Information Blocking (IB) Task Force

Transcript
April 17, 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	Back-up/Support
Morris Landau	Office of the National Coordinator	Back-up/Support
Lauren Wu	Office of the National Coordinator	SME

Operator
Thank you. All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Good afternoon, everyone. Welcome to the Information Blocking Task Force meeting. I know we have a couple of members that will be joining late, so we'll see who we have so far, and then we will get started. Andy Trescott?

Andy Truscott – Accenture – Co-Chair
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
I don't believe we have Michael Adcock yet, Steven Lane?

Steven Lane – Sutter Health – Member
Here.

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

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

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
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Aaron, I believe, is going to be late. As well as Arien. Valarie Grey?

Valarie Grey – New York eHealth Collaborative – Member
Present.

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
Present.

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

John Kansky – Indiana Health Information Exchange – Member
Here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Lauren Thompson? And Denni McColm. Okay. All right, Andy. I will turn it over to you to get us started.

Andy Truscott – Accenture – Co-Chair
Good afternoon everybody welcome to the **[inaudible] [00:01:07]**. And this is actually the last one we get together I think before we go back to the full committee. Because there's a peculiar **[inaudible]** that the frankly the meeting that we had on the hold lines was then, was actually part of the lines of Vakerie. The piece where actually, you've got their meeting of the assisted **[inaudible],** and they are about to take the fallen heroes up to Valhalla, which I thought was peculiar as to where we are right now in the process.

We are going to look at the reminder of the definitions coming out of workgroup one as a group. And then we are going to go through the main bits of workgroup two that we haven't touched upon. We had a most excellent meeting last week coming on the full committee with going into the **[inaudible]** definition. And I know Arien has been working assiduously on that. So Mark, if you could possibly – or you are turning the screen. Has anyone got anything they would like to chip in that's on your mind before we begin?

Steven Lane – Sutter Health – Member
Which document is Mark on and what page? I just want to follow along in the document.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Yes, this is the consolidated document.

Steven Lane – Sutter Health – Member
I don't have that one handy.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I can send it to you.

Andy Truscott – Accenture – Co-Chair
[Inaudible] Yes, everyone should have been sent a link to it. Asil, can you just send that. I'll explain it in the chat.

Steven Lane – Sutter Health – Member
No, you can't put it in the public chat I'm sorry.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Yes, that could be problematic, good point.

Steven Lane – Sutter Health – Member
Yes, I've done that before. I learned that lesson the hard way. We had to start a whole new document.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I can send it to you Steven, right now. I have it. I'll just do that.

Steven Lane – Sutter Health – Member
Thanks. Sorry, didn't mean to slow us down.

Andy Truscott – Accenture – Co-Chair
That's okay. It's important everyone's got it. Because it's a **[inaudible] [00:03:15],** we're working through. It's a collaboration. Okay, so we have on the screen, Mark can you zoom in. Oh, you have zoomed in. Okay. We have the definition here of health information exchange and health information network. Does anyone have any comments or suggestions at this stage or are we all comfortable with it as it stands? Don't all shout at once.

Cynthia A. Fisher – WaterRev LLC – Member
Andy, how do you deal with all the entities today that justify naming of themselves as exchanges are exchanges? Are you just going to have all those entities that call themselves information exchanges are now networks? Or the sharing of? So just a question, the common use of capital words of HIEs.

Andy Truscott – Accenture – Co-Chair
That's a good question. I would imagine under this current definition as it stands, they would fall under the definition of a network. Or they can be the organizational entities conducting the act of information exchange. I'm not sure it matters.

John Kansky – Indiana Health Information Exchange – Member
Andy this is John. If I could weigh in, my answer to Cynthia's question would – sorry?

Andy Truscott – Accenture – Co-Chair
As you are one.

John Kansky – Indiana Health Information Exchange – Member

Yeah, I just figured I would have some credibility. So my assumption that the answer to Cynthia's question as it doesn't matter if I call myself Fred, I read this definition, and I meet it, then I am one. So as mentioned earlier, we have health information exchanges that are called the Indiana Health Information Exchange. We have health information exchanges that are called the Kansas Health Information Network. And we have health information exchange that is called Health Current. And they all meet this definition.

Andy Truscott – Accenture – Co-Chair
And it doesn't matter which definition they meet, they're included. Is it a specific concern, Cynthia, you're trying to address?

Cynthia A. Fisher – WaterRev LLC – Member
I just want to make sure that we didn't have any way that they'd be an existing health information exchange that would fall out of what ONC defined as. I can't know. You are all experts, so I am asking you all is there any entity that might not – are we making sure that we are not eliminating an entity that would be today considered an exchange that wouldn't be a network. So if it's -- I wanted to make sure how the language is nuanced that were not then -- by accident doing a carveout for some other entity that may today be held accountable as an exchange.

Andy Truscott – Accenture – Co-Chair
I don't believe so. Because we focused on the function. And I'd like everyone else to look at this and see if we've gotten a carveout and excluded people. And certainly, someone like Houston Health E-connect who don't have the word exchange in their title still will be covered in this they actually do Health Information Exchange. So, Mark, your screen keeps blanking, by the way. Makes it hard to read.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Oh, really. Is it now?

Andy Truscott – Accenture – Co-Chair
No, it's fine now. It just keeps moving out. Anybody else got a comment on this?

John Kansky – Indiana Health Information Exchange – Member
Andy, it is John. It is nothing new, but for the larger group, I'll repeat that I think the definition basically implies, if you think about or look at Health Information Exchange, you are one. Meaning I think the definition is very broad, and as we discussed somewhat deliberately so. And then the only other comment I made earlier, doesn't probably matter. But I can't – I don't know how an individual can be – is that still in there? Yes. I don't know how an individual can be a health information network, because anybody that would meet the definition is a legal entity, but it is my two cents.

Andy Truscott – Accenture – Co-Chair
That's a carryover from the prior wording thousand the regulation between two or more individuals or entities. If we think that no one can fall into it, then I have no issue with It staying. Are there any unintended consequences of these definitions that we think people might be inadvertently included who shouldn't be?

John Kansky – Indiana Health Information Exchange – Member

Sorry, I think someone else should be talking, but I think we were definitely these definitions are definitely going to loop in. We will be surprised by organizations that end up deciding they meet this definition.

Andy Truscott – Accenture – Co-Chair
Yes. It's quite a bit of question here. Go on.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I'm sorry. This is Sheryl, I agree with what was stated. It does appear that these definitions are very broad, and I think we would be surprised at who would consider themselves covered by this. A health information Network might be the clearinghouse that provides the X12 transactions. It could potentially under this definition. I am looking at all the business partners we have today where we have contractual agreements that are performing this type of health information exchange, and I don't know if we are intending to encompass all of those.

Andy Truscott – Accenture – Co-Chair
That's a good question, Sheryl, so to the broader group, do we want to have this broader definition deliberately. Which is essentially the same as what ONC drafted anyway. And it's actual intent to include those business partners, for example, that Sheryl was citing and actually to say look if you're handling and accessing processing or other such use of the EHI you included. And that's the intent, and we are in a good place if we believe…

Steven Lane – Sutter Health – Member
I think that is the intent. Are we really trying to make it better for all the data, for all the stakeholders? What is the risk of drawing this net broadly or suggesting ONC throw the net broadly?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
This is Sheryl. The risk is that today we hold those business partners because of their vendors of ours. So essentially are under cover of a covered entity. Going forward, they are not going to be so. And if they then create their own secondary uses of the data, then we may not have the ability to limit those unintended secondary uses because now they are governed by an agreement either an MSA or a vendor agreement. And then in the future, this seems like this is going to blow up that business model.

And so I do believe they are going to be a lot of third-party's out there who are going to want to look to how can we monetize this data. Which maybe that's what patients want, but I don't think they want this to happen without their knowledge. And today they have no direct contact with the patient. So how would that happen without them breaking that confidentiality that we hold them to initially in their agreement? And there's a whole host of things that occur like this.

Andy Truscott – Accenture – Co-Chair
It's your suggestion then that the only way to effectively handle patient confidentiality wishes is to block information sharing.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
It's to drop information sharing. I don't know if…

Andy Truscott – Accenture – Co-Chair
It's to block information sharing.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
No, I'm not saying that either. But I think that the definition of health information network needs to really talk about the intent of the type of data sharing that you are doing. Because if I were to hire a vendor to do a certain type of work, I'm not going to and necessarily consider them to help to consider them health information network if I'm joining the health information network in order to share data between a payer in a provider regarding clinical data or something of that nature. I mean, the purpose of – I'll go back to it – the X12 clearinghouse vendors is so providers and payers can exchange data for payment in membership verification and things of that nature. When you then declare them I health information network then that to me is a business opportunity for the clearinghouse to say all right then I will bring patients into this. Well, that is all well and good except they are not going to understand any of that data going back and forth until the data has been adjudicated or the data has been at least somewhat processed.

So to me, there are some things that are set up for that process. And then other things are more; this is behind the scenes. No one wants to join the Internet to see basically how Google builds a search engine, and that's kind of to me is what we're talking about here. Is like how do we build a claim they don't want to see that they want to see the of the effect of the data, and what does it mean to me and how does it interact with me?

Andy Truscott – Accenture – Co-Chair
I'm not sure that this definition actually prevents that. I'm struggling to say why we should second-guess what patient desires are, beyond the fact they get information would not be blocked, and they can handle and look at it and view it however they wish. Someone else I think was trying to say – Denise Webb, you got your hand raised. Yes.

Denise Webb – Individual – Member
So I'm thinking about what Sheryl said. And if we look at affiliated versus unaffiliated, and I'm trying to remember how that was defined. So if a player has a relationship with the provider organization is in the network. Then you have CDI, the clearinghouse exchanging information between that provider group and the payer, I am not they considered affiliated? So that Network is not – its purpose is not to serve up information between provider A in provider B unaffiliated. It is between providers and the payer organization. So would that help at all? I mean how is affiliated and unaffiliated defined?

Andy Truscott – Accenture – Co-Chair
[Inaudible – crosstalk] [00:15:33].

Denise Webb – Individual – Member
What was that? You stepped on Sheryl. So what did you say, Sheryl?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
What I said is you recommended definition takes out the word affiliated, and that's what causes the issue in my opinion.

Denise Webb – Individual – Member
Oh, you're right. I was reading the red part. The original.

Andy Truscott – Accenture – Co-Chair

That's the original. Look above it.

Denise Webb – Individual – Member
So why did we take out affiliated unaffiliated?

Andy Truscott – Accenture – Co-Chair
Because it **[inaudible] [00:16:09]**. We've actually got four paragraphs that said the same thing. One for affiliated one for unaffiliated. So rather than distinguishing in the **[inaudible]** we just included them all together because it has the same effect with half the amount of text.

Denise Webb – Individual – Member
I think it complicates things, taking that out, given Sheryl's example. But something for consideration.

Andy Truscott – Accenture – Co-Chair
We had worked it through to a point where we had agreed that we wanted to be affiliated and unaffiliated to be included. And because we are including those specifically it kind of didn't make sense to have double the amount of text, rather just take out the affiliated versus unaffiliated. Because I think we said that when we had an organization exchanging information between two completely unrelated organizations. There's no affiliation between them at all and affiliation with the organization facilitating the exchange. We still wanted that to be governed and call that a Health Information Network and I see a hand raised.

John Kansky – Indiana Health Information Exchange – Member
I was going to offer an alternative example of an organization or type of organization I think it's caught up in the definition. I might be unintended. So if you think about it, and I can offer specific examples if necessary. But if you think about all the software vendors that provide software that supports health information exchanges, like the HIEs or HINs, go out and sign a contract and fill in the blank to provide the technology to support the exchange. They fit the definition of a Health Information Network under two as they, I'm picking words in number two, provide technology that enables access, exchange, or use of health information.

So I guess that might be a so what, except now those organizations realize they are an actor under the federal law, and they have to get their lawyer to be aware of that, and it takes steps and writes policies to make sure they don't violate anything. But what I don't believe, and we have variables here in terms of the exceptions that are different recommendations we're making. But there's no exception for – you are bound by a contract that says you can't share the information, that is not a stated exception.

So if I'm in HIE or for that matter a provider or payor that participates in Health Information Network that has a contract with their vendor that says you just provide technology, you don't do anything with my data. But patients or whoever comes to that vendor and says – makes a data request on what basis are they, not Information blocking if they don't fulfill it?

Andy Truscott – Accenture – Co-Chair
Wouldn't that organization come under the definition of a health IT creditor anyway?

John Kansky – Indiana Health Information Exchange – Member
I guess they would, so maybe it's not a **[inaudible – crosstalk] [00:19:29]**.

Steven Lane – Sutter Health – Member
They could be a service provider and not a developer.

Andy Truscott – Accenture – Co-Chair
If that's true, only for a service provider, then we would want them to be covered by this.

Steven Lane – Sutter Health – Member
Right.

John Kansky – Indiana Health Information Exchange – Member
I guess the definition might be okay, confusing but okay. And I'll reuse my comment when we get to exceptions, I guess.

Andy Truscott – Accenture – Co-Chair
Additionally, someone who creates software would be covered as a Health IT developer. And we'll get to health IT developers shortly. Does the world provide a little bit behind **[inaudible] [00:20:09]**?

John Kansky – Indiana Health Information Exchange – Member
I think to provide services that enable Health Information Exchange is in HIE is or a HI for that matter. We use the world HIM since I'll adapt my vocabulary to the context.

Denise Webb – Individual – Member
This is Denise and could I add to this. I'm thinking Wisconsin. And we have a state HIE. But there's actual provider organization that participates in that HIE that prevents the HIE from sharing information with certain actors that really are entitled to the information. But it's not the HIE That's doing that, it's the provider organization that's a member of the HIE. So would the HIE/HIN be Information Blocking if they would pervade the information?

Andy Truscott – Accenture – Co-Chair
The HIE HIN can share the information. The information's not been provided to them and permitting them to share. Whether that's technology not being given to them or contractually. So, in that case, the provider would be implicated information blocking rule because the provider is not permitting them.

John Kansky – Indiana Health Information Exchange – Member
This is John. Denise's example is a better version of what I suggested earlier. Is existing contracts might say – so Andy I'm going to augment what you said a little bit. It is not uncommon for a provider or -- to share data with HIE saying it's okay to share this with anybody but not payers. And that will be against federal law in the future, as simple as it is.

Andy Truscott – Accenture – Co-Chair
We had this question at HITAC in full committee, and the response is very clear. Those kinds of contractual provisions are no longer valid as soon as this rule is being acted.

Cynthia A. Fisher – WaterRev LLC – Member
Could you repeat that?

Andy Truscott – Accenture – Co-Chair

Yes, and I'll ask the ONC colleagues to jump on and correct me or support me on this. But the current way the rule is drafted, there are actual statements that the contractual provisions that are causing information blocking are no longer valid once this rule is enacted. Mark or **[inaudible]**, you want to pile on?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
That's right, I mean so there's no exception in the information blocking in proposed for contractual language. And we talked at length or quite a bit in the preamble about how problematic contracts that limit sharing of information are. And that would constitute Information Blocking. And of course, there could be something that would get you off the hook like an exception. But in the absence of that, that's right. You would not be protected by a contract, and there is language as well that contracts that have problematic language like that will not be enforced when the rule is final.

Andy Truscott – Accenture – Co-Chair
Enforceable. Denise, you want to jump in.

Denise Webb – Individual – Member
Yes. So if I understand if in HIE is established to share information between providers or members, and it was primarily built to go provider to provider. Under the new rules, that won't be allowed any longer? And for instance, of the patient wants information that system that sits HIE because they've been to provider ABC unaffiliated, but they all participate in the HIE, is the HIE obligated to give that information to the patient or are the providers? What I am hearing, which it should be because I thought her HIE in Wisconsin should provide the information to the patient, but they will now have to do that. **[inaudible – crosstalk] [00:24:53]**

Andy Truscott – Accenture – Co-Chair
That is the implication of the rule, yes. Otherwise, they would be information blocking.

Steven Lane – Sutter Health – Member
That HIE cannot charge the patient for that service correct?

Andy Truscott – Accenture – Co-Chair
Beyond the **[inaudible]** beyond the documents of the exceptions rules

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
To clarify, a patient, in the rule we say that patients can access to electronic records for patients is free. It's in exceptions.

Steven Lane – Sutter Health – Member
6.7 million people in Indiana can ask my organization for their information and no matter what it cost my organization; I have to provide it for free?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I'm saying what's in the rule I mean. There are also exceptions for Information Blocking that can be looked at. But overall, I can't get into specific fact patterns or scenarios. But generally speaking, the rule says that electronic access to patient's records is free.

Andy Truscott – Accenture – Co-Chair

John, you need to look at the exceptions rules which not just exceptions, as Mark would saying to get you off the hook with information sharing. But actually exceptions for the free sharing of information that cover over specific examples where a reasonable fee could be charged.

Cynthia A. Fisher – WaterRev LLC – Member
However, Andy, this is Cynthia, when we look at what the patient has already paid for that medical service, either through their plan, their co-pay, their deductible, their tax, or the government is also paying. So if you think about it, the results like in any other industry, the results of their care is due them. So it digitally existed. And so, our understanding was that it was to be free to the patient because it is not really free. They already paid for it. But they can't have determinants on their health without access to their information. **[Inaudible – crosstalk] [00:27:29]**. Because they've paid for it many times over.

Andy Truscott – Accenture – Co-Chair
It's where there are reasonable reasons why the information just **[inaudible]**. Look at the exceptions in the preamble. It's some very good examples cited in there. But in general, Cynthia, you're absolutely right. But I think the concern that John his is that you're certainly going to have a deluge of 6.7 million patients.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Andy can I just jump in quick? In my head, I was thinking everyone was involved in the discussions we had in the workgroup on exceptions. But really the conversation we are having now has to do with the exception for costs reasonably incurred, which is 171 204. And in that, we talk about that you can recover the reasonable cost that you charged. But there is also a section C that says cost specifically excluded, so cost you cannot charge. And C-5 said the fee-based any part based on the electronic access by an individual or their personal representative, agent, or designee to the individual electronic health information. So that is where I was talking about comes from. John, you might also want to take a look at the exception for infeasibility which is at 205. Might be one you'd be curious based on the fact pattern you might want to read into. That's all I wanted to say.

John Kansky – Indiana Health Information Exchange – Member
Thank you.

Andy Truscott – Accenture – Co-Chair
And people who are not familiar with the exceptions need to have a look. Because like is said, they're not just exceptions that prevent information be shared, but also exceptions to allow reasonable fees to be charged. But, now to Cynthia's that this is not about charging patients directly for access to their information, because we know that's not what we want to have happened.

Steven Lane – Sutter Health – Member
Though I think this has opened up a whole interesting area which is that regional HIE's can suddenly become the health record bank for everyone that lives in that region. If the patients can get access to that could be an amazing service and an amazing shift in our industry. But if they can't get any fees for it, they won't invest the time, energy, resources to make that work for the patient from their perspective.

Andy Truscott – Accenture – Co-Chair

It creates an opportunity for the regional health information exchange to start having another business like. It absolutely does. And that's their decisions to make.

Steven Lane – Sutter Health – Member
But it's not a business line if they're completely prohibited for getting any fees for it right, that's the problem is see.

Andy Truscott – Accenture – Co-Chair
Well, they are not completely prohibited. Members have not had the opportunity to read the exceptions and the recommendations around them, I would clearly plead with you to do so. And if you have any comments upon that could you fund them directly back to **[inaudible] [00:30:55]**.

Cynthia A. Fisher – WaterRev LLC – Member
I think we want to make sure for the patient that this is for the patient's benefit and for how this works, that we don't create a whole new built-in protectionism. That we want to be able to allow for competitive and a freer and competitive market that can provide access. So I guess that would be my one concern on the exceptions to make sure that we are driving toward using the electronic medium to deliver real-time free machine-readable access to patients of their health information. And that we are not building in fee recovery for proprietary more expensive tollbooths to be built into the system for – protected tollbooth that prevents technological innovators or prevents the ability for delivering the lowest possible best possible quality of healthcare and information at the lowest possible price and cost.

Andy Truscott – Accenture – Co-Chair
Cynthia, I think if you just hold slightly, we will hopefully get to exception today so we can all look at those together. But certainly, your sentiments are being at the forefront of what and working through that. Cynthia?

Cynthia A. Fisher – WaterRev LLC – Member
Yes. Thank you.

Andy Truscott – Accenture – Co-Chair
[Inaudible] [00:32:56]. So, I think your suggestion was we actually. I'm not quite sure where we landed with your suggestions. So what you're recommending what we do with the actual text in front of us. Are you suggesting that we insert, make into the affiliated only?

Steven Lane – Sutter Health – Member
Sorry, who was that directed to?

Andy Truscott – Accenture – Co-Chair
That was to Sheryl. I was trying to get to what your actual recommendation was. Was it to include affiliated in some of the HIN definition?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
The problem is we didn't know how to define affiliated. And so that is my issue with that is that without a definition of affiliate, then we are unintendedly scoping things out. And I do understand that we don't want to do that either. But I do think that there is a different standard that should be there for potential vendors that we hired to do specific types of work should not necessarily be considered

health information that works in this definition. Because going along with my other point that I do think information should be shared from the source, not from necessarily a vendor doing work for Anthem. Because then the message could be delivered in an unintended way. I mean at the end of the day – we as vendors to many types of things for us. We would certainly not want those vendors to then unintended lee come under this definition reach out to the patient separately, and the patient gets information out of context. That would be completely inappropriate.

Andy Truscott – Accenture – Co-Chair
Where an entity has no means of sharing information with the patient for example to pick a particular example, you have then it would be unfeasible for them to show that information to the patient. And therefore be governed by one of the exceptions.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
That's not quite accurate because some of these vendors see this as an opportunity to create a new revenue stream. And all I am saying is patient data sharing should be done with patient knowledge and approval, and I think everybody should understand that. I don't think patients want to open the floodgates if you will, to everybody using the data in an unintended way. I want my data to be shared, but I wanted to be shared with who I know I am sharing it with for a purpose that I have approved. And allowing the definition to scope in all of these things that I can't even anticipate the bad actors that are out there but there are many of them. We've been hurt by them in my own company.

So at the end of the day, that's all I want to balance. And there should be some wording that provides some guardrails, so that our vendors, your company vendors or directed vendors. That would be like IBM hires a vendor to do something. They're not anticipating that the vendor will reach out to the individual for data sharing arrangements, but it could be based on this wording of this particular rule.

Andy Truscott – Accenture – Co-Chair
The patient consent to sharing and they consent to how that information is shared and regardless of the relationship between the organization for example, and the company that you contracted as the patient says to for that company, I allow you to do this with my information. Why would you see that you can block that?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
If we contract with the vendor to do work for us, we hold them to our standards for data protection and security. We make sure they are high trust certified, and the patient has agreed to allow us to use vendors to perform our work. They are not expecting vendors going to reach out to them to say we are doing this part of the work, so we are going to reach out to them without us providing notice to the patient in advance. And that is what I am saying. If that was contracted as part of the vendor arrangement that is one thing. But many of these vendors are looking to create a business opportunity. Which under this rule would they need to communicate to the corporation or entity that hired them? And so how is the patient going even to be aware that this is how this entity got their data. To me, I would want to sue them.

Andy Truscott – Accenture – Co-Chair
I must confess I'm not quite tracking you, Sheryl, because the patient needs to consent before the nefarious company can do anything. They can't arbitrarily just go off. Otherwise, they're guilty of breaching a whole bunch of other arrangements around confidentiality.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
What holds them accountable? Because today a vendor is held accountable to meet our standards-based on a contract. Under this new rule with Health Information Network, they have not covered entities, and basically so who is going to hold them accountable to the standards of data protection? That still has yet to be decided. Is it the Federal Trade Commission? Because it's not going to be HIPAA because are not a covered entity and they're not doing it under the arrangement we have with them.

Andy Truscott – Accenture – Co-Chair
This definition doesn't force them it merely says if you are doing either one or two. You are classified as a Health Information Exchange. Sorry Health Information Network I meant. I don't think we want to stifle useful innovation inadvertently. And similarly, we don't want innovation to go completely unchecked.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Right so how do you balance that is what I am saying, And maybe there should be an exception for vendors that are already contracted with organizations to perform a specific service that this is not intended to replace that relationship. That's all I am saying.

Andy Truscott – Accenture – Co-Chair
That's an interesting point. I don't believe there is an exception around that right now.

Cynthia A. Fisher – WaterRev LLC – Member
May I ask a question? Is there a difference for ONC based upon the definition of the covered entity, based upon business associate on treatment? Just trying to understand.

Andy Truscott – Accenture – Co-Chair
The difference between what? The way the rules apply to them based on a covered entity or not?

Steven Lane – Sutter Health – Member
Please rephrase the question, again.

Cynthia A. Fisher – WaterRev LLC – Member
I'm working on it. I'm trying to understand Sheryl's concern; I think there is a couple of things. Girts the question I have on hand is on any of the definitions of HIN or accountability or developer, is there any defined in ONC or in CMS rulings of anything different between – carved out or difference between covered entities or business associates?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
So Morris is on the phone, and I know he's an expert on these types of HIPAA issues. But I will say I think this might be a little off course as far as was covered for Information Blocking. So for Information Blocking as we talked about there is for actors, providers, developers, and exchanges, and we're talking about interference with access, exchange, or use of electronic health information. So within that construct, that's kind of what would be applying, and OIG would applying. So I'm not sure where different interpretations of business associates and covered entities would fall in that. I am still a little confused.

Cynthia A. Fisher – WaterRev LLC – Member

Okay, then that's helpful then, and I appreciate it. Just on consent, I think I brought it up in the in-person meeting, but one of the major hospital's systems that we are familiar with in Boston, on their electronic records focus the consent was merely a signature line with no handing out or any written words of what you are consenting to. It is just an iPad with the signature line. And so the question I have I think it is also helpful that as we go and moved to this new future direction that, I do agree with Sheryl's point that patients really need to know what the consenting to.

And I saw an op-ed recently that said even on pricing, wouldn't it be nice if patients actually consented to agree to those charges on pricing. But that being said I think we want to make sure that consumers don't have to sign a signature line with no written words available to them.

Andy Truscott – Accenture – Co-Chair
Cynthia, I am with you, I actually -- I had to sign I take responsibility for her because it's an outpatient procedure and it was just a signature line. And I looked at her and I and exactly what am I signing to? And it was like I just asked him to disclose the golden plates or something. Because they had no idea why anyone would possibly want to know that. So I filled them in, in Technicolor.

So I just want to – can I, with your permission and restate your question because I want to make sure I'm getting it, and everyone is grasping it. And I think your concern, and please correct me if I'm wrong, is that we may be might be giving a crutch to a nefarious actor who is on levels, an organization whose enter contracts right now to certain organizations, such as your own, and providing services. They say look we have to keep this information available otherwise we are guilty of Information Blocking. But in the contract to have with them you know they are taking appropriate cautions for the safeguarding of the confidentiality of the patient data. But if they turn around say look, we have to give people access to it, there is no way of knowing that they are.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Exactly. And then we don't know what protected the way they are providing access. And that would be the other concern. And I mean it is the same issue that I brought up in the USCDI meeting because data should come from the source. If a payer, for instance, were to have clinical data, I don't think to appear to be providing it to the patient. Because then it could be provided without additional understanding that the doctor can provide. So although it is unlikely, it is possible we could have a lab result, or we could have some sort of result that the patient has not yet had communicated by the physician. We are not the right entity to be providing that message. And what're the unintended consequences if there's a negative result with the patient because we can't provide the frame around that message.

So to me, the same issue exists if we hire a vendor, we would not ever allow them without that being specifically part of the contract, to engage with the patient. Because we wouldn't want to have unintended consequences to occur as a result of the way they would communicate it. But we already know the clearing houses have already tried to create a business opportunity out of selling patient's data. They have already got to the Senate with a bill to do just that. So this isn't just a nefarious actor, this is an entire industry of clearing houses that actually want to create a monetary gain by using patient data. And I as a patient would not be in favor of that. What is a benefit to me? None. I am not here and not getting sick and not getting care to create a business opportunity for anybody.

Andy Truscott – Accenture – Co-Chair
John has had his hand patiently raised for the last ten minutes. John?

John Kansky – Indiana Health Information Exchange – Member
Thanks. So I think I have a similar example. This group doesn't have time to educate me on the nuance, and Andy you gave me the assignment to ensure I read the exception comments and I will. But I just wanted to note this example of this question. So there is a presumption that there will be application developers that will take advantage of the installed base, for example, smartphones across the United States, and offer to be the enabler of patients to get their data on their phones. Is that a well-stated assumption?

Andy Truscott – Accenture – Co-Chair
It's a reasonable assumption.

John Kansky – Indiana Health Information Exchange – Member
Yes, I think it's the government's assumption and our assumption. So any app developer is now going to meet the devastation of either or both developer and/or HIN because they, I guess the recommendation doesn't say providing any more, technology that provides or exchange of information. Okay, so now there an actor and actors are prohibited from charging patients or their agents, which by the way I think they are their agent. So I have this bubble on my head where I the circular reference where I say are, we, first of all, we are making app developers actors. So now small app developers are probably going to have berries to entry in the business because now they have to figure out whether they can comply with the federal law or not now the big ones have an advantage. Never mind. So there are actors, but they can't charge patients, and there goes a business model.

So I think now I'm going to get connected to Sheryl's point, there is a giant potential for unintended consequence. If you say you can't charge the patient, or you can't charge other than cost recovery, then every organization in the business of getting this date is going to start looking for different business models that monetize other stuff. Including the identified data or etc. Maybe the federal government doesn't care. But I better stop there.

Andy Truscott – Accenture – Co-Chair
Thanks for that. And good points, but please do go and look at the exceptions, especially the fees exceptions, which in one place on the under the draft that has come out workgroup two. And I think that will help you understand not as clear-cut as I think you articulate or think of right now. It's actually your hand midway through, John says this.

Sasha TerMaat – Epic – Member
I was just wondering as John was a maybe I need to review the exceptions also. But in addition to monetizing the identified data the other concern I would have would be that it would force models that are premised on advertising again I think we should have a policy question if that's desirable if advertising to patients becomes a way to monetize when the patient can't be charged. But could be helpful to patients who don't necessarily have to pay for the service or application directly, but it would have other consequences for the healthcare industry because of advertising based on health data has indications for privacy and cost and some of those elements.

Andy Truscott – Accenture – Co-Chair
That's a good point. Thanks, Sasha. Cynthia, you are looking to jump in.

Cynthia A. Fisher – WaterRev LLC – Member
I will pass. It was at an earlier stage. So I'll pass.

Andy Truscott – Accenture – Co-Chair
Anybody else at this point? Does anyone want to put any kinds of dissenting opinion around this drafting?

Cynthia A. Fisher – WaterRev LLC – Member
It's our understanding that a lot of the identified data is already brokered and sold behind the scenes and aggregated, and the patients are not aware of it as a whole. By various players that have access to it. So perhaps just wanted to ask that question or put it on the floor.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Cynthia, this is Sheryl. You are absolutely 100% right. That is happening today, and it is something that I do believe a patient should be made aware of. But in many cases, the way that is happening is especially with the Rizzo employer groups who utilize relies on third-party vendors to do data aggregation, some of the data aggregators will require they participate in the normative database. Which requires that they use the underlying data and the employer groups are giving permission for that. And there's essentially not a lot that a patient can do about it because they don't know about it.

Cynthia A. Fisher – WaterRev LLC – Member
And the insurance industry and providers industry as well. So if you look at that aggregation in data and behind the scenes of the patient data that the patient is not aware of all the places that their data is shared and can be de-identified and re-identified and monetized. But I think the other thing is that the information blocking occurs because the patient isn't aware of all the players and middle players that also have hidden agreements and hidden pricing of that capitalizes their health incident, or test, or lab, or result all along the way. So there's also the problem of lack of awareness of all the ways the patient information is shared and also capitalized upon in the food chain.

Andy Truscott – Accenture – Co-Chair
I'd like to move on to health IT developer as a definition. Whoever's in charge of the screen now could you scroll to the word scroll, please.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Hey, Andy. One note for the group, as your thinking through the health information and exchange definition, I do just want to flag that in our definition we had an unaffiliated Health Information Network. And I encourage anyone who is still thinking through these definitions to read the preamble discussion. Because we talked about why we added that language and it might help understand our intent there.

Andy Truscott – Accenture – Co-Chair
And read the language take it onboard and strong view, could you please get in touch with me ASAP, and we'll look at maybe putting together the group again if we will tweak the definition around this. Thank you, Mark.

I'd like to move to talk around a section we have around the party's who are affected by the Information Blocking provision. That's where there's some whole section we are looking at now. And talk about the actors being healthcare providers, Health IT providers, Health Information Exchange, and Health Information Networks. And discussed those providers exchanges and networks at length.

Health IT developers a section definition we talked about briefly, and we've not really delved into any detail on.

So as things stand inside Cures right now, the Health IT developer is a stated actor. And the enforcement ability of OIG is bound to Health IT developers of so certified Health IT products. It's further refined from saying if you're a developer of a single product, then all your products you develop are therefore within scope.

It has been mentioned by many of you and elsewhere inside HITAC itself that it seems a juxtaposition of if you have product there than all your products are in scope. And also, it has been mentioned and the query to Health IT developers who are developers of products which are not certified. Do we want to make a recommendation to ONC that Health IT developers as a definition should be clear that they are developers of Health IT whether or not that technology is certified? All albeit that means it would be difficult for ONC to enforce it as it currently stands, and there could be other routes of enforcement. But do we want to make a regulation to apply equally to all Health IT developers?

Cynthia A. Fisher – WaterRev LLC – Member
This is Cynthia, I'm curious to think today the Health IT developers that have been innovative and providing higher value service at a much lower cost, much lower price to consumers. And the consumer makes a choice to be outside of the certified system in working with them with full awareness and knowledge to do so. But because of the consumer is a very satisfied consumer/patient in their system and has readily available access to care and health information, telemedicine as well, they will leapfrog and are catapulted to the novel new innovators.

So I think you know if a patient chooses differently in innovative and knowledgeable of the consequences, shouldn't that be a consumer choice in the free market? And again I say it is separate and what's been developed and provided, and I misquoted the last time it is $36 billion of taxpayer money that went toward helping to put in place the electronic health records to the providers in the Health IT developers that benefited from the government's support of the certified program.

Andy Truscott – Accenture – Co-Chair
That makes sense Cynthia. And if I cut it down to one sentence. Your suggestion is we shouldn't seek to include all Health IT developers because that would stifle innovation in the marketplace?

Cynthia A. Fisher – WaterRev LLC – Member
Thank you for being succinct, Andy.

Andy Truscott – Accenture – Co-Chair
As long as it's accurate then great. Thanks. John, your hand is up.

John Kansky – Indiana Health Information Exchange – Member
Yes, I wholeheartedly agree with the philosophy that Cynthia described. Except that we are incredibly putting our thumb on the scale, disadvantaging certified technology providers, if we don't define both as actors if I am thinking about this correctly, no? And we want innovation, and we want the patient to choose from the best solution available, but why would we pick sides by burdening one. It is not just the regulatory burden, but as the ramifications of you have to share data and comply with all aspects of the law but I don't, and I'm your competitor that doesn't seem like a level playing field.

Sasha TerMaat – Epic – Member
Cynthia posited that patients could choose whether they valued purchasing certified technology or not. But I actually think that it's the availability of certification criteria for a particular domain that has more influence on that. So there are many domains of health information technology that simply don't have pertinent certification criteria. You know, scheduling products, for example, billing products, products that have to do with secure chat. And all of those are just domains where they might have provider users, they might have billing administrator users, there could be patient consumer users of different products. Where it is not really a choice of do, I want to certify my product and have that be a competitive distinction or do I want to certify my product and participate under these regulatory requirements. As it is sort of whether the domain of the product as part of the certification suite today or not.

And because of that, I think it's maybe challenging to rely on the market dynamics and choice that Cynthia proposed. It seems, and maybe this is similar to John's point, that it's important to set an expectation that if there are certain behaviors that are detrimental to the industry into patient care, refusal to share information when the patient authorizes it being a prime example, but then all actors should be expected to comply with that expectation. And for that reason, I would favor a broad definition of Health IT developer, that places the same expectation that we prioritize on all of the actors.

Andy Truscott – Accenture – Co-Chair
Thank you, Denise? Denise, your hand is up.

Denise Webb – Individual – Member
I had to get myself off mute, sorry. So just building on what Sasha talked about. So when you think about the domain of a product, let's take an example, there's a Health IT developer that principally does revenue cycle management products. That can run, and that's all they sell, that can interact with the HER, the LIF, and so forth. And so it is a consumer data from a certified product. Yet that developer has none of this regulatory overlay. It seems to me that it should apply to the Health IT developers. And maybe we define it that if there's an app developer, so, for instance, a third-party app, that may be a patient uses, but that app can't function without having access to the certified technology through an API to get data. And consume that data within their app, I mean why shouldn't they be subject to these regulations? Even though their product is not certified. I think it has to do with preventing Information Blocking, providing a free flow of information that the patient once moved and where they want it moved. And yet there needs to be some oversight that is fair and evenhanded across the domain of HIT products.

Andy Truscott – Accenture – Co-Chair
Thank you, and Cynthia?

Cynthia A. Fisher – WaterRev LLC – Member
I guess, my point is that the Information Blocking Cures Act was in response to after the 36 billion was provided to the Health IT handful of developers and the providers throughout our system. Then the challenges were that the patients haven't been able to get access, and they been more or less held hostage within the health systems of which they get their care primarily. Because that's where the information resides. And we live in a mobile world, and have 50 states in the country, and have a global society, so we need this now on to our mobile devices.

That being said, a lot of the rules we are seeing here out of Cures and out of definition is with the players at the table that have the information. So to allow for innovation and allow for choice is to push information to the consumer, which is why we are sitting here at the tables and having these discussions, and empower the consumer with their data that they can provide it across the country, across systems, and get the best quality care at the lowest possible price. But on top of that, we all need to allow for innovation and disruption. And otherwise, we are building systems through protectionism of status quo.

And that is my concern because right now we are here delivering access to the patients of the data that's being exchanged behind the scenes, every single day, 24 ways of Sunday, but not getting to the patients. So, I propose that we have to be very, very careful here to make sure that we allow for innovation and disruption that did not have the competitive advantage of sitting at this table nor the competitive advantage of $36 billion of our taxpayer dollars.

Andy Truscott – Accenture – Co-Chair
I get that Cynthia. And you make a compelling case. I don't think any of us want to achieve, is we want you to be innovative, and if that means you don't share information and it's okay for you to block. I don't think we mean that do we?

Cynthia A. Fisher – WaterRev LLC – Member
No, we don't mean that. But I think it is that we need to provide access to these entities.

Andy Truscott – Accenture – Co-Chair
Why would expanding the definition of Health IT developer to include developers of noncertified Health IT do that?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Say the question again.

Andy Truscott – Accenture – Co-Chair
Why would expanding the definition of Health IT developer to include developers of all Health IT whether or not the idea certified through the certification program why would that prevent innovation?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I don’t think it would. It may disincentivize folks, but that would be about it.

Andy Truscott – Accenture – Co-Chair
Cynthia’s point is that by disincentivizing folks we’re going to short change patients, by not giving them the capabilities they want. Because it’s a barrier to entry to the market by making Health IT developers you have information share. I think to correct me if I'm wrong I think that's what you are saying.

Cynthia A. Fisher – WaterRev LLC – Member
I think it's a question of certification versus information sharing. So I think the question is you want to make sure that we don't prohibit innovation.

Andy Truscott – Accenture – Co-Chair

We agree on that one. I don't think the suggestion on the table would be that all Health IT has to be certified, that isn't the suggestion. The suggestion is that all Health IT has to comply with the Information Blocking regulations.

Cynthia A. Fisher – WaterRev LLC – Member
Thank you for the clarification, Andy.

Denise Webb – Individual – Member
So, Andy, this is Denise, going back to my example earlier in the health system that decided we would use best in the breed for their various functions. And have a best in breed revenue cycle management system and best of the breed of this and best-of-breed of that, and now they decide they want to move to an integrated platform Health IT that provides all of those where some are certified some is not but it's ultimately the vendor. What is to protect the health care provider when they want to get their information out of that revenue cycle system that is not certified in the Health IT developer is not subject to any of these rules concerning information sharing and Information Blocking? So I would just make that point of another point of support for the idea of having the definition apply to more than just developers that have certified products.

Arien Malec – Change Healthcare – Member
I don't know if we talked yet about the cures language and some of the inherent ambiguity of the cures language and if we have then I'll except assume it's understood by everybody.

Andy Truscott – Accenture – Co-Chair
We're about to get there because if we say Health IT developer is a developer all Health IT whether or not it is certified, there is a gap in the cures language doesn't give the ability for sanctions for anything apart from certified Health IT. Within the act itself. Now, that's not to stop an individual entity who says hang on a second, you're blocking – So you're developing software which blocks. Therefore, I want to perform some sort of litigation against you, it doesn't stop that. But it would mean we have a rule with no potential enforcement mechanism or no obvious enforcement mechanism. I mean that's where you were going right?

Arien Malec – Change Healthcare – Member
Correct.

John Kansky – Indiana Health Information Exchange – Member
And that my recommendation we could give back to the ONC to ask for updated statutory language down the road. But to me as a hostile purchasing power, as a CIO who buys products, I do ask the question often, is it a certified product or not? And if I make a conscious decision to buy a product say is from a startup or whatever else because it's a great idea, there this contractual language I built in to make sure I get my data. So I would think that maybe there would be a mechanism for hospitals to reach out that are maybe small independent to ask how to do I handle a noncertified product because there is no covered or whatever else. But I don't think we can solve the issue of a lack of language. All we can do is recommend we need an update, right?

Andy Truscott – Accenture – Co-Chair
Okay. And we would say I think implicit in what you are saying is we should ensure that all Health IT developers are covered by the regulation, and then seek some kind of clarity from ONC on how enforcement could take place.

John Kansky – Indiana Health Information Exchange – Member
Exactly, and provide a phone a friend lifeline. I'm using that tongue-in-cheek year for folks I want to engage with products that are not standard but don't know the right contractual language to put in there. Maybe there could be a simple language as provided on the HHS website of contracts to consider. Obviously, I don't think the government to tell people how to do the business, but they could provide some guidance on what other people have done.

Andy Truscott – Accenture – Co-Chair
It's okay. I'll publish your cell number.

John Kansky – Indiana Health Information Exchange – Member
Sure, why not? I'll just forward it to you, Andy.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
This is Mark. I want to make a point this is good conversation, but your recommendation you should consider that ONC is limited by the statutory language as it currently is written. So that being said, we have to interpret it how it is written right now. So you can make recommendations that are kind of outside the scope of how it is written potentially about making a change to that language. And just want to make that point as far as the way that we go through the regulatory process, is that we have to look at the statutory interpretation of the words in front of us in cures.

Arien Malec – Change Healthcare – Member
I think everybody understands that and everybody agrees with you.

Steven Lane – Sutter Health – Member
Cures itself is, I don't want to say poorly drafted but inconsistent into whether it talks about Health Information Technology or developers of Health Information Technology or developers of certified Health Information Technology. So for example in the standardized reporting process on claims of information blocking, it mentions Health Information Technology. But concerning OIG, it specifically mentions certified Health Information Technology. I think presumably because there is a specific call for conditions of certification relative to Information Blocking. So there's some maybe some wiggle room in the role of ambiguity in the rule. But every time when it comes down to actual teeth all those teeth are aimed at certified developers and certified health technology.

Arien Malec – Change Healthcare – Member
Yeah, and remember guys, there's another mechanism to enforce on say application startup developer. There is FTC, there is duplicitous behavior, there are a zillion other dimensions there that may befall outside of the ONC to regulate this.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
And I do want to note what Arien was saying, you can see in the preamble we talked about how we went through, how we got to our interpretation, and we talked about the different references within Cures that we worked with. And I guess if you read Cures and you think there's a reasonable interpretation that is different than ours, then that's a recommendation you can definitely make. Or you could also make a recommendation that Congress missed the mark and to change it. I guess those are two possibilities.

Andy Truscott – Accenture – Co-Chair
Okay. What I'm going to do is I'm going to put us out for the public, in a moment. I'd like the public to comment especially about this particular aspect if you are willing. Then I'm going to run through the votes as well of across task force members, about whether we want to take this position that Health IT developer should be health developers of all health IT versus certified Health IT and I will draft with Michael appropriately and put it out for consideration. So, operator, can we go to public lines, please?

Operator
If you like to make a public comment, please press star one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star too if you'd like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your headset before pressing the star keys.

Andy Truscott – Accenture – Co-Chair
Do we have any comments in the queue?

Operator
There are no comments at this time.

Andy Truscott – Accenture – Co-Chair
I will quickly run through the task force members. The question on the table is, does this task force want to make a recommendation that the definition of Health IT developer be augmented to include the developers of all Health IT whether or not the IT is certified?

Steven Lane – Sutter Health – Member
Can I ask a question? How or better yet who is going to define what makes a developer a Health IT developer? Or what makes a piece of IT Health IT?

Andy Truscott – Accenture – Co-Chair
[Inaudible – crosstalk] [01:17:30]. Let me think about that as I come up with some drafting. I'm not going to do the drafting here. I suspect it will be based on the definition of EHI technology achieves to facilitate the access or process or handling. However, the wording is set up, around electronic health information. Let's hang it that way.

Arien Malec – Change Healthcare – Member
I would advise if you go that direction to use the Public Health Service Act definition because there is one. Yes, I am looking for it right now.

Andy Truscott – Accenture – Co-Chair
You think they'll use the EHI definition, Arien?

Arien Malec – Change Healthcare – Member
I think there is a definition of Health Information Technology already statutorily defined.

Steven Lane – Sutter Health – Member
And we need to make sure we are comfortable with it, right?

Arien Malec – Change Healthcare – Member

Yes, and to the extent that we are asking for things that are squishy from the statutory definition, the more that we ground this in the pre-existing statutory definition, I think you are making it easier for our friends at ONC.

Andy Truscott – Accenture – Co-Chair
Arien, would you like to assist in drafting that I'm taking on?

Arien Malec – Change Healthcare – Member
I can find the definition.

Andy Truscott – Accenture – Co-Chair
Just say yes.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
I have the definition and can read it if you want. But in our definition of Health IT developer, certified Health IT we do reference USC 300JJ5, which is the Public Health Service Act regarding Health Information Technology.

Steven Lane – Sutter Health – Member
Can't we just pull up the definition, if you've got it handy?

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
The definition, I can read it maybe because I don't have my screen share right now. But it says the term Health Information Technology means hardware, software, integrated technologies, or related licenses, intellectual property, upgrades, or packaged solutions, sold as services that are designed for or support the use by healthcare entities or patients for the electronic creation, maintenance, access, or exchange of health information. And I know that's a lot, and I can send it around if you want to think about it.

Arien Malec – Change Healthcare – Member
That's great but is striking it refers to healthcare providers organizations and patients and seems not to specify a lot of the other actors that we are so concerned with. The Amazons, the Googles, and of the world that would not seem to immediately fall under that which is why I asked the question.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
That would support the use by patients for the electronic creation maintenance act health exchange information.

Steven Lane – Sutter Health – Member
I want to spend too much time on this but if that's a recommendation we want to point to that is seems the only way to do It. It sounds like Andy was saying another way to do it would be to say any IT that deals with electronic health information but it seems like we can't do both.

Andy Truscott – Accenture – Co-Chair
To be fair, the information definition is leaning heavily on that definition that you said right now anyway, so I'm ambivalent on that and happy to ground in a pre-existing definition. That's fine. I just want to know whether the group want to do that or not and wants us to define health information

developer Health Information Technology developer more broadly or make a recommendation more broadly then it's been covered. So set that on the table.

Steven Lane – Sutter Health – Member
I would ask Sheryl. Sheryl, do you have any concerns about that?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I like the way it is currently defined so I would vote for keeping it the way it is currently defined in the way they just read it from the public service act.

Andy Truscott – Accenture – Co-Chair
Those are different. Hold on a second, those are different Sheryl. The current definition is a Health IT developer, is a health IT developer of certified health IT. Not the definition that Mark read out to the public health services act which is the broader definition.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
What I read is the definition from the Public Health Service Act of Health IT Health Information Technology which is just a component of our definition of Health IT developer.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I like the definition you just read so I guess I am all up for broadening it.

Arien Malec – Change Healthcare – Member
It sounds like there is a consensus for broadening and a recommendation…

Andy Truscott – Accenture – Co-Chair
I want this very clear because I want a clear direction from the task force, so I do want to get it out to vote. So can we just quickly do that, please? Lauren, can you quickly run through the members, please?

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
One second. Andy?

Andy Truscott – Accenture – Co-Chair
Yes. Lauren, I'm here.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Yes. Did you want me to run through the roster?

Andy Truscott – Accenture – Co-Chair
I'm taking a vote.

Arien Malec – Change Healthcare – Member
She's asking you to vote.

Andy Truscott – Accenture – Co-Chair
Oh, she's asking me to vote. I abstain because I have to abstain.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Andy, can you restate the question of what you are voting on?

Andy Truscott – Accenture – Co-Chair
Yes. I don't think Lauren heard what we are voting on, guys. We are voting on whether the task force wants us to make a recommendation to alter the definition of Health IT developer so that if there are no longer developers of certified Health IT in a more broader definition aligned with the definition of Health IT in the Public Health Service Act.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
And currently, it is defined under certified Health IT developer.

Mark Knee – Office of the National Coordinator for Health Information Technology – Staff Lead
Currently, I'll just read the current definition, so you are crystal-clear, the Health IT developer certified Health IT means an individual or entity that develops or offers Health IT as defined in the Public Health Service Act, which I just read, and which had at the time it engaged in the practice that is the subject of the Information Blocking claim, Health Information Technology, one or more certified under the ONC Health IT certification program. You may proceed, Andy.

Andy Truscott – Accenture – Co-Chair
Take the vote, please

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Andy, I'll start with you,

Andy Truscott – Accenture – Co-Chair
I abstained because I'm in the chair.

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

Steven Lane – Sutter Health – Member
I support the change.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Sheryl? Is Sheryl still on?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
I'm going to abstain for now.

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

Denise?

Denise Webb – Individual – Member
I support the change.

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

Sasha TerMaat – Epic – Member
I support the change.

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

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

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

Arien Malec – Change Healthcare – Member
Support, but I believe we should note the legislative issues noted.

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

Valarie Grey – New York eHealth Collaborative – Member
I support broadening it.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
Anil? Maybe he dropped. Cynthia?

Cynthia A. Fisher – WaterRev LLC – Member
I would like to have further consideration, and at this time I would keep it as status quo and revisit after being able to read and consider. And seek input from outside parties of developers, and that would be my act. So to get further information.

Andy Truscott – Accenture – Co-Chair
Cynthia, we need to vote either abstain, to vote for, or vote against.

Cynthia A. Fisher – WaterRev LLC – Member
Abstain.

Andy Truscott – Accenture – Co-Chair
Thank you.

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

John Kansky – Indiana Health Information Exchange – Member
I vote for the change to broaden the definition.

Lauren Richie – Office of the National Coordinator for Health Information Technology – Designated Federal Officer
I believe -- did I miss anyone? Maybe Anil has been dropped. So we have two abstentions and **[inaudible] [01:27:21]** of changing.

Andy Truscott – Accenture – Co-Chair
So Arien, can you help me when we go to the current recommendation. This is our recommendation and not that a change will happen and but that also so everybody before it goes to recommendations -- we are at the end of time together. Anybody have any other things they want to get off their chest as we go to final throes of transmittal?

Steven Lane – Sutter Health – Member
I want to acknowledge the thing we just voted on is really important and profound. And I want to thank everyone for going through that exercise.

Andy Truscott – Accenture – Co-Chair
Thank you, sir. Anybody else? Okay, thank you. I like to give you my heartfelt thanks over the last two weeks we spent a massive amount of time together, as we have waded through many complex issues which have been brought to light by the Information Blocking proposed rules. And we've actually covered an enormous amount of ground and doing so. I would like to thank the ONC team as well for putting up with some of our deliberations. I'm sure you discuss these things at nausea before us, and it was just nausea making and discussing it all over again. But thank you for the same. And task force members thank you and will next meet again in full ONC meeting when we are putting to a vote our letter of transmittal going forward and apart from that I like to adjourn for the last time and thank you ever so much.

Steven Lane – Sutter Health – Member
Thank you.