec – Change Healthcare – Member

Any part on the electronic access by an individual, their personal representative, agent or designee. This is why my interpretation is C5 overrides C4 or is more restrictive than C4.

Andrew Truscott – Accenture –Co-Chair

C4 – actually here's the curious thing – C4 doesn't really have any prohibitions only by exclusion.

Mark Knee – Office of the National Coordinator – Staff Lead

So the guidance in this area – and this is some of the work that Devin did when she was Deputy Director at OCR – the guidance on API access is that an API is a form and format that's been requested and it's readily producible by the patient and that the cost provisions of HIPAA only cover the direct cost of – sort of the direct marginal cost – of that API, which would be electricity and server time, for example. So, it should be close to zero and I think C5 is saying "well, it should be actually zero."

Andrew Truscott – Accenture –Co-Chair

So, I've copied the text in below.

Anil K. Jain – IBM Watson Health – Member

To Mark's point we probably should move on.

Mark Knee – Office of the National Coordinator – Staff Lead

Just to direct you guys to page 445 of the preamble. I think it has to do within 5 we're talking about electronic access for the individual which we're viewing as it should be free. But we do say – we emphasize that access to EHI those provisions are supplying some form of physical media such as paper copies, or were EHIs copied onto a CD or flash drive.

Arien Malec – Change Healthcare – Member

I hear the distinction. So if I can read back out the distinction that's attempting to be made it is reasonable to, if the patient requests physical media, it is reasonable to charge the patient that actual cost of the physical media but it is not reasonable to charge the patient the cost of purely electronic exchange.

Mark Knee – Office of the National Coordinator – Staff Lead

Yes and we don't want to conflict with HIPAA and those costs that are allowable under HIPAAA – the way we're looking at that them they are reasonable as they would be under this exception.

Arien Malec – Change Healthcare – Member

Yep, got it. I couldn't charge a penny for patient access for access to an EPI because it cost a penny of electricity.

Mark Knee – Office of the National Coordinator – Staff Lead

Well no and it goes to the data export as well. The patient should be able to get this electronic access free.

Andrew Truscott – Accenture –Co-Chair

And so let's take it a step further **[inaudible][01:20:35]** I couldn't charge for the electricity but could I charge for the portal that I provided into my EMR that gives them access to their records?

Arien Malec – Change Healthcare – Member

No, by my reading.

Andrew Truscott – Accenture –Co-Chair

I don't think so. And that's my reading as well. So, the fact that I've had to procure software to give a patient access I can't charge them.

Arien Malec – Change Healthcare – Member

So, maybe in 5 it would be helpful to put the word purely or something similar just to help distinguish 4 and 5 better for the easily confused like me.

Andrew Truscott – Accenture –Co-Chair

As is that's really the case – easily confused. Yes. I'll add that in my comments. Okay, so we've moved to 6. **[Inaudible] [01:21:43]** health IT certified – why didn't you say certified health IT?

Arien Malec – Change Healthcare – Member

Certified 2 – now this is referencing the specific certification criterion. So, you can't charge, again, relative to our conversation about electricity and compute time, if I'm a **[inaudible] [01:22:10]** provider of technology and I incur electricity and compute time for producing an export certified to that capability I don't get to charge for that? Nor do I get to charge the compute time associated with providing the patient the electronic information?

Andrew Truscott – Accenture –Co-Chair

I think we agree on that.

Mark Knee – Office of the National Coordinator – Staff Lead

Was that a question or are you just stating?

Arien Malec – Change Healthcare – Member

That's our interpretation.

Mark Knee – Office of the National Coordinator – Staff Lead

Yes, because I was going to say I can't weigh in on the – everything is going to be very fact based. But I will say an important key part of 5 is to the individual or their personal representative. There are circumstances where we're talking about exchange between other entities not the individual.

Andrew Truscott – Accenture –Co-Chair

We've moved on to 6 Mark, but yes.

Arien Malec – Change Healthcare – Member

We're on 6. So, if I'm using the capability and I'm using it for the intended purpose which is for health IT then you can't charge me for that.

Mark Knee – Office of the National Coordinator – Staff Lead

Yes, I believe that's right, yes.

Andrew Truscott – Accenture –Co-Chair

So 7, okay. I actually do have an issue with 7 in that it calls out specifically EHR technology and I'm not sure that that's a helpful **[inaudible] [01:23:30]**.

Arien Malec – Change Healthcare – Member

Is it a defined term?

Andrew Truscott – Accenture –Co-Chair

No.

Arien Malec – Change Healthcare – Member

It's problematic when it's not a defined term. So it's the convert data?

Andrew Truscott – Accenture –Co-Chair

Well it says a fee to export or convert data , so it's export or convert, from an EHR –

Arien Malec – Change Healthcare – Member

So, one issue is do you we want to use the term EHR technology if it's not a defined term. The other issue is the "or convert" – and I think Steven's dropped off – but this would be an interesting area where –

Steven Lane – Sutter Health – Member

I do have to drop. I apologize. I'll catch you guys on the next one.

Arien Malec – Change Healthcare – Member

-- So this is an interesting area where there are some conversions that are reasonable. There are some conversions that are necessary for interpretability. So, if I just dump out a hex dump of my database that's not really an export that I can use.

Andrew Truscott – Accenture –Co-Chair

If you dump out a bunch of SNOMED codes. A patient doesn't intentionally read that and understand that.

Arien Malec – Change Healthcare – Member

This one is about converting technology.

Andrew Truscott – Accenture –Co-Chair

For export actually it says.

Arien Malec – Change Healthcare – Member

This is another question which – I think 7 – I think the intended application of 7 is for switching technology.

Anil K. Jain – IBM Watson Health – Member

Wouldn't that be covered by 6 then?

Arien Malec – Change Healthcare – Member

No, 6 covers the use of a specific certified capability.

Andrew Truscott – Accenture –Co-Chair

This is a much more general – it's a general statement but around EHR technology specifically.

Anil K. Jain – IBM Watson Health – Member

Right, but I don't know if this is about switching as much as it is about all those EHRs who are charging providers for every single export for this disease society or for that registry or for that other registry. And I think what's interesting here is that the word convert is kind of vague, number one, and number two it says unless such fee was agreed to in writing at the time the technology is acquired which doesn't really leave room for the ongoing needs that might differ as practice incidentals by participating in programs.

What we hear from our clients is that every single time they want to do a new report in converting from their dataset to another format whether CSV or a database format they get charged.

Andrew Truscott – Accenture –Co-Chair

Okay, so reading the preamble this is specifically concerned with technology transitions so moving between EHRs.

Anil K. Jain – IBM Watson Health – Member

Number 7?

Andrew Truscott – Accenture –Co-Chair

As discussed in this section most EHI is currently maintained in an EHR to other sources since it used propriety data in one of its old formats. This puts EHR developers in a unique position to block the export and portability of EHI for use in competing systems or applications.

Valerie Grey – New York eHealth Collaborative – Member

It's Val. This is was one of the few places where I felt like I had something to say. I interpreted this as involving sort of switching of EHRs but the phrase where it sort of says it's not allowed except that if it's in the contract sort of led me to think for all practical purposes every EHR vendor is going to put it in the contracts going forward and we haven't really accomplished what we're trying to accomplish which is to try and make it easier for providers to make a switch if they desire. I don't know. I could be completely wrong.

Andrew Truscott – Accenture –Co-Chair

That's a good point and it lines up – your thinking lines up clearly with another set of clauses we've got in one of the other work groups where we're saying EHR health IT vendors with your contracts you've got two years to go and change those contracts to make them conform and not to any prohibitive actions. I agree with you. This seems to be a bit of a – "well okay, well as long as it's in the contract you're okay." Also –

Valerie Grey – New York eHealth Collaborative – Member

It seems disingenuous and not consistent with the goal.

Andrew Truscott – Accenture –Co-Chair

Yes. So you're suggesting actually removing this back section?

Valerie Grey – New York eHealth Collaborative – Member

Yes, that would be my suggestion.

Anil K. Jain – IBM Watson Health – Member

I've got a slightly different issue which is that there are conversions that – so let me give you an example – if I have proprietary codes in my EHR and I need to convert to snowmed that seems like a necessary conversion because who knows what my proprietary code set is in my EHR but if you want me to convert from snowmed to your target EHR's proprietary code set that doesn't seem like a reasonable expectation on me as an EHR provider. That seems like an expectation that I should be able to charge for.

Andrew Truscott – Accenture –Co-Chair

So it's actually – if we were rewording this we would reword to "a fee to export or convert data from our health IT technology to a standard format?" And we say to or from –

Anil K. Jain – IBM Watson Health – Member

I don't know about standard because it could be a CSV, right? That could be too broad.

Andrew Truscott – Accenture –Co-Chair

-- or to a health IT standard. Or something like that. We'll come up with a definition that makes sense. The principle there I think you agree. Do you guys see my screen? Or see as I'm updating stuff?

Anil K. Jain – IBM Watson Health – Member

I don't see any movement.

Andrew Truscott – Accenture –Co-Chair

I'm making a comment or –

Anil K. Jain – IBM Watson Health – Member

There it goes. Now it's moving.

Mark Knee – Office of the National Coordinator – Staff Lead

No, that's me. That's me moving so you can see my screen still. Andy, do you want your screen to be showed or –

Andrew Truscott – Accenture –Co-Chair

No, it's fine. As long as you can see the Google document – that's fine. – this is to prevent vendors charging to convert data to or from standard health IT. Got it. We're going to have fun coming up with our recommendations around all of this, aren't we?

Arien Malec – Change Healthcare – Member

Aren't you glad you signed up?

Andrew Truscott – Accenture –Co-Chair

I'm just a humble vessel by which you manifest your ideas.

Arien Malec – Change Healthcare – Member

Yeah, that's not the way it works.

Andrew Truscott – Accenture –Co-Chair

And I'm not that humble but okay, cool. D1. I must confess this is – from a draftsmanship point of view – I wasn't quite sure why D1 was necessary.

Arien Malec – Change Healthcare – Member

Is this relating to API certification? I didn't memorize it.

Andrew Truscott – Accenture –Co-Chair

D1 is "notwithstanding any other provision of this exception if the actor is a health IT developer subject to the conditions of certification in 17402(a)(4) or 17404 the actor must comply with all of the requirements of such conditions for all practices in all relevant terms.

Arien Malec – Change Healthcare – Member

Yeah, I haven't memorized those yet. So 402 –

Lauren Wu - Office of the National Coordinator – SME

So I can speak to this. This would be those health IT developers that – I think the language is "electronically manage data" – and thus must certify to that criterion you were just speaking about a few exceptions to the exceptions ago of the electronic health information export

criterion. The one called B10. So it's basically talking about the health IT developers who electronically manage data are subject to that requirement.

Arien Malec – Change Healthcare – Member

Yeah, 404 is API.

Lauren Wu - Office of the National Coordinator – SME

And 402 is the assurances condition. And A4 says that if a health IT developer electronically manages electronic health information they have to provide their customers the capability to do the electronic health information export.

Arien Malec – Change Healthcare – Member

It's confusing in the fee sections although 404 does actually have specific language on fees. What is it – 402? What subsection?

Anil K. Jain – IBM Watson Health – Member

A4. And with the API…

Arien Malec – Change Healthcare – Member

And then that points to 173 315 B10?

Lauren Wu - Office of the National Coordinator – SME

Yeah, don't you love the cross-references. I also wonder is this meant to be D or B? I was just looking at that earlier. Not to confuse matters further.

Mark Knee – Office of the National Coordinator – Staff Lead

What do you mean Laur – where you're at?

Lauren Wu - Office of the National Coordinator – SME

D. Compliance with the conditions of certifications. Is it really D? Oh yeah, I guess it follows C.

Mark Knee – Office of the National Coordinator – Staff Lead

I know in the conditions and maintenance it's usually B. It's just we're trying to create this crosswalk between the API section because there's a lot of overlap. And as you see in D2 we also address – we want to be clear that API data providers, because in the conditions we are only talking about the technology suppliers – the developers, we want to be clear that API data providers under information blocking would be held to the same standard.

Anil K. Jain – IBM Watson Health – Member

And B10 is export. You also have to – I think the intent here is to say notwithstanding anything else you say about fees you've still got to comply with those provisions.

Mark Knee – Office of the National Coordinator – Staff Lead

Exactly. We have similar clauses in other exceptions I believe as well where we are trying to say that you still have to comply with the conditions of maintenance of certification.

Andrew Truscott – Accenture –Co-Chair

Is D2 supposed to also start with the notwithstanding any other provision of this exemption or is it deliberately not?

Mark Knee – Office of the National Coordinator – Staff Lead

We didn't include that language, I believe, because , in my opinion, I don't think it's necessary because we're really just trying to get at clarifying the actors – well I shouldn't say actors because that's specific to what we're talking and we defined that – but the entities that are involved in the API section we use these terms "API data provider" and "API technology supplier" which API data provider pretty much links up to a healthcare provider a lot of times and the API technology supplier links up to the health IT developer. So, we're just trying to show because information blocking is broader than the conditions of certification and would apply to providers that the API data providers are held to the same standard.

Anil K. Jain – IBM Watson Health – Member

Yeah but in some cases that could be more restrictive and so people shouldn't interpret 204 as permitting fees that are excluded.

Mark Knee – Office of the National Coordinator – Staff Lead

Sorry – you mean 404?

Anil K. Jain – IBM Watson Health – Member

Sorry, in 171204 they permit some fees that could be excluded under 17404.

Mark Knee – Office of the National Coordinator – Staff Lead

So you're saying? Say that one more time.

Andrew Truscott – Accenture –Co-Chair

This section, 204, **[inaudible] {01:37:04]**

Arien Malec – Change Healthcare – Member

And they could be excluded by 404 and notwithstanding what I could charge in 204 I still can't charge it because it's prohibited by 404.

Mark Knee – Office of the National Coordinator – Staff Lead

Yeah, I believe that's right.

Andrew Truscott – Accenture –Co-Chair

Is there an order of precedence between these two or not?

Mark Knee – Office of the National Coordinator – Staff Lead

No. I think what we're trying to say is that you have to comply with both. You can't get out of your requirements in one or the other. They both apply.

Andrew Truscott – Accenture –Co-Chair

So by staying mute on an exception one place but the other place gives you the exception or gives you the prohibition – either way. You look at it as a whole not just a **[inaudible] [01:37:54]** but with one taking precedence over the other.

Mark Knee – Office of the National Coordinator – Staff Lead

Right, so there's a lot of – you all may not have read the API section as in detail because it's a bit outside of this, but there's a lot of overlap in talking about fees and reasonableness and value-added services – stuff like that that we talk about. And we want to create this so that it's a clear, like I said, crosswalk or they work with each other and there's not contradictions between the two sections.

Andrew Truscott – Accenture –Co-Chair

You can rest assured that I suspect that – well I know myself – I suspect Arien and Anil with our day jobs have read that in explicit detail. See APIs **[inaudible] [01:38:39]** in them.

Arien Malec – Change Healthcare – Member

Now I've got to admit that I've spent 99 percent of my time reading obsessively 171 in its entirety.

Mark Knee – Office of the National Coordinator – Staff Lead

I appreciate that.

Arien Malec – Change Healthcare – Member

If you're the guy who wrote it just recognize that I've spent a good amount of my time trying to memorize it and read every word.

Mark Knee – Office of the National Coordinator – Staff Lead

Well it was a group effort. We had a lot of authors.

Andrew Truscott – Accenture –Co-Chair

Okay, let's move on from D. We've got 20 minutes left of the call today and we're supposed to be moving into looking at 206 which is around the **[inaudible] [01:39:22]** evidence although reasonable and non-discriminating –

Anil K. Jain – IBM Watson Health – Member

Oh man, 206 is going to be another whole day.

Arien Malec – Change Healthcare – Member

Can we do 207?

Mark Knee – Office of the National Coordinator – Staff Lead

I was going to make the suggestion that since we skipped security, do you want to go back to security or do you think that one is going to be a lot of discussion?

Andrew Truscott – Accenture –Co-Chair

I think security is going to be a bit of a headache. It's short but it's got a lot of implications. I was going to suggest either 205 or 207.

Arien Malec – Change Healthcare – Member

205 is going to be a hard one.

Andrew Truscott – Accenture –Co-Chair

You reckon? Infeasibility, I like that.

Arien Malec – Change Healthcare – Member

Infeasibility but then just parsing through all of the ways that even if you say it's infeasible you've still got to provide access.

Andrew Truscott – Accenture –Co-Chair

You can channel your inner Princess Bride.

Mark Knee – Office of the National Coordinator – Staff Lead

I think what you're talking is that you have to provide an alternative means is the key aspect of that.

[Inaudible] [01:40:20]

Andrew Truscott – Accenture –Co-Chair

I think I've just showed our age. Okay. 207, let's go to 207. Maintaining and improving health IT performance. **[Inaudible] [01:40:34]** must meet the following conditions at all relevant times. Anil, you had comment on this already.

Arien Malec – Change Healthcare – Member

I've got a bunch of comments I haven't gotten to write them but, yeah, maybe Anil should go first.

Anil K. Jain – IBM Watson Health – Member

I was going to say I'm not sure my comments ranking more than the very first read but are we on number 7, is that what you said?

Andrew Truscott – Accenture –Co-Chair

Yeah, 207. We're on maintaining and improving health IT performance.

Anil K. Jain – IBM Watson Health – Member

Okay, I think one of the comments would be that I don't see the words – and maybe It's in the preamble. I skimmed the preamble. I don't remember every word of it. But thinking about planned and unplanned downtime and then how do the SLAs that vendors typically have with their clients – how do we make sure that the responsibilities are in the appropriate spots especially if this is an exception. You just want to make sure everything is tightly integrated without having to re-do the contracts that exist right now. That could be problematic. If there are issues where the system is not available because there is planned down time, that's one thing, but if its unplanned there's corruption, data corruption, whatever – I just want to make sure. Maybe another read to the preamble will help address some of the concerns I have. My biggest thing was making sure that we were really clear and that we don't have unintended consequences of being too specific about some of these things.

Arien Malec – Change Healthcare – Member

I had a long Twitter thread on this, unsurprisingly, and it amounted to both the same level of concerns which is to what extent are negotiated SLAs part of planned down time. And then if I have a contract with the provider that already addresses the situation of SLA, lack of SLA compliance, am I subjecting myself to a possible million dollar fine or breach of the false

claims act to unexpected or unplanned down time instead of SLA even when the contract may contemplate reasonable consequences for being out of SLA.

So, I think just for context the notion of negotiating SLAs in a contractual situation is pretty common. And it's not clear to me that there's a ton of market failure around negotiating SLAs In addition, I just don't ever want to be on the wrong side of this. There are cases – so some examples that I gave were cases where a provider was flooding us with duplicative requests that I wouldn't be able to – this occurred as I was reading this section – I couldn't say that this was a prevention of patient harm because we handled the duplicate request just fine. It's just that in some it could take down the entire site so we would shut off that particular actor and say "sorry, until you go fix your issues you can't use our exchange services." That kind of denial – those kinds of anti-denial service provisions are very common. So there's all kinds of legitimate reasons to take a site down to do immediate or emergent redress or to take an endpoint down because of bad behavior that I want to make sure are covered here. That's number one.

And number two is if the contract already contemplates SLA and SLA performance then I don't think it's appropriate for this provision to be extra to the already negotiated contractual performance requirements.

Andrew Truscott – Accenture –Co-Chair

I would agree with that. But I don't think that's the purpose of this is to override agreed contractual positions.

Arien Malec – Change Healthcare – Member

Yeah, if you read it though it says…

Andrew Truscott – Accenture –Co-Chair

I'm reading the reg. If the intent was otherwise then we should make some recommendation is to fix this.

Arien Malec – Change Healthcare – Member

I agree with that. I think the intent was otherwise and this is just – based on our personal practice, our personal history understanding some of the contingencies that happen that are reasonable in the real world. Or, some of the contingencies that happen that are – stuff goes down. And it's bad. And you go fix it. But it's not clear that stuff going down – that the penalty for stuff going down is a breach of the False Claims Act for example.

Andrew Truscott – Accenture –Co-Chair

Okay, that was astonishingly quick and easy. I think B and C are pretty straightforward. They're saying that **[inaudible] [01:46:21]** the regs which in here 201 and 203 which cover them.

Mark Knee – Office of the National Coordinator – Staff Lead

So did you guys have any comment – I just see that one comment. Was there anything you wanted to add or no. Recommendations?

Andrew Truscott – Accenture –Co-Chair

We're going to make a recommendation to move out with some updating wording a way of expressing this one.

Mark Knee – Office of the National Coordinator – Staff Lead

Ok, great. It just sounded like there was a recommendation in there so I just wanted to make sure it was captured.

Andrew Truscott – Accenture –Co-Chair

Yeah, we are. I've made a comment on it out to the side. Hopefully Arien has got some wording he's already devised for this.

Arien Malec – Change Healthcare – Member

I've got a long Twitter thread.

Andrew Truscott – Accenture –Co-Chair

Unfortunately we can't use Twitter as a means of making regulation.

Arien Malec – Change Healthcare – Member

Incorporation by reference. The content of Twitter thread blah, blah, blah, blah, blah is herein incorporated by reference.

Andrew Truscott – Accenture –Co-Chair

Moving on. It's a Friday afternoon. We've got 11 minutes left. Should we open it up to public comment now? Yeah, let's open up to public comment.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Can you bring up the public comment slide? Great, thanks. And operator, can you open the lines for public comments.

Operator

If you would like to make a public comment please press star 1 on your telephone key pad. A confirmation tone will indicate your line is in the queue. You may press star 2 if you would

like to remove your comment from the queue. For participants using speaker equipment it may be necessary to pick up your handset before pressing the star keys.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

Any calls to the public comment line?

Operator

No public comments at this time.

Andrew Truscott – Accenture –Co-Chair

In the absence of public comment and the fact that it's a Friday afternoon I am proposing that we actually close this meeting forthwith and hand it back over to Kim who is the acting Designated Federal Officer.

Lauren Wu - Office of the National Coordinator – SME

Actually that's Cassandra.

Andrew Truscott – Accenture –Co-Chair

Oh sorry. It's Cassandra. I meant Cassandra. Sorry Cassandra.

Cassandra Hadley – Office of the National Coordinator - Acting Designated Federal Officer

That's all right. So you guys want to end now?

Andrew Truscott – Accenture –Co-Chair

I think so. Guys, thank you ever so much. I know it's been a bit of a grueling day because we had the full task force earlier and we've had this one this afternoon. Thank you for your diligence. I really, really, really do appreciate it. Thank you.

Valerie Grey – New York eHealth Collaborative – Member

Thanks Andy.

Lauren Wu - Office of the National Coordinator – SME

All righty. Thanks everybody. Have a great weekend.

Arien Malec – Change Healthcare – Member

Thanks all.

Mark Knee – Office of the National Coordinator – Staff Lead

Thank you everyone.

Anil K. Jain – IBM Watson Health – Member

It's been fun. Talk to you later.

Andrew Truscott – Accenture –Co-Chair

Have a good weekend.