Information Blocking (IB) Task Force

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
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back-up/Support
Mike Lipinski	Office of the National Coordinator	Staff Lead
Mark Knee	Office of the National Coordinator	Staff Lead
Penelope Hughes	Office of the National Coordinator	Staff Lead
Morris Landau	Office of the National Coordinator	Back-up/Support
Lauren Wu	Office of the National Coordinator	SME

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning, everyone. Welcome to what is now the second meeting of the Information Blocking full Task Force. We have a lot to discuss, so I won't waste time. I will jump right in just starting with a brief roll call. Andrew Truscott?

Andrew Truscott – Accenture – Co-Chair
Present.

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

Michael Adcock – Individual – Co-Chair
Here.

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

Steven Lane – Sutter Health – Member
Good morning.

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

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
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Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Denise Webb?

Denise Webb – Individual – Member
Present

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

Sasha TerMaat – Epic – Member
Here.

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

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin – Member
Good Morning.

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

Arien Malec – Change Healthcare – Member
Good morning.

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

Valerie Grey – New York eHealth Collaborative – Member
Here.

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

Anil K. Jain – IBM Watson Health – Member
Here.

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

Cynthia A. Fisher – WaterRev LLC – Member
Good Morning.

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

John Kansky – Indiana Health Information Exchange – Member
Good morning.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Lauren Thompson? Oh, wait. She's going to be absent today. And Denni McColm?

Denni McColm – Citizens Memorial Healthcare – Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Perfect. And with that, I'm going to turn it over to Michael Adcock who's going to get us started today with a review of the progress of Workgroup 1.

Michael Adcock – Individual – Co-Chair
Well, good morning, everyone. I'm happy to be here on a Friday. Thankfully, it's Friday. We've had a very busy week of workgroup calls. I know you're all aware since most of you have been on at least one, if not two, so far this week. So, first I just wanted to thank you on behalf of myself and Andy for all of the hard work. I know that there's been a lot of time taken out not just in the workgroup meetings but also in the pre-work before and reviewing and coming up with great comments. So, I wanted to thank you all for that and for all the hard work that goes on and that will continue to go on as we move forward.

You can see the agenda on this page. We have a full agenda. The first three are going to be overviews. We're going to walk through the overviews of the different workgroups. These are for informational purposes just so you can see what the workgroups have been working on. For those of you who are in different workgroups, I want you to just have a flavor of what we're going through.

And then when we finish Workgroup 3's overview, Andy's going to lead us into some discussion around some of the, as we call them, big rocks – some of the issues that we need to review and discuss as an overall taskforce. Andy will lead us through that discussion just trying to get some idea of some of the bigger things that we need to work out and get some comment from those, especially comments from people who are in other workgroups. So, if we have an issue that we're working through in Group 1, we'd love to hear what Group 2 and 3 have to think about that or individuals from Group 2 and 3, primarily just so we can hear those perspectives. As we discussed originally, there's going to be a lot of work going on in the different workgroups, but we want to have time in the overall Task Force to hear people's opinions that have those on the individual, bigger issues.

So, we'll jump right into the overview of Workgroup 1. Next slide, please. So, you can see here. We'll go right through these. You'll see these. Here's the agenda. Here are the meeting dates. You're already into these, so you know what this looks like. Next slide, please.

So, Workgroup 1, these are some of the items that we talked about. And, again, this is for informational purposes just so you can know what we're working through. As we talked about health information networks and exchanges – and Andy can chip in here any time he'd like – we talked through the scope of definitions. You know, are these definitions too narrow? We looked at whether they're too narrow or whether they're too broad. Is there potential for gaming? We looked at situations when a provider is also a health information network or health information exchange. That was a discussion that came up. We looked at the penalties and what those penalties should be. Are they too harsh or are they not harsh enough and the intent of definitions to cover external interfaces from a hospital.

So, one of the big discussions that we had in Workgroup 1 over the last couple of meetings was based around the intent of the definitions. You know, because the rules are meant to cover a wide range of different actors, what's the intent around those definitions as we're looking at whether it's the interface from a hospital to a hospital or something along those lines? EHI definition – should this definition be augmented to include clarity around actors? The human-readable or codified information – should we exclude aggregated patient information? So, there are lots of discussions around these different topics. Next slide, please.

This was a big one, and this is one that Andy will talk about when we get to the discussion point of this – pricing information. There are a couple of views that we had on that. One view is that we need price transparency, and now's the time to address it within the context of information blocking. There are no other levels to address that are available, so this might be the perfect opportunity to discuss it and to address it. Andy will bring that up again after we go through the overviews. And there's also a view that price transparency is important but out of scope for this rule. Unintended consequences also need to be considered, and we had a long discussion about unintended consequences of including price transparency or addressing price transparency as a part of this rule and a part of this workgroup. So, there will be discussion around that, again after the overview of Group 3.

Practices that may implicate the information blocking provision – we had some discussion regarding the scope and implications of examples of potential information blocking. There was a good discussion around that. And then we also looked at parties affected by the information blocking provision and exceptions. Definition and scope of actor – obviously, there was a lot of discussion around that. What the payer role is – what the definition of payers are and the concern regarding self-insured companies and where they fall in this process as well. Next slide.

As you can see, there's a lot of information going on in Workgroup 1. Andy will lead us through Workgroup 2 now.

Andrew Truscott – Accenture – Co-Chair

Thanks, Mike. Go to the next slide, please. Okay, so the topics that we've been discussing in Workgroup 2 – first up – preventing harm. There's an overarching concern around many of these exceptions that they could become large holes that give organizations an opportunity

to exempt themselves from information blocking obligations. So, there is a need to tighten these as much as possible to make them as prescriptive as possible and as narrow as possible.

In (A)(1) around preventing harm, rather than just looking in accuracy, the comment was made that everybody's health record has some level of inaccuracy, but the suggestion is that we actually talk about being true data corruption, so technology-based data corruption where the data was being messed up somehow by the technology itself.

(A)(2)– As you can see here, why would a provider correct a mistake if there's no obligation to do so? So, we're discussing where a provider should be told to make a correction and to correct the deficiency that's in the record.

(A)(3) – And we're talking about whether this is actually aimed specifically at mental health conditions. We're working through where there is an individualized finding, how that should actually be recorded inside the record itself or whether that would also be counted as EHI. And then we're picking up just some semantics around the use of the word relevant versus the word appropriate. We're just making sure that there's appropriate usage in the relevant paragraphs of those terms. Next slide, please.

And secondly in the workgroup, we're looking at the topic around most of the privacy of EHI, itself, so we've been working through how the language could be added. The organizational policies must be lawful even of themselves. Just because you have a policy that says that you won't share, that doesn't mean that the policy is valid or legal and then counting on how to include that. Again, we have around recording where consent or dissent has been expressed by a patient. And it's not simply enough, potentially, to say, "Oh, they must have consented, and we won't." And then, again, semantics around the use of the word meaningful and then what that actually means. And, again, this is another one of those overarching topics that has come through every workgroup around some of the semantics and making sure that words are understood and are not too subjective and allow too much wiggle room. Next slide, please.

Okay, Mike, back to you.

Michael Adcock – Individual – Co-Chair

Very good. Again, here's the agenda and the cadence of meetings. Next slide, please. So, in Group 3 one of the things that we discussed a lot of was assurances looking at the ambiguity and full compliance and unrestricted implementation language in the preamble, so we spent a lot of time going back and forth between the preamble and the regulatory text. Again, there's lots of discussion around intent. We talk a lot about intent. What's the intent of? What's the scope of retention? And under area (B)(1) comparison of time periods for record retention and records access, a proposal of a three-year retention period for voluntary withdrawals and a proposal for infinite retention periods, so we had a discussion around what the periods should be. Self-developers was a topic that we covered as well. Next slide, please.

Under assurances and the request for information on participation in the TEFCA, we cannot comment without seeing TEFCA. So, we need to see that before we can make comments on that.

Communications – we spent a lot of time talking about intellectual property issues and how to protect the developer community from nefarious purposes. There's a lot of discussion about fair use, and we need to make sure we fully understand the intent of and the definition of fair use, and how it pertains, and how we're allowing fair use but still protecting IP. We looked at whistleblower protection. We looked at notification to vendors and what that looked like because there was some language in the rule that may have been a little bit difficult to operationalize, so we're looking at that notification period to vendors and third-party vendors.

The scope of non-user facing – so we looked at the proposed amendment. It was to adjust definitions to clarify that the administrative functions of HIT would be **[audio cuts out]** user-facing aspect. There are a lot of administrative functions that go on within HIT that don't really impact the user so should be non-user facing and based on the assessment that those communications are not matching the purpose described in 21st Century Cures. And it's also a limited set of users, so we're not talking about even the large list of providers. We're talking about a very limited set of users in that, so that was our proposed amendment. Next slide, please.

Screenshots – we spent a long time talking about screenshots and whether or not layouts are and should be considered IP. We know that there are varying opinions on that, so we had discussions around that.

Purpose of prioritizing communication between healthcare entities – comparing configuration between healthcare entities should pose minimal risk to IP rights. So, as we're working within health systems or health entities try to make sure that workflows are moving in the best way possible. A lot of times, it's very helpful to be able to share and build the share between those healthcare entities without posing risk to IP rights. A possible proposal would be to draw a distinction around purpose of use. I think also in relation to fair use definition, fair use might be applicable or insufficient just depending on how that is defined and how we use that definition.

The discussion of (D)(2)(3) and (4) would be that possible proposals should be amended to a list of which third-party content might appear in a screen. Enumerating elements per screen is not feasible. There could be a great deal of third-party content and being able to operationalize that could be extremely difficult. There was extensive conversation about the complexity and impossibility of doing this. Again, this was around being able to operationalize some of the third-party content.

The discussion of (E) – Possible proposal for Section E would be an effort for notice and contracting is only 40 hour **[audio cuts out]**. It's massively underestimated. We recommend that the ONC should revise the estimate – more roles involved than just a clerk – work involved on the part of recipients. Eliminate the two-year timeframe or propose an update at

the next renewal. There was some discussion around changing the contracts and amending contracts, and we know that would be extremely burdensome and are looking at whether you eliminate that two-year timeframe for that and propose an update at the next renewal. So, it would go in effect for those new contracts immediately but allow for a renewal period since we know that some of the contracts that vendors have are five years and ten years, so we need to just look at that as well. Next slide, please.

Discussion of (B)(2) – Again, that's where we were talking about the contract renewal – state a roadmap within two years with compliance not to be unreasonable. So, we're, again, looking at ways to make sure that this is not overly burdensome and does not create a huge change or a huge unintended consequence in changing those proposals.

Enforcement – as we were looking through the enforcement pieces of this, there is a band that is very serious but fair given the process proposed by ONC. ONC has a process concerning enforcement that has been very well thought out. It's actually not originally a part of this rule. It was a rule from 2016, but it's a great chart and graph as to how the process is proposed by the ONC. A possible proposal would be to use both email and certified mail for notices initiating direct review. Potential nonconformity, nonconformity, suspension, proposed termination, and termination – so, again, one of the pieces of the enforcement is a ban, and we want to make sure there are clear steps as to what stage a vendor is in before we get to the overall ban. So, there was a lot of discussion around that. The process is great but we want to make sure that the ban is the final step unless it's some type of nefarious act. Next slide, please.

And now, Andy will talk about, again, the overarching charge but more importantly talk about some of these discussion areas that have come up in the different task force groups, again, the larger ones that consumed more of the comment period so that we can get some input from others. Andy?

Andrew Truscott – Accenture – Co-Chair

Thanks, Mike. Just before I do that, I want to open it up to any of the members of the workgroups, so the task force members. Are there any burning issues that you would like to raise that have come out of this first week of work that you think we could usefully discuss or share with the broader group?

Arien Malec – Change Healthcare – Member

You know, I do. And maybe one of the burning issues better relates to the definition of health information networks, so if we've got a section on that, I'll hold.

Andrew Truscott – Accenture – Co-Chair

Well, I wasn't going to touch on HIN in this morning's call, so go for it.

Arien Malec – Change Healthcare – Member

Yeah, so the breadth of the definition of EHI and HIN places a large number of entities into the scope of information blocking rules and, in particular, into the scope of the information

blocking exceptions and pricing rules. And I'm not sure that anybody's looked at what possibly would be unintended consequences of that nor do I think people have looked at Congress relative to information blocking. So, my read of the combination of electronic health information and the definition of health information network would place functions like a billing service, a clearinghouse, electronic records retention, and a whole set of activities under information blocking and associated pricing restrictions. And it's not clear to me that Congress intended that the scope of information blocking be extended to those entities. So, I just wondered if the workgroup had looked at the potential broad scope of the definition of health information, not health information networks.

So, as an example, banking services could be considered electronic health information. It's information related to **[inaudible]**. It contains an identifier that ties back to a claiming or remittance ID, and it's going from a payer to a bank to a provider. So, that falls under the definition of electronic health information and under the definition of a health information network. So are banking services considered to fall under information blocking provisions and associated price transparency provisions? Anyway, that's the nature of the comment and a request for the workgroup to take up that particular item because I don't know that anybody's thought through all of the consequences of the two definitions.

Andrew Truscott – Accenture – Co-Chair

Thanks, Arien. That's so useful, and thanks for the input there. To help reassure you, yes, the group has already had extensive conversations around the definitions of EHI, HIN, and also HIE. The definition of HIE within the current drafting is fairly broad and could, in some interpretations, be used to apply to pretty much everybody out there, every provider no matter where they sit. So, that is being discussed, and, actually, I was premature when I said that I didn't intend HIN to be one of the big blocks to discuss, but, actually, where you went, it is one of the big blocks. It's the scope of encompassment of the current drafting of the rule. There's been lots of feedback across all the workgroups to this whole board. Okay, so **[inaudible]** that could be included.

Arien Malec – Change Healthcare – Member

Just as a request to include maybe some of the use cases or some of the consequences that I drew out like our banking and payment services associated with claiming and reimbursement and remittance. Should they be part of the scope of information blocking and associated provisions? Should clearing houses fall within that scope? Should billing services fall within that scope? So, maybe just some examples to sharpen people's minds in terms of what the potential scope of those definitions might be.

Andrew Truscott – Accenture – Co-Chair

Absolutely, and we are going to do that. I also would like to solicit your input to that because I'm pretty sure you've got some of this stuff already scribed in your thoughts. There's an interesting chick and an egg scenario here a well which ties into another one of the big blocks I'd like to discuss around the price transparency that Mike was mentioning earlier. That's what ties into lots of the billing services too where if price becomes an element of EHI, then it makes sense that a billing service becomes an actor **[inaudible] [0:20:27]** for information blocking purposes. I'd like to kind of come back to price transparency, but I'd like a bit more

of a discussion across the entire task force about what our beliefs are around the intent to 21st Century Cures and the breadth of actors within the healthcare ecosystem that we believe should be touched by these rules. Open floor.

Okay, I'm going to ask Arien, specifically. Arien, do you think that that breadth that you articulated is the original intent that the act was drawn around?

Arien Malec – Change Healthcare – Member

I do not believe that the breadth that I articulated was the intent of Congress. I think if you look at the deliberation of Congress and the thrust of the 21st Century Cures Act that the intent of Congress was to address potential rent-seeking behavior by EHR's as well as provider organizations that refused to make information flow. I don't know that Congress thought through or intended to make these provisions apply to market-based services that were already in full flight and working quite well.

Andrew Truscott – Accenture – Co-Chair

Okay, so you think that would be an unintended consequence which will be an unfortunate unintended consequence as opposed to a fortunate one?

Arien Malec – Change Healthcare – Member

Yes.

Andrew Truscott – Accenture – Co-Chair

Okay, and is that the consensus across the group? John Kansky has raised his hand. John?

John Kansky – Indiana Health Information Exchange – Member

So, Andy, sorry. This will be some re-runs from our discussion on the workgroup meetings but just echoing my version of, I think, Arien's perspective is that I just think that good policy is as precise and focused as it can be being a blunt instrument to begin with. So, we want to understand Congress's intent, but we need to make this as clear as possible for 1.) To achieve the desired end but also, 2.) To minimize the confusion and cost of complying with the regulation, and I daresay, 3.) Minimize the industry pushback if it's too broad. So, I feel like I don't yet have a grasp on what the unintended consequences might be, and I think we need to think about that. But, regardless, precision as narrow as possible but no narrower is best.

Andrew Truscott – Accenture – Co-Chair

Thanks, John. Arien, I've got to put you on the spot again because you've obviously been thinking this through. You know, the unintended consequences are certainly from the angle you were coming on around market-based services, etc. Could you possibly just talk to those a moment?

Arien Malec – Change Healthcare – Member

Sure. This is going to overlap with some stuff that we haven't gotten to in the information blocking exceptions.

Andrew Truscott – Accenture – Co-Chair

That's okay. That's okay.

Arien Malec – Change Healthcare – Member

If you look at what's required to comply with the pricing provisions, in particular, as well as some of the other provisions of information blocking, the net is that a whole range of services that are currently available and working well for provider organizations and for payer-based organizations are going to have to be re-thought and re-priced in ways that I don't think anybody's really intended in drafting the regulation or, certainly, was the intent of Congress.

So, for example, my belief – and, again, I think we need to get through this in the Exceptions Workgroup – is that as we think through the accounting rules and legal and compliance rules associated with pricing out services to comply with 171, 204, and 206, what we're going to end up with is raising the price for basic commodity services that already serve industry well. So, the price of the claim will go up. The price of the remit will go up. The price of banking services for healthcare will go up because there'll be additional compliance burdens associated with those. And those can be fine but without actually any information blocking concern currently in the market. So, we won't be addressing any significant market failure, but we will be putting a substantial burden on top of organizations that are already working the practice.

Andrew Truscott – Accenture – Co-Chair

Okay. Thanks, Arien. That is helpful. So, one of the viewpoints that we have heard through another one of the workgroups is certainly that there is a failure in the market for the benefit of patients to provide adequate transparency to pricing. And if you look at some of the drafting inside the current rule where there is a request for insights which could help lead towards price transparency. Wouldn't that be an argument where, actually, we should be, extending information blocking to include those kinds of entities?

Arien Malec – Change Healthcare – Member

In general, it's the provider organization. So, if you think about where pricing comes from, pricing ultimately comes from the payer through a remit, but many of the interesting issues in pricing are coming from providers in terms of chargemaster, in terms of the amount of claim, and in particular, with respect to out-of-network billing. And in many of those cases, it really is the provider who is the ultimate source for pricing information as opposed to the intermediaries. But I can definitely accept the point that intermediary access to pricing data could be good relative to opening that up. I still think the other issues associated with putting those services under information blocking provisions will just lead to a net increase in healthcare costs. So, it's one where there is a reasonable policy outcome, but the currently chosen tools are a pretty blunt instrument.

Andrew Truscott – Accenture – Co-Chair

Yeah, and to John's point, my policies, by necessity are blunt because it touches everybody equally. Was someone else trying to interject there?

Steven Lane – Sutter Health – Member

Yeah, that was Steven. I just wanted to add that when you talk about the provider being the source of the pricing, I think we have to remember that we're talking about clinicians. We're talking about labs. We're talking about imaging centers. We're talking about pharmacies. The provider, as you use the term, is all of those.

Arien Malec – Change Healthcare – Member

Yes. I'm, of course, referring to USC 300jj in my use of the term healthcare provider, of course.

Andrew Truscott – Accenture – Co-Chair

Yeah, and I think price transparency isn't necessarily just what you were describing there, Arien. There is a large ecosystem around the entire revenue cycle that has blunt-end cost. And transparency into that isn't just necessarily a provider thing but also an element of the payer as well. Would you concur? Arien?

Arien Malec – Change Healthcare – Member

Sorry. I wasn't thinking that the question was directed to me, sorry. Could you repeat it?

Andrew Truscott – Accenture – Co-Chair

It was a statement that I then answered and you concurred with that. It sounded like you weren't listening to it.

Arien Malec – Change Healthcare – Member

Got it.

Andrew Truscott – Accenture – Co-Chair

But yeah, does it work for you?

Arien Malec – Change Healthcare – Member

Was I listening? No, I was not listening.

Andrew Truscott – Accenture – Co-Chair

Okay, Arien. I'll bear that in mind for future use.

Arien Malec – Change Healthcare – Member

I'm sorry.

Andrew Truscott – Accenture – Co-Chair

Okay, all I was saying was that it's not as clear cut I think you're saying. It's a provider issue there. We're talking about broader transparency across the health continuum **[inaudible] [0:29:34]**.

Arien Malec – Change Healthcare – Member

Right. So, again, I go back to my point that there could be some policy goods for expanding access and speaking – and, again, just putting on my Change Healthcare hat – there is some industry interest here because we run a clearinghouse. We run payment services. I think we generally would prefer to open up more access for information and would prefer, if permitted, to open up access for pricing information. We've got a strong interest in offering access to consumers for self-payment tools.

The obstacles in practice are generally not the obstacles in information blocking in with that although there is an unintended consequence where the information blocking provisions could help. Most of the issues involved in either liquidity at the clearinghouse or the payment network side are a common play because of the AA contractual restrictions. It's usually the payer or provider who has restricted data use at a BAA level in ways that make it harder for information to flow to patients.

Andrew Truscott – Accenture – Co-Chair

Okay, thanks, Arien. So, one of the questions we have been asked is whether price should be considered EHI. Now, if I look upon your opening statements around the original intent of Congress or your understanding of the original intent of Congress for the act being more focused around the exchange of clinical information for the purposes of clinical care. I'm paraphrasing you but I think that's where you were going.

Arien Malec – Change Healthcare – Member

Yeah, that's right.

Andrew Truscott – Accenture – Co-Chair

Oh, you're listening. Okay.

Arien Malec – Change Healthcare – Member

Yes. I'm definitely listening to you. I apologize. So, I would generally agree. So, first of all, I have an interest, and I think a number of organizations have an interest in increased pricing transparency and increased access to patients for self-billing tools, payment tools, and other areas that help them drive transparency and flexible decision making. At the same time, I think if Congress had intended 21st Century Cures to address these issues, then Congress would've written things like price transparency into the legislative text. So, that's the justification for driving these things in. I do think there's clearly a policy interest – and I'm rambling a little bit – but I think we need to minimize or more finely tune the policy interests to the consequences of information blocking regulation. And I don't know that right now the rules strike the right balance. I know the rules right now don't strike the right balance.

Andrew Truscott – Accenture – Co-Chair

Okay, so the act doesn't say that the information inside information blocking is solely clinical?

Arien Malec – Change Healthcare – Member

I'd have to go back to re-read the act.

Andrew Truscott – Accenture – Co-Chair
That's why we're trying to go through the definition of EHI right now.

Arien Malec – Change Healthcare – Member
Yes, that's right.

Cynthia A. Fisher – WaterRev LLC – Member
This is Cynthia. I think we had a long discussion about this yesterday on our committee even. I think what's really important is that we look at the definition and you look at the HIPAA definition of portability and how important access – that the intention of Cures was to empower the patient to have access to their health information, and that information, looking at that original health information from 1996, is both the physical and mental health information and the condition of the patient – past, present, and future. And the second part of that definition is the payment information – past, present, and future payment.

So, just like grocery or any other industry – and forgive my members of Committee 1 who are hearing this twice – is that we need a functional, free, and competitive marketplace, and that was the intention of the law. That was the intention of Cures. It is to cease and desist on the anticompetitive processes that don't empower the patient with decisions. And everywhere you go today, if someone can choose to get their MRI or their breast imaging with their high deductible at a much lower out-of-pocket cost and a much lower cost to their employer and their self-insured employer, it puts money back into the pocket of the consumer, and it lets them drive their health decisions and their wealth decisions. So, if you look at the whole, the intention was for competition because only in competition can we drive down and improve our quality, and move towards excellence, and drive down the cost of care.

Arien Malec – Change Healthcare – Member
Yeah, again, I think we agree with the goal. It is clear to me that the tools that are being applied are rather blunt to achieve the goal and will do so, actually, in ways that probably will reduce data liquidity because they'll just increase the cost of services. So, this is really about making sure that we open up the data without using a hammer to open up a faucet.

Cynthia A. Fisher – WaterRev LLC – Member
Well, I disagree with that. You know, back in '92 the healthcare company would accept insurance and cash, and you could do it **[inaudible] [0:35:53]**, and people paid out of choice, and they could evaluate quality, and they could evaluate the service and price. So, I think if we look across the spectrum, we could see what people are willing to accept both in cash, both in payment from coverage, and that choice –

Arien Malec – Change Healthcare – Member
You're maybe misunderstanding my point.

Cynthia A. Fisher – WaterRev LLC – Member

Think about what we have of this opportunity and moment of time, and I am so excited to be on this committee with you all because this is transformative. I mean, what we can do collectively as an organization and our efforts here is to plow that runway of the opacity that exists in today's system of the high mountains and the piles of opacity on the runway and clear it for a technological revolution. I think Don Rucker, when he kicked off the first ONC HITAC meeting, spoke about how Yelp, and Uber, and Amazon, and the rest of the tech world works so well to drive down – you know, look at Uber on the cost of going to the airport versus a taxi. And Uber didn't wait until the medallion in the taxi cab set standards on how their pricing would be posted. So, I think we have this incredible – I'm an entrepreneur, so I look at this incredible opportunity for us to deliver to the healthcare marketplace options, and choices, and knowledge. It's so cool.

Arien Malec – Change Healthcare – Member

I'm pretty sure you wouldn't start a company in an environment where your prices were restricted, your ability to define value-based pricing was restricted, and where the compliance needs associated with pricing placed an additional burden on your accounting systems and your legal and compliance systems.

So, first of all, I completely agree with the point on the generative value placed on transparency and increased data liquidity, and that's clearly been the goal of a good chunk of my career and the work that I've done in the US healthcare sector. It is the overlap of the price regulation in the information blocking exceptions with the broad definition that causes me concern. And I think if we found an approach for price regulation that was targeted at rent-seeking behavior but not targeted at market-based services, I think we'd find a place where we'd drive the innovation that you're looking for.

My basic concern right now is based on the broad definition and, particularly, many of the pricing regulations that are in Cures. What we'll end up doing is actually impeding innovation because the Ubers and Lyfts of the world aren't going to start up their services if they're under price controls.

Cynthia A. Fisher – WaterRev LLC – Member

Well, Arien, we can agree to disagree because if we don't provide a framework and follow what we've been asked to do, then are we not information blocking ourselves from progress to do so? And I don't know of any industry where I wouldn't want to go buy something as a consumer, or partake in something, or manage something so critical such as my health with having absolutely no knowledge and having to show up with a blank check that whatever some entity wants me to pay.

So, you know, Arien, we're seeing people suffer from $101,000.00 out-of-network surgery bills and facilities fees and being sued by their own hospitals with days in court over fragments of medical bills with court fees on each segment of a bill. It's out of control, and we have the opportunity – we are being asked to do this by HHS, and I think it's our job to find a way how rather than to come up with the blocking reasons of why not and to protect status quo. Status quo is broken, and we are in the moment of time to deliver.

Arien Malec – Change Healthcare – Member

It's quite possibly broken, and understand my point that I suspect it's going to be an ongoing point of conversation for this group.

Andrew Truscott – Accenture – Co-Chair

And this is why we're raising it. Now John raised his hand and then Aaron. So, John Kansky?

John Kansky – Indiana Health Information Exchange – Member

Yeah, just quickly, listening to the back and forth, I think this is about balancing our responsibility to have a regulation that moves us toward the desire for health data transparency and pricing transparency and balancing that with having a regulation that is implementable, enforceable, and at a reasonable cost.

Andrew Truscott – Accenture – Co-Chair

Thanks, John. Good points. Aaron?

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin – Member

Yes, hello. This is Aaron. I agree with John, and I want to expand upon that a little bit more. I think there are two dimensions to this. One is the information blocking from clinical diagnoses, results, images, and all of that that's not being shared. I'm going to give you a couple of real-world stories here very quickly on that dimension which is I'm acutely aware of a couple of metropolitan areas with hospitals that are only a couple of miles apart that refuse to share, excluding any treatment purpose type of data unless they are in urgent care. They won't share commercial payer information at all, again unless that's treatment purposes at the point of care because they're worried about losing referral patterns. Other issues like that occur in magnitude, and that's what we're here to solve is those types of issues.

On the pricing comment, I think it is our charge to look at how can we better incentivize and make sure that information is disseminated out there. Generally speaking, healthcare institutions are reluctant to share those prices as it relates to the chargemaster and what the negotiated rates are with the payers, for whatever reason.

And again, to the comment that was made earlier about patient suffering, that does happen because people have those surprise medical bills that now you're seeing bills go through various state legislators trying to eliminate that. So, I think on both those dimensions, it's up to us, the committee, to address them, be upfront with them, be transparent, and say this type of behavior has to stop.

But I also do agree with Arien's comment that we don't want to try to boil the ocean, but we should be specific in how we go about this so that we don't have the unintended consequences of HIE organizations trying to solve the price transparency issue and otherwise. It needs to be very defined and very pragmatic, but we do need to call attention to this practice.

Andrew Truscott – Accenture – Co-Chair

Thank you, Aaron. That's a helpful spotlight on some of this as well. Does anybody else have any comments in this particular area? We've moved into the price transparency discourse.

Denni McColm – Citizens Memorial Healthcare – Member

So, this is Denni. I made it clear, I think, in the workgroup that I feel like price transparency is outside of the scope of this regulation. But I wonder if it'd be helpful if ONC could maybe bring to our workgroup and maybe the full task force what's already going on with price transparency and what's already proposed in other parts of the federal government. It's like as hospitals we were already required to publish our pricing as of January 1st of this year. Are we treading someplace or overlapping something that's already going on?

Andrew Truscott – Accenture – Co-Chair

That's good. Mark, can you just provide maybe a written update that we can put to each of the workgroups? That would be useful.

Mark Knee – Office of the National Coordinator – Staff Lead

Yeah, I can work on that. Are we talking about for each workgroup or just the one specifically focused on –

Andrew Truscott – Accenture – Co-Chair

Just a one-half page that just describes what else is going on, and we'll just make sure every workgroup has it so that every member of the task force has it.

Mark Knee – Office of the National Coordinator – Staff Lead

Yeah, I can work on that.

Denni McColm – Citizens Memorial Healthcare – Member

I think, Mark, it would be helpful for anything in the Cures act that relates to price transparency if there is something there that could be interpreted that way. It would be helpful to see what that is.

Mark Knee – Office of the National Coordinator – Staff Lead

Sure, and I can definitely do that. I would just direct everyone to read the definitions in the rule and to read Cures like how it describes the information blocking and the actors because it's important for the scope of this conversation to understand those definitions really well, including you guys.

Andrew Truscott – Accenture – Co-Chair

Thank you, Mark, for joining us.

Cynthia A. Fisher – WaterRev LLC – Member

This is Cynthia. I just want to make sure that we all keep in perspective from the patient's point of view. You know, if we're representing a provider or you're representing an insurer

that you just remember the patient. I think if you put the patient in the focal point – so, you look at a colonoscopy. Somebody's 50, they're well, and they're just told they need it by their primary care at the time. Tick-tock, you're on the clock. It'll be covered. But no one knows. Okay, but what hospital system do I go to? What will my out-of-pocket be? What will my insurer pay? So, they don't have any optics to know. We even have physicians say that they don't even know themselves. They just found out that their own pathologist, and the radiologist, and the anesthesiologist are out of network and don't even know it. And then all of a sudden, you have a surprise $6,000.00 bill and that it was no reference-based billing, no references to be able to see. Is that reasonable or not reasonable? And you know that you could've gotten it elsewhere where everybody was in-network and only had a small co-pay.

So, you know, a $6,000.00 difference is real money to most citizens in this country, and I think we just have to remember that we are in this moment of time where HHS has done a beautiful job. Basically, we're there to help to be able to change the game in healthcare so that we're not devastating the wallets and the financial future of families and patients.

So, I think we all should call to our inner responsibility and fiduciary to our citizenry.

Mark Knee – Office of the National Coordinator – Staff Lead

Andy, can I jump in? I just want to make one point really quick. I know we need to get to the public comment. But just to clarify what is in our regulation. As far as pricing, we have a request for information, and what we're trying to do is better understand how to address pricing information in a standardized way and how to define pricing information in the context of information blocking. So, I just want to emphasize that right now, it's a request for information that's in there specifically related to price transparency. That's all I wanted to say.

Andrew Truscott – Accenture – Co-Chair

Yes, actually, Mark, to be clear that was actually described but there's also a question about whether price would be included in the definition of EHI.

Mark Knee – Office of the National Coordinator – Staff Lead

Yeah, I believe that you're referencing the request for information still, though, right?

Andrew Truscott – Accenture – Co-Chair

Yeah, it's two parts to that. Okay, given we have three minutes before we have to go to public comment, Lauren, can we go to public comment now?

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

Yes. Yeah, we're actually right on time for public comment.

Andrew Truscott – Accenture – Co-Chair

Okay, great. So, I believe there are actually some public questions already filling in the chat box. So, if you could possibly repeat them in the public comment, I'd much appreciate that.

Thank you.

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

Great. Operator, can we please open the line?

Operator

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

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

Thank you. We've had the number up for a few minutes, so hopefully, that has given folks time to dial in. Operator, do we have any comments in the cue at this time?

Operator

Not at this time.

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

Okay, so that leaves us with just about nine minutes or so. We'll leave the phone number up just for another minute or so, but, Andy, in the meantime, I'll hand it back to you.

Andrew Truscott – Accenture – Co-Chair

Thanks, Lauren. Okay, so there was a question that came through into the public chat box from an individual named Mark, "Won't information blocking the content apply to the stuff covered in the USCDI only?"

Mark Knee, you can secondarily comment on this. My understanding right now is no. It's as per the definition that Arien Malec helpfully posted into the public chat box as well with the existing proposed definition of that health information. That is actually the definition that would apply to information blocking, not purely the USCDI conceptualization. Mark?

Mark Knee – Office of the National Coordinator – Staff Lead

Right, yeah, so I would encourage folks. Definitely, we do have part of the regulation that talked about USCDI, but you definitely don't want to mix those two up. In the information blocking context, we'd be looking at EHI – the definition that we provide. You're looking at whether you're an actor as defined in Cures that would be covered by the information blocking provision. You'd look at whether there's an interference with access, exchange, or use, whether there's the requisite knowledge by the actor, and whether the practice is required or covered by an exception. So, that's kind of the framework for information blocking.

USCDI, it's very important to understand, that it fits in somewhat, but as far as information blocking goes, we're looking broadly at the EHI definition that we describe.

Andrew Truscott – Accenture – Co-Chair

Thanks, Mark. Do we have any questions coming through from the public?

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

Operator, are there any more callers in the cue?

Operator

Not at this time.

Andrew Truscott – Accenture – Co-Chair

Okay. Steven Lane has his hand raised.

Steven Lane – Sutter Health – Member

Yeah, thank you. I think you asked a really key question about whether or not pricing information is electronic health information, and I think that Arien and the text that you shared is very helpful in the last sentence where it says that the past, present, or future payments for the provision of healthcare to an individual is part of the definition. So, that seems very clear to me that that would include price, net price, etc. Is there a question about that still?

Andrew Truscott – Accenture – Co-Chair

Well, we're being asked whether that definition should include price.

Cynthia A. Fisher – WaterRev LLC – Member

Well, it does, doesn't it, Andy?

Andrew Truscott – Accenture – Co-Chair

It does right now. Yeah, it does.

Cynthia A. Fisher – WaterRev LLC – Member

Yes, and that is the intent of this. If we move it out, then we're information blocking, you know, quite frankly, because healthcare and electronic records, at least when I was an IBM'er many decades ago were shared electronically first in billing and payment information before we got to the digitization of the clinical. So, this has been in place for years, so I think this is just saying that that's all inclusive of what's been digitized and able to be shared and portable to the patient as well.

Steven Lane – Sutter Health – Member

And I'll just say that Cynthia does a great job representing the voice of the consumer. One of my hats here that I wear is the voice of the clinician. And I can tell you that having that price information at the point of care would be transformative, as Cynthia has laid out. So, I hope that we can include in our comments that keeping that price information in the definition is really in the best interest of patients, and providers, and I also believe that that was the intent of Congress and really what we've been hearing from Dawn since the launch of that at HITAC.

Andrew Truscott – Accenture – Co-Chair

Thank you very much. John Kansky has his hand raised.

John Kansky – Indiana Health Information Exchange – Member

Just real quick. So, regarding the point that ONC has written into the definition payment, my understanding, which may be right or wrong, is that they somewhat borrowed the definition from HIPAA and are asking us specifically if payment should be in that definition or not. So, we're trying to feedback and answer that question. One of the observations I made on the workgroup call yesterday is that HIPAA was a regulation designed to define information that should be protected, and we're now defining information that should be shared, and I don't know that that necessarily answers the question of whether payments should be in or out but it's worth considering.

Andrew Truscott – Accenture – Co-Chair

Thanks, John. Arien? You were trying to raise your hand.

Arien Malec – Change Healthcare – Member

I just want to go on record as saying that I am pro-transparency and, actually, have been the victim of out-of-network billing. For me, the issue here is the unintended consequences of the application of other parts of information blocking. I think many people are looking eagerly at the notion that information will start to flow. I may be looking more pessimistically at the pricing regulation in 171, 204, and 206 and seeing a net disincentive for startup and innovation services that actually affect price information flowing. So, to me, this is about getting the policy balance right to make sure that the information that we open with one hand we don't close with the other.

Andrew Truscott – Accenture – Co-Chair

Thanks, Arien. That's helpful. Now, just so everyone's aware, inside the rule they're drafting right now, there is a request for information that is in two parts. The first part is about whether the definition, which we have on the screen right now, for EHI should include price information or not. Right now, it has past, present, and future payment. Should that be there or not? And the second is to what extent could ONC, with rules, address price transparency? And that's kind of the crux of where we're discussing.

John Kansky, you've still got your hand raised. Is that inadvertent? It's down again. Good.

Operator, are there any public comments?

Operator
We have none at this time.

Andrew Truscott – Accenture – Co-Chair
Thanks very much. Lauren, given that we're coming to the bottom of the hour, it's been a great conversation as far as I'm concerned. Oh, hang on a second. Denise Webb has just raised her hand. Denise?

Denise Webb – Individual – Member
Yes, I just wanted to make one comment concerning the discussion around the definition of EHI and what's intended under information blocking relative to the USCDI. If information blocking has that broader definition of EHI, yet there are not the standards and the capability to electronically exchange beyond a set of elements defined in the USCDI, don't those potentially conflict? So, if you're not providing through exchange a request for EHI, to that broad definition, because your system only provides and is able to exchange what's defined in the USCDI standards, my question is don't those two conflict? Maybe I'm not understanding that correctly.

Andrew Truscott – Accenture – Co-Chair
Why would they conflict?

Denise Webb – Individual – Member
So, if the definition of electronic health information is broad – it's any electronic health information related to the patient care, payment, and so forth – I guess what I'm asking is does every one of those elements that are under EHI – does the USCDI provide for the exchange of those?

Andrew Truscott – Accenture – Co-Chair
Oh, I get what you're saying. Okay, I think the USCDI is a proper subset of EHI. So, the USCDI defines a subset of how to start to transport information, but it's not all of EHI, if that makes sense. So, EHI is an even larger sphere.

Denise Webb – Individual – Member
Okay, so if I'm a provider and I have a certified electronic health record system that can exchange the elements that are in the USCDI yet I'm requested, by a patient, to provide all electronic information available on that patient and I can't give it to them because my system only exchanges or is capable – I mean, I guess I can give it to them. It might not be useful. That's what I'm asking. Don't the two conflict – the information blocking?

Andrew Truscott – Accenture – Co-Chair
Mark, we'll check this with Steve Posnack. My understanding right now is they wouldn't conflict because there is a whole wealth of information standards **[inaudible] [0:58:21]** here in the US which USCDI will touch upon in leverage but won't be completely consuming of. So, I don't believe that they are in conflict with each other. I think USCDI supports it.

Denise Webb – Individual – Member

So, what you're saying is under the information blocking, if a provider has an authorized request to provide all of the electronic health information on a patient, some of that might be provided through a standard way like FHIR API in the USCDI elements, but the rest of it would have to be provided another way. Is that what we're saying?

Andrew Truscott – Accenture – Co-Chair

Essentially, yes. I think so.

Denise Webb – Individual – Member

Or you would be information blocking.

Andrew Truscott – Accenture – Co-Chair

There's a whole wealth of information sentence. Correct.

Mark Knee – Office of the National Coordinator – Staff Lead

This is Mark from ONC. I'll definitely look into it more and talk with the folks who focused on the USCDI section, but I don't believe there is a conflict. I believe Cures is pretty clear about the breadth of information that we should be looking at, and I think it goes to the definition of EHI and not necessarily just to USCDI.

Denise Webb – Individual – Member

Well, Mark, there's a specific part of text in the proposed rule that says that at the present time, ONC acknowledges that the Cures Act does say all EHI, all electronic health information, but right now, the capability can only focus on a subset of that. So, I'm just trying to understand what their expectation is relative to the information blocking.

Mark Knee – Office of the National Coordinator – Staff Lead

Well, I just want to be careful that the USCDI's discussion is a bit different. And, again, I know we're running out of time, so I'm happy to follow up on this and talk to Steve or others at ONC to clarify. But, I guess, I still don't believe there's a conflict. Did someone else want to say something?

Andrew Truscott – Accenture – Co-Chair

Denise, we can follow up offline, but we are out of time. John Kansky has had his hand raised for a while. John?

John Kansky – Indiana Health Information Exchange – Member

Just quickly, I think building on the point that Denise is making and something that came up in our workgroup call is when thinking about the ability of, for example, a provider to comply with the regulation, if they have to share all EHI, and some of it's in USCDI that their EHR can spit out but other financial information is elsewhere and then there's other information in a third system because we defined EHI very broadly, and they can't comply with the law if they

don’t share everything, the implementation of that just seems to have gotten dramatically more difficult and costly.

Andrew Truscott – Accenture – Co-Chair

Thanks, John. Okay, team, we are out of time. Good conversations. We are going to need to broaden this out and continue the conversation. Thanks so much for everything and all your efforts this week. We’ll be continuing next week. Lauren?

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

That’s it. I think everyone should have the schedule of the workgroup meetings as well as the full task force meeting, so I’m looking forward to the next call. Thank you, everyone. We’ll adjourn for today.

Andrew Truscott – Accenture – Co-Chair

Thank you. Take care.