Health Information Technology Advisory Committee
Office of the National Coordinator for Health Information Technology

Information Blocking (IB) Workgroup 1

Transcript
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Virtual Meeting

SPEAKERS

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

Operator

All lines are now bridged.

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

Good afternoon, everyone. Welcome to workgroup one of the information blocking task force. Quick roll call. Do we have Andy Truscott, Sheryl Turney…

Andrew Truscott - Accenture - Co-Chair

Present.

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

John Kansky and Cynthia Fisher? I believe Michael as joining us as soon as possible. Denni McColm? Okay. Not yet. First thing of the order is to revisit outstanding issues discussed in our prior call. So, I'll turn it over to Andy to get us started.

Andrew Truscott - Accenture - Co-Chair

Hey, everybody. So, we decided that the agenda item for today's call is going to be focused upon price transparency. So, I wanted to just touch upon just a quick bit of background about where we're at in terms of where we have ties in the work we've been doing before we crack on with actually getting down our thoughts. So, what we have right now is inside the definition of electronic health information, we have a statement around price for any past, current, or future healthcare services, which is focused upon the individual. So, it's the price of an individual's prior, current, or future care.

We have a request for comment about effectively asking how we would seek to address price transparency inside the regulations and we've got guidance from Mark, the ONC oracle, that we can, if we wish, recommend some regulations around price transparency or seeking to enable price transparency if we see fit.

We can make any kind of other suggestions to ONC on how they could address price transparency issues, but also tasks which we might want to undertake. In the current drafting around our response on the request for comment, we advise that we profoundly believe this is an important topic which needs to be addressed.

We also suggest that given the legislative authority that ONC does have with HITAC an additional task force should be created which begins work immediately outside of the information blocking work specifically that's going on and outside of the regulations which are going on right now to actually frame up a more holistic ONC-type response. That's currently in the drafting that we have.

However, we do have the opportunity to give some more direct recommendations and the purpose of this call is for us to start with that contextual background I've just given around the information blocking, slant on price, and also, the recommendation we're making around

essentially a task force. With that as background, what else do we want to say? That's the purpose of this call.

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

Andy, I just want to jump in real quick and say the recommendation to create a separate task force, you guys can make that recommendation, but as far as timing for getting things into the final rule, I think you really should focus on – if there are recommendations or proposals you want included in our considerations for this go round with this rule going from proposed to final, I would recommend that you focus on getting them through this work group and not wait on another task force.

Andrew Truscott - Accenture - Co-Chair

No, no. Don't misconstrue the point. The purpose of this call is to get down right now those **[inaudible] [00:03:53]** recommendations, etc. Given the timeline that we are working to and given the complexity of price transparency and the fundamental shift, which we all agree on this call is warranted into how we handle price, those changes are going to take longer to think through. We actually have within the whole rule setting a timeline we're working to, but that doesn't mean it shouldn't happen and it doesn't mean we shouldn't make recommendations now either.

So, I'm kind of saying we hear you, but I think there are two approaches here. One is the stuff we want to put in right now, to your point, to get into these regulations, but then also, just being, with all sense of jurisprudence, providing more scrutiny than we can do within the timeline we're working to.

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

Okay. That sounds good.

John Kansky - Indiana Health Information Exchange - Member

This is John. I just wanted to echo what Andy said. I heard you just agree with it, which is extremely helpful. I just wanted to add that as a task force member, there are times when I feel like I understand and can recognize and advise ONC on the way to implement a regulation and possible unintended consequences, etc., etc., and there are times that I'm concerned that I am creating them myself. So, one of the things I think ONC wants to have that additional care taken consistent with this approach that we're recommending.

Cynthia A. Fisher - WaterRev LLC - Member

This is Cynthia. I think we can deliver a lot on this task force to not really delay the game. If there's a nuance after that that we need to delve into further, I'm happy to volunteer to work to do that on behalf of patients and businesses outside of the healthcare system.

Andrew Truscott - Accenture - Co-Chair

That's awesome. In my mind, Cynthia, if ONC seizes the opportunity to create an additional

[inaudible] task force, then you would be a pivotal point of that. That said, we have the opportunity right now to get some recommendations in to ONC. So, the floor is yours, Cynthia. Do you want to start getting out there some of your initial thinking on things we should be saying?

Cynthia A. Fisher - WaterRev LLC - Member

I added a couple of comments into what you have written. So, I'm going to pull it up on my iPad momentarily. If you want to start just pulling up where we are –

Andrew Truscott - Accenture - Co-Chair

I will ask somebody else to be the orator then because I am not online. I'm on phone.

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

I'll share my screen. I'm not volunteering to be the orator, necessarily, but I can be the sharer.

Andrew Truscott - Accenture - Co-Chair

I'd like to listen to Sheryl's calming tones.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Oh, that's so nice of you. I also would be willing to take on the work on a task force if that's what's decided, but I do have some input on pricing transparency. I think I brought it forward before. I was going to send you a document, Andy. Hopefully, you'll get it later today. Essentially, what we're recommending is that pricing information needs to include data around what services are in and out of network, which is something that Cynthia has spoken to already, but it should also include cost estimates for procedures or services based on some logical groupings of what typically a patient would need.

The real dilemma here is that we can – and as insurers, have actually tried to create sort of bundled services. Let's take a simple one like going for your annual visit. If you bundle all the things together that could possibly be needed for that, it could be quite expensive. So, not everybody's going to need those services. Some of which for a woman in her 30s might be a pregnancy test, an STD test, a mammogram, a whole list of things.

What we have to do is look at these in some sort of reasonably components to say if we're going for an office visit and it's an annual visit, this is what it's going to cost, but you also could be asked to perform some additional services because of the care condition. As a result of that, these additional services might be the things on the menu that Cynthia mentioned before, the lab work or additional things as a result of the visit. Those are things that potentially could be anticipated because they might be there and then some may not be.

That's the difficulty with how complex do we make this. If it then extends over to a more complicated procedure like knee surgery, again, some additional things may come into play when they actually open the person up and find out, "Okay, well, there's this other thing we

have to deal with that's unanticipated." That's the part that makes cost transparency more difficult.

But to speak to the things that would normally occur, if there are anesthesiology services and pathology and a lab test and all of these other things, making the data available to the patient that identifies what their cost would be, what their cost share would be, whether or not that provider that they're going to go to is in network or out of network, making that data available for most carriers today – now, some of the stories that have been told, I don't know how old they are, but there have been a lot of changes recently based on a number of rules that require a lot of this data to be already shared within cost transparency tools.

That takes care of the insured population, but then what about the uninsured, which is also who Cynthia is speaking to. How do they see what the cost transparency is? I literally have done for Anthem a survey and there are no less than about 30 cost transparency websites out there, most of them are regional. It doesn't cover the entire country and the variations are pretty wide in terms of what cost transparency tools are available.

So, having something available, even if it's based on at this point CMS rates up 125 percent or whatever it is, is average or normal would at least give people some semblance of what is the cost if I go here. The problem is that I don't know how each area – and it does seem to be unique to different states because there are different rules – how they price different procedures.

So, you might find the hospitals in California handle it differently where there is sort of a balanced billing law, then Tennessee where there isn't one. Some of the stories that Cynthia's told about people going bankrupt I know happen a lot in Tennessee. I'm picking that state because my mother used to live there. There is no balanced billing rule. Essentially, when you leave the hospital, if you're not insured, you have a gigantic bill that you're basically going to be responsible for and they'll chase you everywhere to get it.

So, again, I guess my point is I don't think there's one solution that's going to apply to everyone because I think the problem is very complex. Yes, we need to quantify it as much as possible and make it realistic and make it accurate. But I think that trying to do that is very difficult because none of the insurers or hospitals are set up like retailers. Maybe that's where they need to go. To go there is going to take some time. Right now, that's not how their systems are set up.

Andrew Truscott - Accenture - Co-Chair

Thank you, Sheryl.

Cynthia A. Fisher - WaterRev LLC - Member

Thank you for your comments. This is Cynthia. I think a couple of things, just to go back on some of the points that you raised – right now, the insurers and hospitals and providers have their rate cards. So, they do have the contract negotiated terms digitized and available and they're adjusted on a continuum. Those could simply be posted and available. If you think about how we can get to real pricing transparency where we get to see the net price and

consumers can be able to search a quick Google search. You could search through a mobile app and we can get to that Uberization of healthcare that Seema Verma talks about in her speeches.

One of the things that we can see is if the entities post the rate cards, if they post by CPT code, DRT code, line item or bundle. It was readily available. I've had a group of people consult technology companies and innovative technology companies in the healthcare system that say it would take about three months to aggregate and readily put up a very consumer-digestible format, but we could get to a real pricing visibility into the system.

So, ultimately, this is doable, having it posted. You have the charge master price to set it up. You have the Medicare rates that are up. We could actually see real visibility into pricing differences. Just yesterday, we had a case of two separate entities, one stitch each, cyst removal. One bill was outrageously $4,000.00 for that. The next bill, very similar type surgery, same person, $21,000.00. That's for one stitch. You think, "Oh my gosh, how can these people handle the egregious differentiations in pricing?" If they could see up front the alternative, it would be much better.

What we've experienced from patients that we've heard from is the cost estimators don't work. I think we've talked about that on a previous call, that the reality of where everything is going within your system, a cost estimator could be off – we've seen it off by a factor of ten. The thing is, we have the ability to see the real price and know the real price. If you think where do we want to go in the future, wouldn't it be apropos that both the physician and the patient get to choose what is within a portable range for the patient.

Since the rate card, even at the point of care, the insurer and the provider communication could be provided ultimately to that patient, that bill should match the pricing quota and we should be able to say if something is really far askew, then the patient should have negotiating leverage to say that bill, just like when we go to a restaurant, doesn't match the pricing that was provided.

Andrew Truscott - Accenture - Co-Chair

That's helpful too, Cynthia. Coming out from that, I heard at least two, maybe three or four, distinct recommendations for regulation that should be put into place. I heard one that was just at the tail end there, which is basically a price that is quoted can never be exceeded. Is that pretty much what you're saying?

Cynthia A. Fisher - WaterRev LLC - Member

I didn't say never be – my point was if you look at what's in the electronic health record definition, health information definition, its past, present, and future payments, patients should be knowledgeable, transparent of the price and that comprehensive billing – right now, patients get surprises that might come seven months leader from a procedure that they're built or even **[inaudible] [00:17:18]** the collections of the charge master price. It's all digitally available that whatever is billed, then they have the price and they have the bill comprehensively, digitally as well as their clinical information.

Andrew Truscott - Accenture - Co-Chair

Okay. That's my mistake. I thought you said something different. I thought I heard you said if you're quoting a price, then the price you're billed should never exceed that price. But you're saying you didn't say that.

When I go back and look at what else you were suggesting, which I thought – please keep me on the straight and narrow – I thought I heard you say that having agreed rate cards, that the agreed rates for procedures should be publicly posted and available to mainly provide organization. I thought that's what I heard you say. That sounds like it's something that we can discreetly make a recommendation around.

My question would be – I don't think we have a lever right now in our current drafting to make that happen. We'd have to amend. Right now, we have past, present, and future price information around an individual's care. But what you described is actually more the agreed charge masters, which an individual's care always tailors off that slightly. It has the same baseline and it has that baseline that you want to publish.

So, I think we might kind of – we would need to make another recommendation to get that information published. I'm not sure it's called out specifically in the current EHI definition. I'm not sure that's the right place for it either. It's almost like there's another definition needed around that kind of financial information and the inner workings of the finances of the health system, which should also be made available and shared. I'll stop there.

Cynthia A. Fisher - WaterRev LLC - Member

I think it's there – past, present, and future payment – I think it is part of that. I think that's what we've been asked to say how technologically did you get to that.

Andrew Truscott - Accenture - Co-Chair

I get we get to it, but how would that definition of EHI relate to the charge master?

Cynthia A. Fisher - WaterRev LLC - Member

Well, you could show the contract negotiated, right? You could get to that through your CPT codes or your DRGs, bundled and unbundled.

Andrew Truscott - Accenture - Co-Chair

That's not individual. That's across my group.

Cynthia A. Fisher - WaterRev LLC - Member

And the rate cards and the insurers have that even on the individual basis between they and the provider. They already digitally have done this for decades.

Andrew Truscott - Accenture - Co-Chair

Sheryl, throw your weight in here because you're much closer to this than any of us because of where you sit professionally.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

I think that it is as simple as what is being identified, especially in light of the value-based arrangements that have been negotiated. I can't even internally reduce it down to an Excel spreadsheet because of the complexity of the way that things are being done. I can't envision what this rate card is going to look like. Again, if it's a hospital or a provider that's in a value-based arrangement, then what happens with that rate card in that case? The problem is because of the way that these things –

Cynthia A. Fisher - WaterRev LLC - Member

The **[inaudible] [00:21:08]**. We don't look to have a whole other level **[inaudible]**.

Andrew Truscott - Accenture - Co-Chair

Cynthia, let Sheryl finish, please.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Yeah. I just think it's not as simplistic as is being made out to be because it takes our team – not only us, but other payers – I've heard the same months to program for these things. So, if it was something that was simple as a rate sheet, that would not take more than a few days to do and it takes us months to do these. I think it's more complicated. There are a lot of variables that all come in to the price.

If you're basically paying for healthy outcomes, which is different than procedures, what Cynthia is suggesting what work if it's all fee for service, which is the way it used to be, but we're moving away from that. So, how do you make a value-based arrangement, which is based on keeping people healthy and based on outcomes in terms of price transparency. It's not that simple.

Again, I don't have the 100 percent answer. I am going to provide some sort of suggestion because I do think we need to have one. Otherwise, we're going to keep saying it's complex and how are we going to go forward. But even the APCDs – and I know I brought this up before – have not known how to deal with a value-based arrangement. So, they're basically taking the information and making it look like fee-for-service, when it's not.

So, it's not even really a valid representation of what's being paid, but it's the only way they know how to do it. So, I'm just saying it's not as simple as you're making it, especially in the current environment. Maybe we need to change the environment. Maybe that's what we need to stay here. Maybe we don't go to value-based arrangement. That completely changes what CMS's direction is.

Andrew Truscott - Accenture - Co-Chair

Thanks, Sheryl. Cynthia, go on.

Cynthia A. Fisher - WaterRev LLC - Member

Although, look at value-based. Right now, who determines the value? There are self-

reporting, self-metrics of the provider systems themselves on the value-based metrics and outcomes reporting, when in fact, looking at any other industry or the opportunity that we have at hand with price transparency is that true value-based reporting could be actually provided by the patient, the reality of the patient outcomes, and their longitudinal patient record, which will reveal the actual health and wellbeing of that individual.

So, think of the opportunity of how participative and how the metrics can actually be consumer-driven, patient-driven on care. As we go to it now, those digital records by patient or already the economics are already worked through and baked through between the contract negotiated terms between the players.

So, those are digitally available. Those can be deployed and be transparent. I think this whole shadow of complexity, once we get to pricing transparency, it basically allows that what we can do is actually be quite transformative of having players compete on performance and compete as in a true competitive marketplace on care. That's where value-based care really will succeed. You could call it another term, call it performance, price performance delivery.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Okay. So, to speak to that point, there are some states that are putting up common risk models that all the payers would need to use. Those are not there yet either. So, right now, what you have is you have multiple payers using slightly different risk models that are not all the same. Then basically, in these value-based arrangements, that risk score sort of determines what the payment approach is, if you will, for people that fall within that risk score.

If I envision what Cynthia's model is saying, you could then say, "All right, I'm Johnny B and my risk score is 94. Who wants to bid on me and take me on as a patient?" That's great if you're a 94, but what happens if you're a 37? Nobody wants you. So, there are dangers to everything that you're looking at this way. I think we have to think about all of that as we're creating whatever the goal is here.

Cynthia A. Fisher - WaterRev LLC - Member

I think the goal is to lower the cost of healthcare and to provide transparency and allow that patient to get access and manage both their health and their wealth. Right now, the model is broken. If you look at where you know it's broken and it's not been working in light of both the American public, the American worker, and the American businesses and economy.

So, speaking, like we talked about, as a self-insured employer, you look at the cost, the rising cost of plans and the rising cost where there is no transparency affects individual wages based upon – we've seen great wage suppression in this country. If both the patient and employer can shop based upon price, you could imagine that we could actually flip where people would be in control to be in control of their wallets and their savings versus what we see today.

So, we could get there. Whether they're a 34, a 37, or a 94, you can basically get through transparency the ability to get care and coverage and management and more participatory

choices by both patient and even employer downstream.

Andrew Truscott - Accenture - Co-Chair

So, I think we've been talking about this – a couple of different things we've been talking about there. I appreciate all the input here. This is a really – I'm going to call it a ferocious conversation, not because we're being ferocious with each other, but because intellectually, there is a lot of thinking to go in here because it is a complicated system. Healthcare provision in general is a complicated discipline and the way we remunerate here in the US adds another level of complexity.

That said, and to Cynthia's point, that model can be still be expressed in some way. It seems like there are a couple of different angles here. One is around making it transparent for the cost of the service. Now, whether that service is going to be remunerated through fee-for-service or fee-for-value, etc., that's one side.

So, the cost of a particular service that you receive from a particular provider, if you're paying 100 percent out-of-pocket, it's X. If you've got Y-payer involved, it's going to be Z copay or whatever. If you've got another payer involved, it's another copay, another payer involved, it's another copay or whatever.

I think that one of the arguments Cynthia was making was that that particular set series of negotiations should be made transparently available to a patient so they can make an informed choice about whether they're going to pay for a particular service out-of-pocket or when it comes to their enrollment selecting a payer who might be providing them coverage. They have that better sense of being informed about what their out-of-pocket costs could be over time. I think that was one aspect of what you were saying, Cynthia. Am I over-simplifying or is that kind of in the right ballpark?

Cynthia A. Fisher - WaterRev LLC - Member

[Inaudible] [00:30:16] from just something simple like the colonoscopy. Patients should be able to see that – what is their annual routine colonoscopy going to be? They don't know that they might get $6,000.00 in surprise billing from a pathologist and the anesthesiologist that weren't revealed to them. In trying to get what is the all-inclusive price of a colonoscopy and where you should go, which are routine procedures at almost a commodity level, but they're not a commodity because of out-of-network pricing and then some charge for facilities, right? You don't know when that's going to come up in a surprise.

Andrew Truscott - Accenture - Co-Chair

Okay. Hold on.

Cynthia A. Fisher - WaterRev LLC - Member

So, if entities posted their prices and patients knew that they weren't going to have coverage, then you have that transparency. I think ultimately, what you're going to have is you're going to have systems that it will be all in for a colonoscopy and they'll do it at another price – a much lower price. Then the patient can go where there are no surprises.

<u>Andrew Truscott - Accenture - Co-Chair</u>
I think that was a yes.

<u>Cynthia A. Fisher - WaterRev LLC - Member</u>
Yeah.

<u>Andrew Truscott - Accenture - Co-Chair</u>
Okay.

<u>Cynthia A. Fisher - WaterRev LLC - Member</u>
And then they don't even know – like the last one –

<u>Andrew Truscott - Accenture - Co-Chair</u>
I think that was a yes with one exception.

<u>Cynthia A. Fisher - WaterRev LLC - Member</u>
Like the last one, you find out it can be up-coded – if there is a polyp, you can get it up-charged and up-coded as a different type of procedure and that's a whole other level of charges that's not transparent to the patient today.

<u>Andrew Truscott - Accenture - Co-Chair</u>
Okay. Let's get back because **[inaudible] [00:31:45]**. So, I think in principle, you agree with the statement. The point I just want to pick apart is whether your position here is not only to know what your out-of-pocket cost or out-of-network cost would be, but also, what the cost could be to you depending on who was running your network, who is your insurer so that you can make an informed decision about who you want your insurer to be. Is that also included in your premise?

<u>Cynthia A. Fisher - WaterRev LLC - Member</u>
Ideally, a patient should be able to see what – ideally, **[inaudible] [00:32:22]** and say, "Why is a small business employer average health plan in Massachusetts $30,000.00 to $31,000.00?" And many have high deductibles, $4,000.00. That's just for small business. Now, a medium-size self-insured business pays $15,000.00 for a family of four. So, they may pay around $15,000.00 or a family of four. And then a larger business may be closers to $11,000.00 to $12,000.00 for a family of four.

So, one is the health plan coverage is different based upon what size company or business or organization you work for and that just seems wrong, secondly, unfair, and there's no visibility into those differences. The second part is oftentimes, those plans are less. You pay more, but you get less. You get a worse negotiating leverage than the larger entities or larger companies or organization.

So, even as you stand in line for your MRI, one patient may pay five times more than the

next. That difference, if we had price transparency, entities posted their prices, you could see a substantial **[inaudible] [00:33:53]** shopping with their fees, where people would save both on their deductibles and they would save on their out-of-pockets, but they would save also for their companies and their organization. If I could save my company unnecessary tens of thousands of dollars in their healthcare coverage for a family of four, then that bucket of savings could go to increasing those employees' wages per cost of FTE per organization. So, we would change the game to allow for control of cost, both for enterprises and for patients.

Andrew Truscott - Accenture - Co-Chair

Okay. So, that's another layer around this as well. I could see where you're coming from. We've got this onion we're constructing of different layers of transparency, which actually have an overall transformational impact upon the healthcare system. Got it. I'm with you. I'm understanding you. I think going back to the original question, you were saying we want to have publicly available differential in rates still be charged to different plans. That's going to help drive down those costs you were outlining by making the plans able to more effectively compete against each other in negotiating the rates of the providers in the first place. Got it.

Right now, I don't think in the current drafting of the regulation, we have the level of – let's call it "information sharing" in quotes right now, although the right definition of information to be shared to enable that. We certainly have the individual services received level, the mandate around the sharing of the prior costs, the current costs, and the future costs. I think the future costs as it currently is drafted might cause some consternation about how you actually contemplate that because it is – it's specific to the individual in the way that it's expressed in the regulation.

Honestly, I think, Cynthia, to enable what you're describing, it's almost behoven on us to have a very appropriately worded richer definition of price and cost information that must be shared between a public **[inaudible] [00:36:33]** or however you want to do it. But it sounds much richer than the simple focus around an individual's care experience that we have right now. I know it's a person to it, but the way it's currently structured in EHI, it just feels quite a thin definition for what we're seeking to achieve. So, if you've got any thoughts around that definition…

Cynthia A. Fisher - WaterRev LLC - Member

I think for the provider to payer care, the pricing can be provided, as can the payment information as part of the digital electronic health record as described both in HIPAA and described in ONC's definitions as electronic health record.

Andrew Truscott - Accenture - Co-Chair

That particular service, we can put the price against that service, absolutely. Got it. I get that. Yeah.

Cynthia A. Fisher - WaterRev LLC - Member

The insured rate at the net negotiated rates are digitized and known. Earlier in the task force, one of the things that I had mentioned is looking at providers posting their net negotiated rates, what they're willing to take to buy CPT code, buy **[inaudible] [00:37:51]**, buy bundled

on bundled, buy value, post it publicly, made it all available – there's a wide range today that a provider is able to do and negotiate.

Andrew Truscott - Accenture - Co-Chair

That feels like that's another step that we're looking at taking to achieve that, right?

Cynthia A. Fisher - WaterRev LLC - Member

There's a wide range today. But I would argue to say okay, why should one entity – if you post those ranges, if you post what your different things are by plan and what was negotiated, then you'd have true transparency.

Andrew Truscott - Accenture - Co-Chair

To make that happen, though –

Cynthia A. Fisher - WaterRev LLC - Member

And you do carry responsibility.

Andrew Truscott - Accenture - Co-Chair

So, to make that happen – let's let John – John's been very quiet over this call so far – but to make that happen, to get that level of visibility into the differences in deltas we have in price, do we think that we're going to need to make another statement of regulation?

John Kansky - Indiana Health Information Exchange - Member

Andy?

Andrew Truscott - Accenture - Co-Chair

Go on, John.

John Kansky - Indiana Health Information Exchange - Member

I've been listening intently. A couple of calls ago, I tried and didn't do a particularly good job of making an analogy around regulations as tools and screwdrivers are good for screws and hammers are good for driving nails. I don't want to see us try and use the info blocking regulation and stretch it in a way that is not – that I think it's well-equipped to do. I think that's what we're in danger of doing.

I violently agree, I believe, with Cynthia's free market perspective on we're not going to fix what's broken with healthcare until we can introduce this price transparency. I am contemplating the machinations of using this regulation, which I've said in the past is inherently a blunt instrument to try and accomplish that.

I think we need a different tool for that particular aspect of fixing the healthcare system. I think we need to stick with the definition that we have and focus on liberating the pricing information of the individuals, past, present, and future.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

This is Sheryl, but I didn't really follow what you just said. Somehow, you confused me.

Andrew Truscott - Accenture - Co-Chair

Go back, John. Go again.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Can you just say that again?

Andrew Truscott - Accenture - Co-Chair

Shall I try and paraphrase, John? John, tell me if I'm right or wrong. John's fallen off the reservation. Sheryl, I think what John was trying to get to was saying the information sharing regulations are focused around enabling information about patient care to be routinely shared between their care providers and made available to the patient to share with whoever they want.

The power and control should be in the hands of the patient there and other lawful purposes. That might be using a hammer to bang in a screw if we saw we also want to enable a lot of the price transparency aspirations that we have through the information blocking regulations. I think that's what John was saying.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

I got that part. What I didn't get was the last part of what he was saying.

Andrew Truscott - Accenture - Co-Chair

John, can you fill us in? Mr. Kansky, have you disappeared off the reservation here?

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Maybe he's talking on mute.

John Kansky - Indiana Health Information Exchange - Member

This is John.

Andrew Truscott - Accenture - Co-Chair

There he is.

John Kansky - Indiana Health Information Exchange - Member

Yeah. As soon as I finished my comment, I meant to hit mute and hung up.

Andrew Truscott - Accenture - Co-Chair

Could you just repeat the last bit of your comment? We got the hammers on screws. I was actually going to say hammers on bananas. But the last bit, Sheryl was just looking for a bit of clarity. She didn't quite follow you.

John Kansky - Indiana Health Information Exchange - Member

So, let me see if I can replay it myself. So, it's just that I think we need to not start down the path that you were suggesting would be necessarily, Andy, to broaden or revisit the definition. I think the definition, as stated, which is focused on the individual's pricing information as part of electronic health information, I don't feel it's a good idea to open that can for the reasons stated.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

That clarifies it for me. That's the part I wasn't understanding what you were meaning. Okay. Thank you.

Cynthia A. Fisher - WaterRev LLC - Member

I also heard John – correct me if I'm wrong, but this is from my notes of what you were saying – is you also said that you would support liberating the information on pricing at the individual level past, present, and future. That's what I heard you say at the tail end. Is that correct?

John Kansky - Indiana Health Information Exchange - Member

As much as I think that is clearly in the definition of EHI, yes.

Cynthia A. Fisher - WaterRev LLC - Member

Okay. Could I just add something that I brought up – thank you, John – in a previous call was that if we looked at Cures and its definition of the EHI originally as they looked at health information, it was what would be pertinent to an individual, but it wasn't into the protected definition of HIPAA or the – there are two I's and I can't remember the two I's. We spent a lot of hours on information blocking.

My point is that if you want to get at the visibility, one would obviously as a patient want to know what is my insurance negotiating – in today's world, what is the rate agreed upon between – as it's broken down, as it's knowledgeably known between the provider and the payer for my care and for my services that I can have that as an individual level and in order to make a decision, I'm in a provider system that wants to charge me my primary care in a large hospital system.

That tells me I need a certain blood test and I can get it for one-eleventh of the price than if I go across the hall and get it in their system. Where I get it in their system is they tell me they're a quality large hospital system, I get that facilities fee of $275.00 as well. However, I go down the street –

John Kansky - Indiana Health Information Exchange - Member

Then I don't –

Cynthia A. Fisher - WaterRev LLC - Member

Hang on. Hang on. If I have full visibility into pricing of that same lab test by code and I'm able to see that across the spectrum, I can choose to walk with my feet and get it at one-eleventh of the cost and see what my copay would be and save both my insurer, if I have an insurer, or if I have a self-insured employee, walking with my feet in that visibility, then I can choose to save the healthcare system and myself.

John Kansky - Indiana Health Information Exchange - Member

I think you're describing the problem. I don't know if this is an appropriate time, Andy or Mark – are we planning to talk at all about the bullets and the preamble and I'm not suggesting that we need to, but Cynthia's comments are making me think of some of them because I was reading those and flipping back and forth in my own mind between John the patient and John the health IT guy and reading them as a patient, it's kind of, "Well, of course, I'd want that," but then thinking about the how, some of them, I have no more intelligent feedback, then how is that even possible?

For example, some of the pricing information that's asked to be made in advance, which is, I think, what Cynthia is anticipating if it's my planned colonoscopy or if it's my planned annual physical, then that makes perfect sense, but in reading some of the preamble comments, there were things like emergency visits and visits prior to registration that I couldn't wrap my head around the how we would do that.

Cynthia A. Fisher - WaterRev LLC - Member

If you look at like a CABG procedure – you look at coronary artery bypass, it's very common. The thoracic surgeons have done a fantastic job of evaluating accountability in their care and that has been narrowed to a very routine – even though it's a well-oiled machine, that's a great place to say okay, if you can have total price transparency as to what that procedure would cost at one hospital system versus another, why wouldn't you look at those comparative prices and then you could look at risk, which is narrowed to a very narrow range, and patients could choose based upon performance and value and price.

But that's something that could ultimately come to be priced, very easily. In the meantime, just put everything up. We've got to start somewhere, post it up, make it accessible on the internet, and then when the players want to compete, they can do it even better by surgical procedures where why wouldn't the institution at some point in the future take on the risk because they know they can do them so well?

John Kansky - Indiana Health Information Exchange - Member

I think this is –

Cynthia A. Fisher - WaterRev LLC - Member

Is it diabetic or has higher risk? They take on what is that price range they'll compete at. You'll be able to change the game, but until we post prices, we can't go anywhere. We can stay in this entanglement of just saying it's too complex and it's too opaque, but it doesn't need to be.

John Kansky - Indiana Health Information Exchange - Member

I think we're on the two sides of that dividing line that Andy was trying to describe a few minutes ago. I'm thinking about trying to prevent information blocking about the healthcare of an individual. I understand, I believe, what you're suggesting is that if all prices of stuff somebody might need are published, then an individual would have access to how much a CABG is at hospital A versus hospital B. That to me is two different things because the latter is definitely price transparency, but I feel that it's trying to use the info blocking regulation as not the right tool, is my concern.

Cynthia A. Fisher - WaterRev LLC - Member

However, John, and to the group, I would say information blocking – if we can't see the prices and we can't know the difference and we're supposed to write a great check, isn't that information blocking by both our provider and our payer and anybody who's exchanging our data behind the scenes?" This is drastically affecting people's lives to not have this information.

Andrew Truscott - Accenture - Co-Chair

We get the problem. It's blocking a different type of information. Do we as a group want to recommend to ONC and potentially **[inaudible] [00:50:33]** they should have so there is a different class of information which we also want to ensure is not blocked? That class of information is the general service cost and services charges that would be made for **[inaudible] [00:50:50]** for what procedures, etc., but we want that information to also be unblocked. Is that the statement this group is making?

Cynthia A. Fisher - WaterRev LLC - Member

Andy, I can't hear you clearly.

Andrew Truscott - Accenture - Co-Chair

Okay. I'll try that again, sorry. I'm in Canada.

Cynthia A. Fisher - WaterRev LLC - Member

If you could try it again, that would be helpful.

Andrew Truscott - Accenture - Co-Chair

No worries. From what I'm hearing from the group right now, there's a different class of information that we also want to ensure is not blocked. We get the class of information that's about the individual. We also want to have a separate class of information unblocked that is specifically around the fees and charges that could be levied against a patient for receiving services. We want that information, those potential charges to also be highly public – I think these are posted on the internet.

I think we want to go one step further and say where it should be posted and suggest where that could be, but do we as a group want that class of information to be described in a regulation?

John Kansky - Indiana Health Information Exchange - Member

So, Andy, let me get my prospective response to that really quick. One is that I think you've done a good job of describing what would be necessary if the answer to your question is yes, meaning that we need to define that as a separate category of information so we don't blow our brains out trying to twist the EHI definition.

So, I agree with the need to separate that out if we're going to agree in the affirmative with what you just asked. Secondly, I'm prepared to philosophically agree with what you just said. What I'm concerned about, because I can't wrap my head around it, is the implications of this using this particular regulation to try to accomplish what you're suggesting.

Andrew Truscott - Accenture - Co-Chair

This is a point where we'd like ONC to actually –

Cynthia A. Fisher - WaterRev LLC - Member

It's already in the regulation. My understanding is it's part of the healthcare information definition anyway and we're trying to give patients access to their healthcare information and ONC has already put it into this regulation.

Andrew Truscott - Accenture - Co-Chair

But what's in there right now, Cynthia, is slightly different. What's in there right now is the – you can see pricing information for the services you have received, the services you are currently receiving, but then the pricing information that you might receive for service – that's for a particular service your going to receive. It would be, I think, a stretch to say that the future price extends to getting the outcome you're looking for with having publicly available service descriptions and pricing posted for anyone to consume. I think that would be a stretch.

Cynthia A. Fisher - WaterRev LLC - Member

I see that you would have pricing information publicly and informed and not be withheld from the patient.

Andrew Truscott - Accenture - Co-Chair

I agree with you on that one.

Cynthia A. Fisher - WaterRev LLC - Member

It's a very important part of the patient's decision. Look at the differences in the new drugs and insulin. We talked about that last time.

Andrew Truscott - Accenture - Co-Chair

We agree on the need. We absolutely agree on the need.

Cynthia A. Fisher - WaterRev LLC - Member

It is part of the patient record, the patient health information, to –

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

But if you take all the components, I think what we're trying to say, in the USCDI today, it doesn't really talk about pricing in the future. It talks about payments in the past – claims and payments, etc. So, if you take all the parts together, in this rule, it's asking through an RFI to give information about further price transparency.

I think that's where they're looking for how can we do it in the future to get at what you're talking about, but this rule itself, if you look at it in terms of what's defined and sharable in the USCDI and yes, it's included in the definition of health information, but in the USCDI, which is the required data elements, it's not there yet. How we make that available, I think, is what we're talking about so that we're trying to say what can we do now versus what is planned for the future.

I think the intent behind this, the way I read it, was that the future is talking about what you're getting at right now, but what's currently here is claims today and claims past and what the RFI is really talking about is what you want to get to in the future, which is posting rate sheets or whatever it is, but it's the pricing transparency for prospective costs that will come.

Andrew Truscott - Accenture - Co-Chair

If you look at the term future in the EHI definition right now, I must confess, I sat there and said, "Okay, that's future planned care." It's the stuff I know is going to happen. So, I have transparency on what that's going to cost because it's planned. Where Cynthia, where you're coming from – and I think we all agree – we just want to work out the right solution to get what you need is to allow me to make informed choices about things I haven't necessarily discussed with a provider yet, the stuff that I don't want to discuss with a provider.

I just want to work out where I want to go. Sheryl is right. USCDI doesn't cater for that right now. It feels like if we're going to do this, let's do it properly. Doing it properly is not trying to shoehorn it into something where it doesn't quite fit. Now, the round peg is a square hole. Let's actually define a round hole.

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

Andy, can I just jump in really quick? I know this is going to bug you what I'm going to say.

Andrew Truscott - Accenture - Co-Chair

Then don't. Stop talking.

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

To Sheryl's point, I just want to be clear about where ONC stands on all of this. You're right that there is a request for information about what the department can do in the future, but there's also a request for comment in here. We say that EHI, the definition clearly has price

information included in it and we're asking what, if you have recommendations on what we can do now as well, so, it's both a what can we do in this rule right now and what can we do moving forward.

Andrew Truscott - Accenture - Co-Chair

That doesn't bug me. That doesn't bug me at all. Given what Cynthia is saying – if this group passionately believes this is what we need to have come out by, then we should be saying we want to have an additional statement in the regulation that says – it might be a new definition that we have, something like electronic health administration information or something like that or health financial information that says that **[inaudible] [00:58:18]** will be published publicly.

There will be an agreement of a common series of rates and definitions of rates that every provider will have to publish. If we agree to that, then we should get it into the regulation right now.

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

Not to throw a wrench in the plan – again, your recommendation is your recommendation – but just to pull it back to Cures, what Cures does is the information blocking would be – the definition is that it's interference with the access, exchange, or use of electronic health information. So, really, to be covered under that definition – for the information to be covered, it would need to be within that definition.

Andrew Truscott - Accenture - Co-Chair

Okay. Then we actually should add another dimension to electronic health information, which is as I just described.

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

Right. Yeah.

Andrew Truscott - Accenture - Co-Chair

Or we define it and say electronic health information should include –

Cynthia A. Fisher - WaterRev LLC - Member

That can also be done with a broader definition of electronic health information is not just protected but as just what is the broader definition in HIPAA of health information. Then it does cover – I think to Mark's point, it is in the comment period for pricing as it refers to electronic health information. So, having that broader definition actually does affect this ability to see the broader playing field of prices.

Andrew Truscott - Accenture - Co-Chair

So, let's do that thoughtfully.

Cynthia A. Fisher - WaterRev LLC - Member
Right now, patients are blocked from information on pricing.

Andrew Truscott - Accenture - Co-Chair
Right.

Cynthia A. Fisher - WaterRev LLC - Member
It is solvable and doable. You don't **[inaudible] [01:00:00]** electronic health information, but also to make it public in the broader sense.

Andrew Truscott - Accenture - Co-Chair
Cynthia, have you got a definition of this information type that you can share with us?

Cynthia A. Fisher - WaterRev LLC - Member
I think I sent it in an earlier group on a **[inaudible] [01:00:20]**.

Andrew Truscott - Accenture - Co-Chair
If you do, can you just talk through it, please?

Cynthia A. Fisher - WaterRev LLC - Member
Hang on. I've got to find it, okay? I think I submitted it earlier.

Andrew Truscott - Accenture - Co-Chair
Mark, what I'm thinking right now is that we actually add a third leg to EHI. I'm tempted just for clarity's sake that we might want to call it like electronic administrative information or something like that, which is EHI.

Cynthia A. Fisher - WaterRev LLC - Member
So, Andy, it's on page – when I printed it out from our workgroup sessions, it's on page two.

Andrew Truscott - Accenture - Co-Chair
I have no screen access right now either, so, you'll need to tell me.

Cynthia A. Fisher - WaterRev LLC - Member
It's the first HIPAA definition of health information.

Andrew Truscott - Accenture - Co-Chair
Well, we have that already in the EHI definition.

Cynthia A. Fisher - WaterRev LLC - Member
Well, it's broader and then it has individually identifiable and then it has protected health. So, HIPAA has three levels of health information definition.

Andrew Truscott - Accenture - Co-Chair
Okay. Believe it or not, I don't carry all the definitions of health information. Can you read it out? I haven't got a screen.

Cynthia A. Fisher - WaterRev LLC - Member
Okay. If I read it out, the first definition in HIPAA from '96 to 2000, it says health information means any information, including genetic information, whether oral or recorded in any form or medium that one, is created or received by a healthcare provider, health plan, public health authority, **[inaudible] [01:02:05]** school or university or healthcare clearinghouse, and two, relates to past, present, or future physical or mental health or condition of an individual, the provision of healthcare to an individual or the past, present, or future payment for the provision of healthcare to an individual.

Andrew Truscott - Accenture - Co-Chair
Okay. So, how would that achieve what you're looking for, which is a visibility into generic service cost?

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Which has nothing to do with a specific individual until that specific individual gets any of those services, is the point.

Andrew Truscott - Accenture - Co-Chair
Yeah.

Cynthia A. Fisher - WaterRev LLC - Member
Not really. You'd have that as a rate card. You'd have it as the plan. You'd have it by what is pre-agreed upon between the insurer and the pet provider based on CPT code or DRG and bundled or unbundled. So, you already have that defined.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Was what you were reading the individually identifiable handheld information definition?

Cynthia A. Fisher - WaterRev LLC - Member
No. I was reading the one above that.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
What's it called? If it's not PHI and it's not IIHI, what is it?

John Kansky - Indiana Health Information Exchange - Member
I think it's health information.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
I'm sorry. Say again.

Cynthia A. Fisher - WaterRev LLC - Member
Health information definition.

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

Cynthia A. Fisher - WaterRev LLC - Member
And health information was referred to in Cures Act of patients needing access to their health information.

Andrew Truscott - Accenture - Co-Chair
Okay. So, a couple of things, Cynthia – isn't that largely synonymous with parts of the EHI definition inside of the proposed regulation?

Cynthia A. Fisher - WaterRev LLC - Member
The EHI definition right now as is, it was narrowed more to the individually identifiable and protected health identifiable HIPAA definition.

Andrew Truscott - Accenture - Co-Chair
That's the first part. But the second part of it is not the HIPAA-protected definition. It's the individually identified with data for current, past, present, and future care provision and past, present, and future payments to change that care provision. But actually, that's largely academic.

If I'm reading right and the vision that you have, I'm not sure that to get that broad publishing of rate and transparency between provider organizations of the charges they would levy for services, it feels like that's an overread of the HIPAA definition and frankly, the one that's in EHI, that's trying to say, "Well, because Andy might receive an infinite…"

In fact, any service – the only services he's unlikely to receive are ones to do with gender-specific conditions, but he might receive anything. Therefore, we need to tell him about the cost of anything – that feels burdensome.

Cynthia A. Fisher - WaterRev LLC - Member
But you know what? You go to a grocery store and there are lots of prices. How many items are in a grocery store?

Andrew Truscott - Accenture - Co-Chair

There's a finite limit, but it feels like that's not relevant. I want to achieve what you're looking to achieve. I'm here fighting with you.

Cynthia A. Fisher - WaterRev LLC - Member

Yeah.

Andrew Truscott - Accenture - Co-Chair

Not against you.

Cynthia A. Fisher - WaterRev LLC - Member

I'm just saying if you publish it and it's posted and it's out there, it can be aggregated by what the prices are in that it would –

Andrew Truscott - Accenture - Co-Chair

Cynthia, that's right, but the cost of a colonoscopy for Andy is different to the cost of a colonoscopy for John is different from the cost of a colonoscopy for Cynthia. What makes it more relevant is that the cost of a colonoscopy without the specific individual context is X. Between providers, it's going to be X, Y, or Z, between the three providers. That's, I think, what you're trying to achieve.

So, you know that the total cost for **[inaudible] [01:06:20]** is never going to exceed $100.00. Now, for Andy, it might cost $75.00. For John, it might cost $71.00. The individuality statements, which are in these definitions actually don't help achieve the transparency you're looking for, at least that's my read of it.

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Yeah. I think I agree with you, Andy. This is the part of what should be there as an RFI recommendation for the future. I read it the same way. I don't see that that's there today. Certainly, if that's what Cynthia is looking for, that can be a recommendation for a future rule.

Andrew Truscott - Accenture - Co-Chair

Actually, we can make the recommendation in here in our comments right now. We can say, "We think you need to include this as a separate information classification that is shared and must not be blocked." We can absolutely do that, to Mark's point.

John Kansky - Indiana Health Information Exchange - Member

Andy, can I get in queue?

Andrew Truscott - Accenture - Co-Chair

You're next. Go.

John Kansky - Indiana Health Information Exchange - Member

I want to make what I think is an actual good point, which is unusual for me, but one of the

concerns that supports, I think, your argument on this one is that I don't want to throw the regulatory baby out with the bathwater, meaning I thought, as a person working in this industry, that when we were writing an information blocking regulation that the things that we were trying to prevent are the things like – Seema Verma talks about when she tells the story of her husband having an out-of-state episode of healthcare and not being able to get his healthcare information from that episode in a very frustrating way.

So, there's information blocking that occurs in the industry. I still think it's not an epidemic, but there are information blocking scenarios we want to prevent with this regulation. I think there's a danger of trying to accomplish other important things that need to be accomplished in the industry with the regulation that was set out to attack these fairly specific examples of information blocking.

Before I give up the stage here, I'm going to cite the example of HIPAA, which set out as its primary goal to administratively simplify healthcare and by the time they tacked a privacy regulation on the administration simplification requirements, it was like putting a 600-pound tail on a 30-pound dog.

Andrew Truscott - Accenture - Co-Chair

Wow, that's unhappy dog.

Cynthia A. Fisher - WaterRev LLC - Member

John, I totally agree with you. The other thing that we have here is there is the broader definition of health information in HIPAA, which was the first one that I read, not the protected level, which has been sort of egregiously misused. As you all know why we're here today, it's because the misuse of HIPAA as protectionism from having patients leave the hospital system because we know they stay within it because they can't access to their record.

We live in a transient world. We manage our lives with mobile. Somebody has a skiing accident in Colorado and they need access to their information. They also need access to pricing. I think the real issue here is this is change. It's huge and it's transformative. It's uncomfortable for many of the **[inaudible] [01:10:07]**. It is changed.

But the thing that we have we have with this opportunity is it is in the rule to have pricing be included because it's a very important part of the patient's delivery of care and choices of delivery of care and affordability within their family life. We have patients today that we have telling us that they make different food decisions on feeding the rest of their family when they have another child that has cancer and is putting them in financial duress. So, it affects the entire family, this domino. I'm sorry, I digressed.

Andrew Truscott - Accenture - Co-Chair

No, no. This is all legitimate.

Cynthia A. Fisher - WaterRev LLC - Member

I see all these patients firsthand. So, I think the thing is we have the opportunity for transparency and we have the opportunity to utilize the tools. I think what HHS is doing here is utilizing the tool of real penalties and fines for players that don't want show prices and want to keep withholding it and keep the complexity and keep the opacity baked into the system.

So, I know you talk about using a hammer on a screw or whatever, but the reality is that the information blocking compliance tool has teeth and we can get there because we can have everyone be accountable to compete for that patient by providing the best performance at the lowest possible price.

Andrew Truscott - Accenture - Co-Chair

Okay. Cynthia, to make that happen –

Cynthia A. Fisher - WaterRev LLC - Member

The only way to get that and transform the system is to have these types of tools in place.

Andrew Truscott - Accenture - Co-Chair

Okay. So, to make that happen – do you agree with my point that you could read the future price definition to be future price in the context of that patient and it might be less than helpful if you try to force the principle we're trying to get through here around price transparency into that tighter or apparently tighter definition? Do you agree with that?

Cynthia A. Fisher - WaterRev LLC - Member

I have a hard time interpreting your English sometimes, Andy. This is where I think you can have the individual information provided based upon today's insurance coverage. They have their summary benefits. They have the digital tracing of copay, out-of-pocket, deductible – all that is baked into a digital back and forth between providers.

Andrew Truscott - Accenture - Co-Chair

Cynthia, let's say that –

Cynthia A. Fisher - WaterRev LLC - Member

You can have that –

Andrew Truscott - Accenture - Co-Chair

Hang on. I need to sort of – I'll use a use case because I think we need to explain this, really get this out on the table. If Andy needs a colonoscopy and Andy knows it's going to cost him $100.00 from the regular provider he goes to and says, "Actually, I want to go get it cheaper." So, I'll go to provider B. Provider B doesn't have any of the contextualization of Andy to be able to come back and say, "A colonoscopy is going to cost you $80.00 with us."

We don't know any of that. I don't think that's what you want. I think what you're asking for is that provider A and provider B will both publish what their baseline cost is for the

colonoscopy. Then I can make a choice about which one I want to go to. I think that's what you're looking for, right?

Cynthia A. Fisher - WaterRev LLC - Member

Well, it would be price. The terminology would be price. What is the price of your colonoscopy and if you have out-of-network anesthesia, out-of-network paths –

Andrew Truscott - Accenture - Co-Chair

Yeah, whatever.

Cynthia A. Fisher - WaterRev LLC - Member

Show it.

Andrew Truscott - Accenture - Co-Chair

But the current drafting doesn't enable that. The current drafting enables Andy to know what his prices are for the currently planned care he wants to receive. It doesn't give him the wherewithal, necessarily, to be able to make those decisions about the care which he isn't planning on receiving. Nobody who's quoting the price on it is going to have the contextualization to define it.

From what you're looking to achieve – you went back to the original HIPAA HI definition, I must admit I'm not a big fan of relying on HIPAA because I think HIPAA as a concept is imbued with a lot of different kinds of predecessors around it. I'm kind of with you that adding another leg into the EHI definition, notwithstanding the fact that I'd like to call it something else inside that definition, but we can cross that bridge when we come to it.

But actually saying that providers – EHI includes baseline price information for a suite of colon procedures to be defined by ONC. That makes sense to me. That would enable exactly what you want.

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

Andy, just a point to note – in the definition of EHI, we do talk about the relationship to the individual. So, I've heard you talk about charge master or different prices and just a potential conflict.

Andrew Truscott - Accenture - Co-Chair

That's the point we've been making. The individualization mentioned in the current definition isn't actually somebody who's going to necessarily achieve the price transparency goals which Cynthia so articulately got out there. That's why potentially we're looking for this extra leg of definition in there, which is moving away from the individual and looking at the generic.

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

Lead

Okay. Great. Just like as far as clarity for ONC, it would be really helpful if you take that route to clearly identify as much as possible what would constitute this new category that you're talking about. What's in? What's out? No, no, we would. I think Cynthia already has lots of thoughts on that.

Cynthia A. Fisher - WaterRev LLC - Member

I think there's another way, too, to attack it, Andy, is that in order for the individual to interpret – you have what the individual may be covered or not covered, right? If it's public, we have people that have covered – we know people that make a deal because they were so outrageously overarched. They'll go and say, "I'll pay cash. You can charge me all-in for a vaginal birth," literally. We have people say, "I'm not going to go through insurance and I need to know what the real price is going to be because I got surprised billed."

Then they get a real price and they'll say, "It's worth it to me to pay cash because I'm going to save more money doing that than I am going through my plan with the surprise billing." So, patients have the option to see – one could argue for the individual, if the entities post and put easily accessible, readily accessible, various prices, they can do it as they can just by that code and quantification, then you could see the range and the patient could choose.

Andrew Truscott - Accenture - Co-Chair

Cynthia, we're on the same page. We're on the same page.

Cynthia A. Fisher - WaterRev LLC - Member

That would pertain to the individual.

Andrew Truscott - Accenture - Co-Chair

Well, yes and no because you're going to need to get the correct context from me as an individual to whomever I'm asking to quote on so that they know for person A, yes, to quote on a vaginal birth is appropriate. But for Andy Truscott to quote on a vaginal birth is not appropriate because it's not a service I would ever physiologically require.

Cynthia A. Fisher - WaterRev LLC - Member

You **[inaudible] [01:18:04]**, Andy, and you could be an expert on the cost of vaginal births as they go around the country, right? So, think about getting it to the place where anybody can search through a search engine on pricing.

Andrew Truscott - Accenture - Co-Chair

I know. That's what I'm trying to help you with. I'm trying to help you get there. As soon as you have the individual contextualization in there, then there's a whole bunch of uniqueness to you as a person that's going to make that a lot harder. Now, when it comes to the risk model side of it and what your likely **[inaudible] [01:18:43]** is going to be, which will be less than one that's put out there that was generic, I get that completely.

I think there is that individual contextualization. But as a first step, having basically the

[inaudible] [01:18:59] for services and a provider organization seems to be that first step. The second step is, as you described, Andy being able to make all my clinical disposition available to a set of tools yet to be **[inaudible] [01:19:18]**, but a set of tools which can take my context and then say, "Right, based upon the risks that you possess and the way we appraise your clinical situation against the possible care services you would be looking for, this is what the likely rates are for you across different organizations."

I'm with you entirely. That's step two. The first step is actually making the information available to start basing those prices. Did you follow that or did my English get in your way?

Cynthia A. Fisher - WaterRev LLC - Member
[Inaudible] [01:19:59] followed **[inaudible] [01:20:01]**.

Andrew Truscott - Accenture - Co-Chair
Okay. Good answer. The point I'm making is that if we try and get the individual prospective pricing piece done inside that EHI definition right now, I think we're missing a step. I know that you are fully aware of companies that can help generate these models pretty quickly, but they're going to depend upon a number of things.

A provider – it's not feasible – this is something I definitely don't want to happen, which is people hiding behind the exemptions to stop this kind of information being shared because let's say I have a provider organization in a reasonably sized metropolitan area and they have a potential population of, let's say, 500,000 people. Those 500,000 people, 10 percent of them are doing their shopping for health insurance. I want to understand what their potential fees would be if they came and received care at that provider organization.

Their individual context is being used to define what those likely fees are going to be for that individual. It could be unfeasible for the organization to actually provide that information in a timely manner. There's so much thinking to go – so much contextualization for the individual. What is more feasible is to say, "Okay, for these 150 popular services, this is what our RAC rate is for them. This is RAC rate that we charge Blue Cross Blue Shield for. This is RAC rate we charge Aetna for. This is the RAC rate that we charge United for." And I thought that that was the initial insights you were looking for.

Cynthia A. Fisher - WaterRev LLC - Member
Yes. So, the point is you could have both, could you not? Only also what it is to the individual with their current plan. Secondly, you could also have it posted that you get to see, as you say, RAC rate, or the negotiated rate across the system. A patient can say my self-insured company, somehow our TPA negotiated 11 times Medicare rate for a blood test that if I saw that I could go across the street for $20.00 for $700.00 out-of-pocket and $10.00 versus $3,300.00 plus my $700.00, why would Blue Cross Blue Shield have negotiated such a high rate with a major hospital system?

Andrew Truscott - Accenture - Co-Chair
You're right.

Cynthia A. Fisher - WaterRev LLC - Member
Why wouldn't I have the ability to **[inaudible] [01:22:52]**?

Andrew Truscott - Accenture - Co-Chair
You're absolutely right. That's entirely based upon –

Cynthia A. Fisher - WaterRev LLC - Member
So, if every one of our 1,600 employees has that type of experience, let's **[inaudible] [01:23:03]** hundreds of thousands of dollars we could put toward employee wages by savings.

Andrew Truscott - Accenture - Co-Chair
Cynthia, you're right. It's amazing that happens. That's not about my clinical disposition. That's about the financial negotiation that's taken place between my insurer and my company and the network that that insurer has got available for me. That transparency, I'm glad you're saying that. We're on the same page here. That's not to do with my individual clinical disposition. It has to do with the context of my – who my plan is and the provider **[inaudible] [01:23:39]**. That information, I think, would be wise of us to define that discreetly and what we want to have happen to plan information if we're going down this line, which it sounds like you want to.

Cynthia A. Fisher - WaterRev LLC - Member
Yeah. I think it can be offered. I guess I was looking at the HIPAA definition of health information that you could offer it both ways. You could get the individual and you could get the broader context because in order to understand future payments, the individual needs to see their options as choices.

Andrew Truscott - Accenture - Co-Chair
You're right. I think there's going to be a whole industry created around let's just call them payment predicters. That's going to take Andy's clinical context, which I've got that because Andy consented to it and because information blocking is not permitted from any provider. So, they will have my clinical disposition and they will look at the plan that I'm on and the providers that I'm seeking to obtain care from and those pricing predicting companies will actually say based upon these three things, which are all independent, we believe that this is likely to be your likely payment profile over the next few years.

I think if we obligated a provider or a payer to do that, I can see them coming back and saying this is overly burdensome. Someone articulately made that case at the beginning of this call. I can well see why it's going to be independent companies who are going to bring those three threads of information together and what the burden on us is right now with the regulation is to ensure that those three classes of information are available for those decisions to be made. Does that make sense?

Cynthia A. Fisher - WaterRev LLC - Member

Yeah. And if a hospital system or provider or insurance system wants to aggregate it and put it together, they can.

Andrew Truscott - Accenture - Co-Chair

Absolutely.

Cynthia A. Fisher - WaterRev LLC - Member

So, I think what we're looking at is really enabling our healthcare system that is so broken today to work. So, no matter where we go as a country politically with two sets of ideas on health plans, it doesn't matter because what we can deliver now is the way to drive down costs across the system and it can expose the surprise – really, I would predict the surprise billing would go away because you're going to have to present it.

So, even all those crazy facility fees and surprise billing, you're going to end up seeing ways of having that dissipate to be competitive. So, I think that cures a lot of the ills that we have in today's system and allows entities to still play in the playing field and on performance and delivery to the consumer and the employer and the government, quite frankly, because the government pays a large par t of our healthcare.

Andrew Truscott - Accenture - Co-Chair

I think we're on the same page here. Members, if you want to say something…

Sheryl Turney - Anthem Blue Cross Blue Shield - Member

Based on the example that you just walked through, who that helps is small employers and employer groups decide who they're going to go with in terms of insurers, like A versus B versus C, but that does not help an individual because most individuals, unless they're uninsured have already participated in a plan.

So, their knowledge of my price compared to Aetna, they don't care. That's something they've pretty much shown based on the lack of using any of these A, B, C, D cost comparison websites where they can look at that information. What they want to see and what they come to us for is, "Tell me what I'm going to have to pay. Tell me the costs and the options I have in my local area." So, I do think that this is solving a different problem.

Cynthia A. Fisher - WaterRev LLC - Member

Sheryl, with all do respect, consumers don't really know about those tools. It's not really presented to them in a way they can find them easily. Even today, I don't even go into my portal because it takes me 45 minutes to try to get through all the password systems. Even when I try to reset, I struggle.

So, the reality is that this catapults to deliver on what ONC has asked us to put in the rulemaking. I think we're challenged with finding out among ourselves ways that we can make it happen. It is disruptive. But the reality is patients do have high deductibles today. They do care. They just don't know how. Your **[inaudible] [01:28:40]** on the complexity has kept us all sheep long enough.

Andrew Truscott - Accenture - Co-Chair

Got it. John, are you trying to jump in?

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

I think that might have been me. This is Mark. I guess what I'm hearing – and I think it was a great conversation, but I guess I think where Andy was trying to go is these are all really good points, but like how do you see it being implemented or recommended in the rule and what can ONC put in the rule to make those recommendations. What we're asking for are more specifics on how we get there and what vehicle we use, I guess.

Andrew Truscott - Accenture - Co-Chair

Where I was trying to go was a couple of places. One is – I think we got there – was an agreement that the current drafting of EHI probably doesn't include the class and utility of data that we are hoping for to be unblocked. The second part of that was following up on your point. We can't define it as a completely new class of data. We have to include it inside the EHI definition. I'm hoping that we can carve it out so it's clearly a subset of EHI that would cover that kind of data.

I **[inaudible] [01:30:08]** to a use case on the utility could be put to. I must confess – I'm not sure the current regulations are going to be the place where we define the how and the what, but I suspect that our recommendation that there's a new task force to define the what. Frankly, that's going to define exactly the marketplace, for want of a better word, the marketplace for information that Cynthia is describing to enable that transparency. I think that's going to be a very fast follower to these regulations. It's my current thinking.

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

Just to be clear, I'm not saying you need to do one or the other or whatever. The recommendations are yours. I guess what I was just trying to do is kind of reframe what we said in the rule about what kind of information we'd be interested in hearing about.

Andrew Truscott - Accenture - Co-Chair

We're trying to meet that need as well. Frankly, what we don't want to do is derail the information blocking regulation by twisting it off in another direction, which we could get to in a more efficient route as well, but we do need to put in place – I think it's the right place to do it, unblocking these types of information showed that we can achieve what's absolutely needed in this country.

Cynthia A. Fisher - WaterRev LLC - Member

Yeah. Andy, I think you had said it well before is if we endure the electronic health information – again I go to the broader definition within health information as HIPAA defines, but if we looked at having access to the pricing information, one could argue that to the individual, the individual would relate to what their payer and provider contract negotiated

terms are and to see what their pricing alternatives are by having for the individual alternatives visible through transparency.

To Mark's point, you can get there by posting it through the digital way it's relayed between entities today – CPT codes, DRG, bundled-on-bundled, the value plan, basically, contractually today hosted. Andy, you had earlier said you can do it by each and every plan. You can do it by cash. And if an entity says, "Look, this is the net negotiated price, this is the price I'll accept for this service and have it comprehensively post it, they can post it in that format." They have options.

The real issue is if the individual is going to see it, then it has to be unblocked. So, what we're asking for unblocked is to see prices across the system, however they're negotiated.

Andrew Truscott - Accenture - Co-Chair

Yeah. Also, the basis for that negotiation because there are different types of bundles containing different – you keep mentioning CPT codes – absolutely, CPT codes are useful, but there's also a finer grain behind that as well of other ways of referring to data. DRTs do vary in definition. That's all detail. Right now, we want to make sure the regulations are mandating that information will be shareable. Correct?

Cynthia A. Fisher - WaterRev LLC - Member

Will be shareable? I'm just trying with the English. It will be shareable?

Andrew Truscott - Accenture - Co-Chair

Yeah. I'll parse it into American in drafting. John, have you got anything at this juncture?

John Kansky - Indiana Health Information Exchange - Member

I do not.

Andrew Truscott - Accenture - Co-Chair

Okay. What I'd like to do is open up public comment at this point. This is a very – I think this is actually quite a complicated issue. I think it's very simple to describe what the problem is. It's fairly complex to work out how we're going to address it. We are faced with the system we're faced with. Can we open to public comment, please? Operator? Lauren? Anybody?

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

Operator, can we open the line?

Operator

If you'd like to make a public comment, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the queue and you can press *1 if you'd 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.

Andrew Truscott - Accenture - Co-Chair
Thank you. Lauren, some calls I can ask the operator and some calls I need you to interject.

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

Operator
We have none at this time.

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

Andrew Truscott - Accenture - Co-Chair
Okay. Cynthia, do you have any proposed drafting that defines the information types that we could look at to start getting into our EHI definitions?

Cynthia A. Fisher - WaterRev LLC - Member
I have the HIPAA definition that I sent, but I can get back to you with that. I have to find it and dig.

Andrew Truscott - Accenture - Co-Chair
I think so, I think when we look at the HIPAA definition with a bit fresher eye, especially with the conversation we've had today.

John Kansky - Indiana Health Information Exchange - Member
Andy, this is John. If I understand where you're trying to navigate in terms of specifically identifying this different class of information, I don't think going back to the HIPAA definition of health information is – I'm not sure that's the rigth direction to head.

Andrew Truscott - Accenture - Co-Chair
Okay.

John Kansky - Indiana Health Information Exchange - Member
I'm just saying if I didn't know about HIPAA and the definitions and I was going to try to describe this class of information it would be characteristically pricing information not associated with the individual but associated with (fill in the blank) with terms that you don't want an HIE guy trying to articulate.

Andrew Truscott - Accenture - Co-Chair
Okay. I suspect that Cynthia's going to go back and look at the HIPAA definition with that

lens, given the conversation we've had today as well.

John Kansky - Indiana Health Information Exchange - Member
I'll but out.

Andrew Truscott - Accenture - Co-Chair
You're equal part of this task force.

John Kansky - Indiana Health Information Exchange - Member
I'm the HIE guy. This isn't really my area.

Andrew Truscott - Accenture - Co-Chair
You're a patient, if nothing else.

John Kansky - Indiana Health Information Exchange - Member
I am.

Andrew Truscott - Accenture - Co-Chair
Sheryl, is this making sense to you?

Sheryl Turney - Anthem Blue Cross Blue Shield - Member
It makes sense to me. I don't necessarily object to it, even though that keeps being subscribed to me. I'm just trying to look at all sides. I do think the people that are going to comment on this are going to be all the consultants and those are currently involved in the sales process of large groups today because it essentially blows up their business model. Again, that's not my concern because I'm not in that business. I'm really trying to look at it from all the other perspectives. That needs to at least be acknowledged.

I do want to focus on what's important for the individual. I do believe the individual wants something that's simpler that they can make decisions around. I'm not sure, quite honestly, that the chart master rate sheet is the way to go. I don't know what that looks like, so, I'm throwing it out there because I really don't know. If I were to get myself a whole list of CPT codes and prices, I don't know what that would do for me. If I'm sick, I want to focus on getting well and I do want to focus on the price. I understand that.

There are variations to that. I would want to know who's in network and who's not in network, but I would want someone to make it simpler for me. To me, my Wisconsin hoist if I was a patient would be to say what are the three hospitals that my physician that I've chosen or the area that I live in that I'm willing to go to, what are they going to cost me and give me comparisons of that for my condition. That's what I would prefer to see versus what we're talking about here. I don't see how this is going to be very useable for an individual.

Andrew Truscott - Accenture - Co-Chair
Thanks for that. That's a good, thoughtful comment. I think where we're trying to get to right

now is purely unblocking the information that could go to where we've discussed, but also to where you **[inaudible] [01:39:21]** as well. What we're talking about is enabling that information to be unblocked versus necessarily the utility that it will be put to. Do we have any calls, any comments coming from the public gallery?

Operator
Not at this time.

Andrew Truscott - Accenture - Co-Chair
Thank you. Okay. Deep breath – an hour and 45 minutes – I'm happy for us to close at this point unless anyone's got anything burning they want to get off their chest. In terms of next steps, Cynthia, can you take that first pass on the potential update to EHI?

Cynthia A. Fisher - WaterRev LLC - Member
Yes, I will. Why don't we – is there some way we can get each other's emails or phone numbers if we want to just bounce off of each other as we're looking at that before our next call, fi that's possible?

Andrew Truscott - Accenture - Co-Chair
Absolutely. Lauren, could you send an email quickly to all the members of the task force, please, just so we all have it and know each other's coordinates?

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

Cynthia A. Fisher - WaterRev LLC - Member
Another feedback is I printed out the now enabled URL that printed it out, but the red line doesn't show up red on my printer, even though I have a color printer. So, I don't know why, but I don't know if it's the same problem with you.

Andrew Truscott - Accenture - Co-Chair
Beyond the ink running out…

Cynthia A. Fisher - WaterRev LLC - Member
I get blue and black, but I have red **[inaudible] [01:40:54]**.

Andrew Truscott - Accenture - Co-Chair
Okay. I'm assuming the ink has not run out. I'll flip you the Word copy that's in Word. It should be straightforward to bring out with all the markup on.

Cynthia A. Fisher - WaterRev LLC - Member
Perfect. Thank you.

Andrew Truscott - Accenture - Co-Chair

No worries, once I get the email from Lauren because than I've got your email address. Okay. Anybody else got anything else they'd like to bring to the table at this junction? Okay. Thank you. This has been a very, very good conversation on one of the most topical, most difficult discussions I've seen coming out HITAC or its forebearers for a long time. Thank you ever so much.

Cynthia A. Fisher - WaterRev LLC - Member

Thank you, Andy.

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

Thanks, everyone. Bye, bye.

Andrew Truscott - Accenture - Co-Chair

Thanks, guys. Have a good day.