Information Blocking (IB) Task Force

Transcript
May 16, 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
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 morning, everyone. Welcome to the Information Blocking Task force meeting, perhaps the last. Of the task force members, we have Andy Truscott, Michael Adcock, Steven Lane, Sheryl Turney, Sasha TerMaat, Aaron Miri, Anil Jain, John Kansky, and Denni McColm. Did I miss anyone who's a task force member who's dialed in? Okay. With that, I will turn it over to our Co-Chairs, Michael and Andy, to get started.

Andrew Truscott – Accenture - Co-Chair

Thank you very much. Good morning, everybody. Thank you for taking some time for this, especially for those of you who are on the West Coast as well. We shall move through what the work that's left ahead of us as expediently as possible. I do encourage everybody to say now exactly what's on your mind because this will be, as outlined, the last call round for us to meet as an Information Blocking Task force unless we are reconvened at some latter point.

So, this is it, guys. We will be roll call voting on the final recommendations so that we can take them through to HITAC at the beginning of next week. So, has anyone else got any comments before we trek on? Mike, did you want to say anything?

Michael Adcock – Individual - Co-Chair

No. Good morning, everyone. I just wanted to say thank you for all the hard work. I can't believe it's finally coming to an end. I don't believe it's an end yet. We will see. But it is hopefully the last task force meeting. I just wanted to thank – if you look at the documents and look at all the – it doesn't even reflect all the work that's been done and it's a tremendous amount of work itself.

So, thank you to all the task force members and specifically to Andy, my illustrious Co-Chair, for doing a lot of the heavy lifting on writing recommendations and getting down what everyone communicated during the task force meetings.

Andrew Truscott – Accenture - Co-Chair

Thank you very much. Let's congratulate everyone when we get to the end of the next two hours. Okay. We'll move on then to recommendation No. 1, which is around health information exchange. You'll see we've still got some discourse going on about what we actually want this to mean. Right now, I think there's still a fair degree of flux around it.

I have – Sheryl, can you bring over the recommendations now? That would be great. You've all got your materials – oh, John Kansky, you've got your hand up already. Wow, I've not even gotten to the end of my introductory statement.

John Kansky – Indiana Health Information Exchange - Member

Finish your introductory statement. I was just trying to get ahead of the crowd.

Andrew Truscott – Accenture - Co-Chair

Okay. Fine. There has been lots of discourse over the last three or four days around this definition. Actually, John, you get your thoughts in because it is still in a state of flux. So, you say what you need to say.

John Kansky – Indiana Health Information Exchange - Member

You want me to go?

Andrew Truscott – Accenture - Co-Chair

Yeah, go.

John Kansky – Indiana Health Information Exchange - Member

Okay. Sorry. I guess there are two major things I wanted to comment on. One is I understand that we're going back to the, dare I say, non-verb version of the health information exchange definition. I've come to grips with that. I'm fine with that. I still think this definition is big and furry. I've quit fighting about that. I think there may be some unintended consequences that will have to be discussed in the TEFCA task force of having a big furry definition. I'm not sure it's any way problematic, but we need to discuss it.

The thing that still hits me in the face – I don't know when this was introduced and I missed it – is that I don't get how a product meets the definition of health information exchange. I understand that there's an organization that can be a health information exchange and an activity that can be a health information exchange, but I would recommend striking the reference to a product that can enable health information exchange meeting the definition of health information exchange.

Andrew Truscott – Accenture - Co-Chair

That's a good point, John. That was one of my concerns as we were drafting it up as well. I'll tell you what – if I propose a re-definition – I've gotten a lot of input over the last couple of days and full consideration now – if we say that a health information exchange or HIE means – here we go – any entity performing the access exchange transmittal processing, handling, or other such use of electronic health information who is not considered a provider health information network or health IT developer. Should I repeat that?

John Kansky – Indiana Health Information Exchange - Member

Sure.

Andrew Truscott – Accenture - Co-Chair

Any entity performing the access exchange transmittal processing, handling, or other such use of electronic health information who is not considered a provider, health information network, or health IT developer.

John Kansky – Indiana Health Information Exchange - Member

I see where you're going. Go ahead.

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

Why did you take out health information network, though? That seems like there's going to be so much overlap.

John Kansky – Indiana Health Information Exchange - Member

That's where I was going.

Andrew Truscott – Accenture - Co-Chair

I'm reflecting some of the opinions. It's kind of taking HIE and saying it's the catch-all for what sits outside the other actor definitions. It might be that it's a very small suite of people that fall inside that definition. But it means that we avoid the protectionist approach which could exist if we deliberately exclude the group.

John Kansky – Indiana Health Information Exchange - Member

I think the end – if no one has their hand up – I think the end result is one, you're going to catch in that definition everyone we intend to catch. Two, it is no less furry or confusing in terms of people trying to figure out which category they fit. Although, three, if it doesn't matter which category they fit, for example, HIE plus miscellaneous, which is what I heard you just say, or HIN, if there's no difference in how you comply with the rules or what your penalties are, then it will just be perceived as a head shake when people go to comply, but it won't be any harm.

Andrew Truscott – Accenture - Co-Chair

I think that might be a difference in enforcement, potentially. I think that might still be straightening out. ONC, if Mr. Lipinski or Mr. Knee want to comment on that… What it does is it covers – then it covers entities who do not create a network of entities who exchange but actually perform provider exchange service.

John Kansky – Indiana Health Information Exchange - Member

Andy, just to jump in while people are thinking about that – I'm not sure I quite follow the enforcement question. The only differentiation Cures makes in enforcement is between providers with the disincentives that are going to be identified, and then the three other groups – developers, networks, and exchanges – which can be subject to penalties up to $1 million. That's really the distinction that's made in enforcement.

Andrew Truscott – Accenture - Co-Chair

That's fine. You're right. John.

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

Andy, this is Aaron. I don't have my hand up. I'm just curious – from that definition – I'm driving, so, I'm not reading it. I'm listening to you. Would that exclude payers? Would that exclude other dimensions of the healthcare vertical that would be known to have some difficulty in exchanging information with folks?

Andrew Truscott – Accenture - Co-Chair
I think it would include them, wouldn't it?

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

Andrew Truscott – Accenture - Co-Chair
I was just saying I think it would include the payer because any entity that's performing the access, exchange, transmittal, processing, handling or other such use of electronic health information. So, a payer would fall into that who is not considered a provider, HIN, or health IT developer. Well, a payer is not considered a provider, health information network, or health IT developer. So, we would be saying that a payer would implicate the regulations under their inclusions as an actor under HIE. We would be saying that.

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
You would be unless you force a behavior from the industry where payers start providing services like we're starting to see. I'm just saying be careful with the nuance of that because there's a lot of folks that use beta, obviously, as a source of monetary income.

So, you can see some behavioral change occur if someone is a traditional payer – I'm not trying to pick on the payers. I don't mean to. I am. Let's assume they start opening provider offices, primary care offices. Now, suddenly, you've changed the game on what they could be considered. So, it's just something to think about.

Andrew Truscott – Accenture - Co-Chair
That's a good point. Is the recognized potential consequence, is it one that we intend to happen?

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
My personal druthers on this is I like the – I'm going to use John's word here – the big furry definition because it allows flexibility for the rule to apply and for provider organizations like myself to make sure that the entire ecosystem is behaving. I'm just saying you know people are going to try to find wiggle rooms around this because there is a lot of money made in the identified data. So, that's all I'm saying.

Andrew Truscott – Accenture - Co-Chair
Okay.

John Kansky – Indiana Health Information Exchange - Member
Okay. Andy, point of operation – I know you can't put it in the public chat, but could you please or somebody please send me a link to the Google doc you're currently working on?

Andrew Truscott – Accenture - Co-Chair

I'm not looking at the Google doc. I'm looking at the lecture transmittal. I appreciate it would be easier if you can see it on screen. Let me see if I can do that. I think my screen might be being shared now. Please shout at me if it's appeared.

Anil K. Jain – IBM Watson Health - Member

Still pretty small. Here you come. There. That's the one we want to see. Perfect. That's better.

Andrew Truscott – Accenture - Co-Chair

I can no longer see hands that are raised, though. You'll need to keep me honest.

Michael Adcock – Individual - Co-Chair

Andy, I can see the hands that are raised. I'll let you know.

Andrew Truscott – Accenture - Co-Chair

Okay. Sheryl, I'm looking for your input as a payer representative.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Yeah. I've been quiet, but I'm not sure that – so, if this then applies to payers, then what does this mean? Within the Blue Cross Blue Shield franchise, we share data with one another. So, would this then apply to the data that we have to share within the association and the affiliates? How about at the client's request? There is some of that data that we consider to be proprietary. I think this is probably going to be problematic from a payer's perspective.

Andrew Truscott – Accenture - Co-Chair

It might be problematic but is it unexpected? My sense was there is a belief from most payers that they are included in the information blocking regulations.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

No, I hear that they are, but I don't know if they would be considered a health information exchange is what I'm saying. They're still an actor in the system, but I don't think everything they do makes them a health information exchange.

Andrew Truscott – Accenture - Co-Chair

I think we are kind of defining, at least within the context of information blocking what we want the term health information exchange to mean. What other actor would you consider that they would fall under?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Well, they're a covered entity. So, they're already regulated from that perspective.

Andrew Truscott – Accenture - Co-Chair

But particular to information blocking and Cures, which actor would a payer fall under out of the four that they have?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Yeah. This is the only one, obviously.

Andrew Truscott – Accenture - Co-Chair

Okay. So, as Mark pointed out, with the exception of health IT developer and provider, HIE and HIN, they're kind of yin and yang a little bit. I think the idea is for this drafting, from what I'm picking up from others on the committee as well is this means that payers, for example, are included and they expect to be included, but this just makes it clear.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I understand that. I also know they're going to think it's problematic.

Andrew Truscott – Accenture - Co-Chair

I beg your pardon.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I think they believe there's some information that they exchange which should not be basically open to the public, which gets to the comment that was made already about the…

Andrew Truscott – Accenture - Co-Chair

This is purely around defining the actor. This is not about saying what you do and what information. It's just about the actor.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

No, I get that. That's why I'm being hesitant. I don't see anywhere else that they would belong, but I do also see that there are some – well, pretty much all of them are going to feel as though there's some information that they have that shouldn't have to be shared. So, that becomes the topic of discussion.

Andrew Truscott – Accenture - Co-Chair

I think that is taken care of with the exceptions, is it not?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Right. It should be.

Andrew Truscott – Accenture - Co-Chair

Also, the onus is on us around the definition of electronic health information because this whole actor inclusion is based around electronic health information and we need to make sure that electronic health information, which will be the next topic of discussion, provides the right scoping.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Yeah. I accept this is where we put it right along and this is what I've been communicating, but I do continue to get points made that this would be problematic. I get that too. I think we should just move on.

Andrew Truscott – Accenture - Co-Chair

Okay. We're going to move on. Did anyone get anymore comment? If not, we're going to call this to a vote for this task force.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Okay.

Andrew Truscott – Accenture - Co-Chair

Has anyone else got any comment on this? Okay. I'm happy to call it to a vote. Those in favor of making this – hello? Those in favor of making this our recommendation for the definition of health information exchange to HITAC for them to consider, please say aye.

Multiple Speakers

Aye.

Sasha TerMaat – Epic - Member

Are we voting on what you read out, Andy, or what's in the document?

Andrew Truscott – Accenture - Co-Chair

You're voting on what I read out and what's on the screen right now. I shall read it out once more. Health information exchange or HIE means any entity performing the access, exchange, transmittal, processing, handling, or other such use of electronic health information who is not considered a provider, health information exchange, or health IT developer. Those in favor, please say aye once more.

Multiple Speakers

Aye.

Andrew Truscott – Accenture - Co-Chair

Those against, please say nay. Those abstaining, please say abstain.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Abstain.

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

Abstain.

Andrew Truscott – Accenture - Co-Chair

Okay. So, that's passed for two abstentions. We're going to move forward now to the definition of electronic health information. There were some changes to this that came through very late which we put in here for discussion around the additional third piece we put in around electronic health information, which can reasonably be used to inform care decisions, including by the patient, including pricing information, which may or may not be identifiable. This has caused considerable lighting up of my email box over the last couple of days. I'll try and reflect some of those sentiments right now.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I'm raising one, Andy, because I have an issue with the including pricing information, which may or may not be identifiable. First of all, that doesn't really clarify the point I think that was trying to be made. But secondly, it makes it too open and too broad and it really needs to be related to the individual.

Andrew Truscott – Accenture - Co-Chair

I think that was one of the comments which I was about to reflect. So, Sheryl, what do we think the intent here is of this inclusion. What are we trying to achieve?

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I think we're trying to achieve providing information that people can make decisions with. Having information that's so broad that may or may not be identifiable, what does that even mean? Identifiable to what? The data is supposed to be related to the patient or the case of the care of that individual. So, somehow, it has to be related to that. Which is why I say that statement isn't clear. So, I can't endorse that and would strongly say we have to change it.

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

A comment – one is, I think, for clarity, we should say individually identifiable or identifiable to the individual. I think the idea, Sheryl, again, not specifically promoting it, but I think the idea is we might be talking about general pricing for the public or we might be talking about pricing data that has been specified to an individual's situation. I think that's what we're talking about.

I think it's reasonable, but to be considered, certainly, individually specified or individually identifiable data. It's interesting because identifiable is odd. It sort of suggests from that pricing data, you can identify who the patient is, which isn't really the point here. The data has been specified to the individual.

Andrew Truscott – Accenture - Co-Chair

Which may or may not be specific to the individual.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I thought the intent was it needed to be related to the conditions for the individual. So, if in the future you think you need to have a knee operation, you should know how much that's

going to cost you. It would be the pricing that an individual would experience in the future for that particular type of condition.

Andrew Truscott – Accenture - Co-Chair

I'm wordsmithing on the fly. Anybody else, please. Help me here.

John Kansky – Indiana Health Information Exchange - Member

I've got my hand up.

Andrew Truscott – Accenture - Co-Chair

I can't see that. Mr. Adcock, please police the handing.

John Kansky – Indiana Health Information Exchange - Member

Sorry. It's John. Unless I'm misinterpreting the conversation, I feel unusually strong about this point because it feels like we spent a collective hour on three different calls talking about this. I thought we came to if not consensus a decision that we were not going to include pricing that was not identifiable, pricing information that was not – clearly, we want price transparency, clearly, pricing information that is identifiable to the patient, yes. But I thought we specifically decided not to go here.

Anil K. Jain – IBM Watson Health - Member

This is Anil. I thought the exact same thing, which is what I was going to say when I raised my hand. I think we're going back to something that we already decided. Then there are some very compelling reasons why we would want to promote it, but there's an RFI out. We need to make sure that when we think about electronic health information, it can be implementable.

Making it broad so that it doesn't include identifiable information around pricing could be an implementation nightmare. I think we should limit the definition to identifiable information regarding price, past, present, and future, and we should let the RFI process play out and then come back to this later if we need to.

Andrew Truscott – Accenture - Co-Chair

Okay.

Valerie Grey – New York eHealth Collaborative - Member

Andy? Sorry. It's Val. I can't raise my hand because I'm on the road. I do agree. I feel like we've talked about this a number of times. I'm not quite sure why we're going at it one more time again.

Andrew Truscott – Accenture - Co-Chair

We want to build a majority consensus and vote on this. It's okay. I must confess, in my personal basis, I struggle with the term identifiable because I think it can mean many different things when it comes to data in general. I think I'm reflecting the sentiment that

actually, we want the information to be attributable to the individual. Is that fair? We don't want this open-ended.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Right. I think that's what we all agreed previously. We wanted it attributed to the individual.

Andrew Truscott – Accenture - Co-Chair

Okay. Those of you that are on screen can see the color drafting I've got in here and I will read this out for those of you who are in transit.

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

Andy?

Andrew Truscott – Accenture - Co-Chair

Go ahead.

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

I just wanted to note – you saw Denise's email about the definition before you move forward on voting.

Andrew Truscott – Accenture - Co-Chair

I did. I have incorporated her sentiments in the middle section of this definition.

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

Okay. Great. I just wanted to make sure.

Andrew Truscott – Accenture - Co-Chair

I saw that. So, electronic information which can be reasonably used to inform care decisions by a provider or patient, including pricing information which can be attributable to an individual patient.

John Kansky – Indiana Health Information Exchange - Member

Andy, are you deliberately trying to avoid the use of the word identifiable?

Andrew Truscott – Accenture - Co-Chair

Yes.

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

Again, as I said, it doesn't really identify the patient-derived from characteristics of the

patient, but there's nothing about the pricing information that's identifiable.

Andrew Truscott – Accenture - Co-Chair
Yeah.

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

Anil K. Jain – IBM Watson Health - Member
This is Anil. I don't want to over-complicate things, but why are we limiting it to using to inform care decisions? What if the decision is about reimbursement or payment? I'm missing something there.

Andrew Truscott – Accenture - Co-Chair
This is the third part of this. So, the thing around payments is really taken care of earlier on. This was specific information. This was a specific broadening which was – I think we had a consensus on it.

Anil K. Jain – IBM Watson Health - Member
Okay. Never mind then. Okay.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
This is Sheryl. This is because it was part of, "What is electronic health information?" That's why. It's the third part of that.

Anil K. Jain – IBM Watson Health - Member
Got it. Okay.

Andrew Truscott – Accenture - Co-Chair
So, I'll read it out again. Electronic information which can be reasonable – sorry, I'll start again. Electronic information which can reasonably be used to inform care decisions by a provider or patient, including pricing information, which can be attributable to an individual patient.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
I'm good with that, Andy.

Andrew Truscott – Accenture - Co-Chair
Okay. Does anybody else want any discussion on this?

Anil K. Jain – IBM Watson Health - Member
It's fine. This is Anil. It's fine. I'm not sure why we're changing the word identifiable, which is used in multiple places in the document to attributable. But again, it's not a big deal.

Andrew Truscott – Accenture - Co-Chair

Well, it's a good point. I'm not **[inaudible] [00:28:01]**. What is it about – is it the data that's identifiable? Is it the patient that's identifiable? I struggle in this sentence. So, I think what we actually mean is the pricing information, which can be attributed to that individual over there for whatever reason. Whether or not that individual is identifiable, whether uniquely or otherwise, it's just – I think we mean something slightly different here, I think. Unless there's a consensus that identifiable is a better word, if so, say now or forever hold your peace.

John Kansky – Indiana Health Information Exchange - Member

I like the changes you've made.

Andrew Truscott – Accenture - Co-Chair

We've made. Okay. So, I'm going to put this to a vote if there's no more discussion. So, all those in favor of modifying this recommendation so that part three is electronic information which can be reasonably used to inform care decisions by a provider or patient, including price information, which can be attributable to individual patients, say aye.

Multiple Speakers

Aye.

Andrew Truscott – Accenture - Co-Chair

Those against, please say nay. Those abstaining, please say abstain. Okay. Thank you. That's a unanimous carrying through. Sheryl?

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

Question, is Cynthia on?

Andrew Truscott – Accenture - Co-Chair

Cynthia is on. I'm not sure she's actively contributing, but she's on the call. I've tried to reflect her feedback and sentiment as well as we've gone through this discussion. We have reflected Cynthia's minority opinion in the transmittal letter. You can always actually modify that as well. Okay. Recommendation five – this was the price information request for comment and request for information.

So, we've updated the text in here just to recognize our position and what we were asked to do. So, you guys have read this material already. Has anyone got any comment on the markup that we put in there?

John Kansky – Indiana Health Information Exchange - Member

Andy, it's John again. I read the paragraph that had been inserted that shows up in my PC in blue – we've got different markups – I was a little concerned based on my reading, but I want to make sure I'm not confused – that's the paragraph right there – task force notes that the prose definition along with a recommendation for amendment provides for an expansive set

of **[inaudible] [00:31:21]**, which could include information on an individual insurance eligibility or benefits, billing health services, payment information for services to be – is this different than what we just struck? This seemed to be in support of what we just took out.

Andrew Truscott – Accenture - Co-Chair
I don't think it is. Any of these – these are based around an individual's health insurance eligibility benefits. That's attributable to the individual. Billing for healthcare services, that's attributable to individual payment information for services provided. That's in the first part of the definition of EHI, to be provided already provided, which may include price information. It should be aligned.

John Kansky – Indiana Health Information Exchange - Member
So, what is the point of saying – yeah, go ahead?

Andrew Truscott – Accenture - Co-Chair
It's all you.

John Kansky – Indiana Health Information Exchange - Member
So, the next sentence, why do we need to say that the task force notes the availability of individually specific and generalized price information enables patients to shop? I guess that's true. Is that making a point? I guess I don't have a problem with saying that.

Andrew Truscott – Accenture - Co-Chair
This is just in a request for comment and request for information.

John Kansky – Indiana Health Information Exchange - Member
Okay. Got it.

Andrew Truscott – Accenture - Co-Chair
Individually specific and generalized price information, that's still useful and attributable to the individual. The generalized price information is still useful and attributable to the individual.

John Kansky – Indiana Health Information Exchange - Member
I'm okay.

Andrew Truscott – Accenture - Co-Chair
Anybody else?

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
Yeah, Andy, just a short comment – the last sentence that I'm seeing in red –

Andrew Truscott – Accenture - Co-Chair
Everyone's confused because it's in different colors.

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
Allows the patients to shop for and make decisions – I would simply add the word informed before decisions.

Andrew Truscott – Accenture - Co-Chair
That's helpful. We'll correct the font sizes as well.

Anil K. Jain – IBM Watson Health - Member
I'm sorry, Andy. I'm still getting a pit of a lapse here. I don't understand how this is different than – this is not the same as what we just talked about. If we have generalized price information as part of EHI, I don't know how that's consistent with what we just discussed a few minutes back.

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
This is not included as part of EHI. All it does is it –

Anil K. Jain – IBM Watson Health - Member
No, no, no – right there it says that it should be included in the scope of EHI as per our recommendations. This refers back to our EHI recommendations.

Aaron Miri – The University of Texas at Austin, Dell Medical School and UT Health Austin - Member
So, we should take out generalize. You're right.

Anil K. Jain – IBM Watson Health - Member
If we really want to think about generalized price information, maybe we put a sentence saying that we should ask for further input from the community about generalized price information should be incorporated, but let's not make it part of our EHI definition.

Andrew Truscott – Accenture - Co-Chair
Later on in this section, we actually say look, there should be a new task force to go through this and consider it. I think maybe we should insert that in here as a clear recommendation.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
I like that.

John Kansky – Indiana Health Information Exchange - Member
I think it's important to acknowledge that none of us is against the sharing of generalized

price information. It's just that it doesn't belong here. That's all.

Andrew Truscott – Accenture - Co-Chair
Our first statement here is the task force profoundly agrees that price transportation is a desirable goal that is achievable. That's our first statement.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
I like that.

Andrew Truscott – Accenture - Co-Chair
Okay. Then we got this last paragraph, which was also in markup since the last draft of this. **[Inaudible] [00:35:47]** notes that existing entities within the healthcare ecosystem have access to pricing information, which could be utilized by patients to make important decisions about the nature and location of their care.

Those entities should be obliged to share that information and recommended amendments to the definition of electronic health information is designed to **[inaudible] [00:36:02]** the sharing of that information by placing a non-sharing within the boundary of information blocking. I don't think that's in any kind of quibble, is it?

Anil K. Jain – IBM Watson Health - Member
This is Anil just wordsmithing here – we've defined EHI so many times I think we should just put EHI instead of spelling it all the way out. It seems like the paragraph is a little bit out of place, but it's fine.

Andrew Truscott – Accenture - Co-Chair
This is the whole RFI RFC.

Anil K. Jain – IBM Watson Health - Member
Right. That's fine. It says pretty much what we've already said. So, it's all good. It summarizes it.

Andrew Truscott – Accenture - Co-Chair
Yes. Actually, the bit that's different is about we say those entities should be obliged. It is a slight finessing. We've included the recommendation for the mandate in charge of this new task force to discuss how generalized price information can be made accessed and available to patients and providers of informed care decision. And we wordsmith a little bit these above points as well. I'm not going to read them out again, but for recommendation five around price information request for comment and request for information, those in favor of our amendments, please say aye.

Multiple Speakers
Aye.

Anil K. Jain – IBM Watson Health - Member

Andy, I'm sorry. This is Anil. Can I make one quick suggestion for wording?

Andrew Truscott – Accenture - Co-Chair

Of course, you can.

Anil K. Jain – IBM Watson Health - Member

You have providers and patients. What about those who are actually paying for care like employers? Why wouldn't they also –

Andrew Truscott – Accenture - Co-Chair

That's a very good point.

Anil K. Jain – IBM Watson Health - Member

Okay.

Andrew Truscott – Accenture - Co-Chair

Where would that go in there?

John Kansky – Indiana Health Information Exchange - Member

Purchasers, I think is the word.

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

Yes, I like that.

Andrew Truscott – Accenture - Co-Chair

Help me here. Whereabouts are these –

Anil K. Jain – IBM Watson Health - Member

It was right where you just were at, where it said patients and providers. Go further down, further down – right there. So, patients, providers, and purchasers – that would solve it. I like it.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

I think it would need to include payers too. They're looking for us to provide information. We don't have all the prices on out of network providers or who even is out of network.

Andrew Truscott – Accenture - Co-Chair

Good point. So, that now says how generalized price information can be made readily accessible and available to patients, providers, purchasers, payers, and other relevant stakeholders to report care decisions.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

There you go.

Anil K. Jain – IBM Watson Health - Member

Good.

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

Throwing in payers, of course, does raise the concern about what should be or what would be appropriate to claim as IP or private. I think the idea that payers somehow, their prices are part of their secret sauce might be a concern. With you supporting this, Sheryl, I don't have any trouble pushing it forward, but some people are going to raise an eyebrow at that.

Andrew Truscott – Accenture - Co-Chair

Bear in mind, guys, that this is a recommendation for consideration of the new task force. We're not saying it should happen. We're saying the new task force should think about it and consider.

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

And the exceptions are there.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Even payers are working on how to make the general information more available when it **[inaudible] [00:40:08]**. So, although as I stated before, the providers on this call seem to be readily able and willing to share data. That's not our experience with many of the providers we deal with. So, I guess the way we have it will work for everyone.

Andrew Truscott – Accenture - Co-Chair

Cool. Okay, guys. I'll call this one to vote. Have we got anymore discussion? Okay. Back to vote on these proposed amendments to recommendation five, those in favor, please say aye.

Multiple Speakers

Aye.

Andrew Truscott – Accenture - Co-Chair

Those against, please say nay. Those abstentions, please say abstain. It passes unanimously. Thank you very much. Let's move on. Okay. Health IT developer, certified health IT – we've added this paragraph to try and capture the sentiment that – the problem we've got is that 21st Century Cures has a definition of health IT developer and then it has enforcement activity to be taken about developers of certified health IT.

That is a slight mismatch, which might be deliberate. It might be inadvertent. One of the potential outcomes is that we could inadvertently create a group of IT developers producing

health IT that actively information blocks because they're not covered by the regulations, whether or not those enforcements associate with that, I think that's for ONC to work through, but you could create this privileged group that doesn't actually have to comply.

That, I think, is the last thing we want to achieve, which is allowing some developers of health IT to information block. The worst thing that could happen would then be people use that software over the provider and then they're found to be implicating information blocking because they're using software that information blocks, if that makes sense.

Michael Adcock – Individual - Co-Chair
John has his hand up.

Andrew Truscott – Accenture - Co-Chair
John, go ahead. Help me here, man.

John Kansky – Indiana Health Information Exchange - Member
I want to characterize this – and you tell me if I'm on the right path – this is further clarification and support for the position that we've taken on a recommendation that HIT developers should include, even those that do not have certified products, right? This is additional clarification and support for that recommendation. Is that true?

Andrew Truscott – Accenture - Co-Chair
That's the intent. Yeah.

John Kansky – Indiana Health Information Exchange - Member
Yeah. I agree with it.

Michael Adcock – Individual - Co-Chair
Steven Lane has his hand up.

Steven Lane – Sutter Health - Member
The very first line, I would replace the word and with or.

Andrew Truscott – Accenture - Co-Chair
Where is that? Sorry.

Steven Lane – Sutter Health - Member
The first line of the first paragraph.

Andrew Truscott – Accenture - Co-Chair
The bottom line is we want to have products which are beneficial to patients. We really want that. We don't want those products that have been information blocked.

Anil K. Jain – IBM Watson Health - Member

Andy, this is Anil. I completely agree with what is being said here. It's consistent with our prior discussions. Every time I read it, it seems a little wordy and hard to understand. Maybe there could be a way to make it more concise, but the vote is that this is what we send to the HITAC, I'm good with it. I just think that it is a lot of words for what we're trying to say. We're basically saying we want to promote innovation and we want to ensure that there is no second track for innovators to circumvent the information blocking rules. That's what we're trying to say here, right?

Andrew Truscott – Accenture - Co-Chair

Yes.

John Kansky – Indiana Health Information Exchange - Member

Yeah, I tend to agree with Anil that once I read this and understood what it said, I'm like, "Yeah, okay." I understand your thinking on this, Andy, or whoever contributed this text. I just think what we're really saying is that health IT developers that are not required to comply with this are given a safe harbor that is antithetical to the point of the regulation.

Andrew Truscott – Accenture - Co-Chair

Yes. That's the point. I'm rewording this a little bit on the fly to try and make it more positive. I think all of you are now on screen. Can you see what the markup is and see if you agree? I'm trying to make it more accessible and less very long sentence. You'd think a lawyer would have been involved in it, wouldn't you? So, the task force is concerned with promoting innovation and preventing barriers for entry for products that may have important benefits for patients.

The task force is also mindful that by limiting the applicability of the regulations that only develop as a certified health IT, there might be the unintended consequences of encouraging developers to not comply with the regulation, which could encourage information blocking practices amongst those non-regulated behaviors. Is that clear? I'll take that as a yes.

This coupled with a movement towards self-developers and operators of healthcare-related services could create a second track of non-compliant actors being detrimental to the integrated patient care and transparency we desire to foster and promote. Has anyone got any comments on those? I'm also reminded that with the approved recommendation change around health information exchange, those organizations who might developer IT and then operate it as a single platform could actually be taken inside that actor provision as well.

John Kansky – Indiana Health Information Exchange - Member

Andy, I speak American and not English, I don't know. But the fourth word right out of the gate being concerned with – I think we're really trying to say that we're in favor of promoting innovation, right? Thank you.

Andrew Truscott – Accenture - Co-Chair

The task force wishes to promote innovation and prevent barriers.

John Kansky – Indiana Health Information Exchange - Member

I'm good.

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

Me too.

Andrew Truscott – Accenture - Co-Chair

You know it's been hard for me to put Z's in words and stuff like that.

Steven Lane – Sutter Health - Member

We all appreciate your forbearance there.

Andrew Truscott – Accenture - Co-Chair

It's the internal dichotomy I go through with every document. Okay. What recommendation are we under right now? So, the health developer of certified health IT and our comments outlined in that – I'll go back to that section here. That's on the screen right now. It's in our precursor ahead of our recommendations. Those in favor of this update to the transmittal letter, please say aye.

Multiple Speakers

Aye.

Andrew Truscott – Accenture - Co-Chair

Those against, please say nay. Those abstaining, please say abstain. Okay. So, that passed. Okay. Recommendation seven, which is inside the practices that may implicate the information blocking provision. So, this is ONC seeking some comment from us around what we think might implicate information blocking.

The first segment we'd outlined was that whilst we have some definitions of actors as per Cures, it's the people who are introduced to our processing, accessing, exchanging, or using electronic health information, we believe they **[inaudible] [00:49:36]**. I think our update to health information exchange is assisted in including them right now. We have this recommendation severed.

There is some slight rewording of markup in here, just to say the definitions of actors is a necessary distinction for the purpose of identifying sanctions that could be levied and is the original intent to progress. We feel that with regards to information blocking, consideration should also be given to the nature of the information potentially being blocked.

Steven Lane – Sutter Health - Member

Are we really talking about the type of the information? Nature seems very fairly vague to me.

Andrew Truscott – Accenture - Co-Chair
This was an approved statement before. We can change it. We have approved it previously. So, what was your suggestion, Steven?

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
This is Mark. I just wanted to say this is a fine recommendation, but I do think that I don't know that there's anything in the rule that says we're not. The definition of information blocking is interference with the access, exchange, or use of electronic health information. We talked about that we'll be looking at both the interference, whether there's access, exchange, and use involved and whether it falls into the category of EHI. So, we are looking at the type of information. So, I'm not sure I totally understand this one.

Andrew Truscott – Accenture - Co-Chair
Well, the sentiment was only that what we didn't want to have happen was that we recognize an entity as information blocking, but they didn't fall into any definition of an actor and therefore it was okay.

Arien Malec – Change Healthcare - Member
Yeah. If that's what we mean, we should say that.

Andrew Truscott – Accenture - Co-Chair
Okay.

Arien Malec – Change Healthcare - Member
I'm just trying to make sure that payers and payer consumer technology vendors who are information blocking…

Andrew Truscott – Accenture - Co-Chair
Yeah.

Arien Malec – Change Healthcare - Member
Okay.

Andrew Truscott – Accenture - Co-Chair
Good morning, Arien, by the way.

Arien Malec – Change Healthcare - Member
It is morning.

Andrew Truscott – Accenture - Co-Chair
Help me with the wordsmithing for this one, guys – or not.

Anil K. Jain – IBM Watson Health - Member

Andy, this is Anil. I'm trying to understand what we're saying here. I'm struggling to understand. If we were concerned that someone who's information blocking who's not an actor – I'm reading this on the fly again.

Andrew Truscott – Accenture - Co-Chair

That's fine.

Anil K. Jain – IBM Watson Health - Member

Concern that entity who is considered an actor could be information blocking and not be implicated through non-inclusion as an actor. I don't understand what we're saying there.

Andrew Truscott – Accenture - Co-Chair

I was wordsmithing on the fly. The task force has said that an entity who is not considered an actor could be information blocking and not be implicated to non-inclusion as an actor.

Steven Lane – Sutter Health - Member

I don't really understand that, Andy.

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

From ONC's perspective, isn't the whole exercise we've been doing to identify those four actors and define them? So, we're just saying that anyone else could be caught up, even if they're not defined as an actor?

Andrew Truscott – Accenture - Co-Chair

I actually think that this recommendation, part of me actually thinks we can almost nullify this one because of the definition we now hold with health information exchange. Does that make sense?

John Kansky – Indiana Health Information Exchange - Member

It does. If we can do without this, I think it's less confusing to not have that in there. I apologize if this was – put this in the chat box a while ago –

Andrew Truscott – Accenture - Co-Chair

Oh, sorry. I can't see that.

John Kansky – Indiana Health Information Exchange - Member

No worries. I'm just making a positive point. I didn't know if it was discussed and I missed it, but the recommendation that we approved on the HIE definition has the additional benefit of something that had been bothering me, which is that all the providers that might also meet the definition of an HIE are now carved out of the definition of an HIE because they meet the definition of a provider. I think that's a great clarification. That was a huge backtrack. Sorry.

Andrew Truscott – Accenture - Co-Chair
It was channeling the inner-Kansky that was drafted.

John Kansky – Indiana Health Information Exchange - Member
You can have it.

Andrew Truscott – Accenture - Co-Chair
I went back through notes as I was drafting that and that was one of the comments you'd made earlier. Okay. So, recommendation seven I removed on the basis that because our recommendation was made on health information exchange, this one isn't actually required as a recommendation. I think the comment we've made around practices is still valid. We can leave that. Is that okay with people? Okay. I'll put it to a vote. All those in favor of removing recommendation seven, please say aye.

Multiple Speakers
Aye.

Andrew Truscott – Accenture - Co-Chair
Those against, please say nay. Those abstaining, please abstain. Awesomeness. I'm not going to go through these minor wordsmiths. They are minor. Recommendation nine, this last bullet point update just brings it into line with our health information exchange definition we've done above.

So, we're saying the parties implicated by the information blocking provision should be a provider, a health information network, or a health information exchange, a health information technology developer, or any other party who's using information technology to access, exchange, or use, EHI to provide information technology services or information technology.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Yeah, Andy, this one kind of confuses me a little bit as well. This is Mark. Isn't it just kind of reiterating your definition for the four actors?

Andrew Truscott – Accenture - Co-Chair
The point is if ONC doesn't take on board our recommendation around health information exchange, then this would be needed.

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

Andrew Truscott – Accenture - Co-Chair
Does that make sense?

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
I guess. Go ahead, Anil.

Anil K. Jain – IBM Watson Health - Member
I was just going to say it seems like, Andy, what you're saying is what our task force is recommending is either ONC adopt our prior recommendation or they adopt this recommendation, but not both because it will be quite redundant. Is that what you're saying?

Andrew Truscott – Accenture - Co-Chair
It will be duplicative. Yes.

John Kansky – Indiana Health Information Exchange - Member
Is that clear maybe at that point?

Andrew Truscott – Accenture - Co-Chair
Sorry. What was the point?

John Kansky – Indiana Health Information Exchange - Member
Anil, did you want to say something?

Anil K. Jain – IBM Watson Health - Member
That wasn't me, whoever was speaking a second ago. I was making the point earlier about either you pick that one recommendation or you pick this recommendation, but not both. I would be in favor of the other recommendation and take this one out so it's not confusing. Go ahead.

John Kansky – Indiana Health Information Exchange - Member
All I was saying was that – I think I agree with what you're saying – either take it out or just be clearer that this is like option B or it's not to be in addition to the other recommendations.

Steven Lane – Sutter Health - Member
I tend to agree.

Andrew Truscott – Accenture - Co-Chair
Is it recommendation one? How about that? Does that work?

John Kansky – Indiana Health Information Exchange - Member
But wouldn't that apply for all of the bullets?

Andrew Truscott – Accenture - Co-Chair
I don't think so. This is just around assigning policy definitions to the actors.

John Kansky – Indiana Health Information Exchange - Member

Wasn't that the whole point of the conversation about the definitions for the four actors, though? Isn't that essentially what you all were doing?

Andrew Truscott – Accenture - Co-Chair

I don't think quite the same way. So, this is us saying we think there's potentially confusion about what bucket people fall into. We believe that one of the intentions of Cures is – this sentence doesn't make sense.

John Kansky – Indiana Health Information Exchange - Member

I guess to restate what I'm confused about is I think what you're saying here is that these are the four groups that should be covered, but you're not providing the same definitions as you did when defining those actors. That was a bit confusing to me what the point is.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

Yeah. We should reference back to the way we defined it previously and not restate it.

Andrew Truscott – Accenture - Co-Chair

That's a good point. We could take this out. I just want to make sure we don't lose something as we take it out. We haven't been asked to define provider. We've only been asked to confirm. We could remove completely. Okay. What's the consensus of the group? Is the consensus of the group that we remove this recommendation completely or we wordsmith it into alignment with the previous recommendations?

Anil K. Jain – IBM Watson Health - Member

This is Anil. I would suggest we remove it.

Andrew Truscott – Accenture - Co-Chair

Anybody object to removing it?

Steven Lane – Sutter Health - Member

No objection.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member

No objection. We can just say we removed it because it was redundant.

Andrew Truscott – Accenture - Co-Chair

Recommendation ten, which was trying to give some greater specificity as to the real world organizational types who could potentially fall into the category of actors because we removed the previous one. I can't type this one. Okay. There were some markups to the last one here.

So, retailers who provide patient information services through IoT-type devices and services from connected consumer devices – there's just a markup to try and make that clearer

around the emerging group or organizations who use groups of IoT, whether they're medical IoT or whether they're consumer IoT devices. They will be implicated because they provide patient information services, not because they're selling devices.

Anil K. Jain – IBM Watson Health - Member
This is Anil. I'm struggling with the word valuable. I see it in a few different bullets. The word valuable just seems out of place. I think it's simply that this should be considered EHI. Once you've considered EHI, then it fits into all the other definitions, correct?

Andrew Truscott – Accenture - Co-Chair
Yes.

Anil K. Jain – IBM Watson Health - Member
Okay. The same thing with the pharmacy one too. We don't want to give anyone the impression that it's because it's valuable that we're suggesting –

Arien Malec – Change Healthcare - Member
Do we need this pharmacy bullet? I don't understand why we need a pharmacy bullet. Isn't it already covered in provider?

Andrew Truscott – Accenture - Co-Chair
No. They consider themselves not providers.

Arien Malec – Change Healthcare - Member
They are providers.

Andrew Truscott – Accenture - Co-Chair
I know they are. But they consider themselves not.

Arien Malec – Change Healthcare - Member
No, no, no. They're providers according to the definition that's provided under the rule.

Andrew Truscott – Accenture - Co-Chair
Not as a retail pharmacy. A pharmacy is, but not a retail pharmacy. There's a difference.

Arien Malec – Change Healthcare - Member
There what?

Anil K. Jain – IBM Watson Health - Member
This is Anil. I've heard the same thing. I'm not an expert, but I've heard the exact same thing as what Andy just said as well. I'm hearing it from people who operate retail pharmacies, by the way. That may be a little biased.

Andrew Truscott – Accenture - Co-Chair
But they have received solid legal opinions from their internal counsels and from their regulatory bodies telling them they are not considered providers in the same way. Arien, it doesn't hurt to say it, does it?

Arien Malec – Change Healthcare - Member
Well, it does because you could be presuming that they aren't.

Andrew Truscott – Accenture - Co-Chair
These are just examples of organization types who could fall into the various categories of actors. It's not exhaustive. It's not exclusive. Are you still considering this point or are you…?

Arien Malec – Change Healthcare - Member
I'm clicking through Cornell Law to find the definition and understand why anybody in retail pharmacy would claim that they're not a provider.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
While Arien's looking, just a plug – ONC, for some of our resources, on the NPRM website, we've put together a useful table that picks apart who are the entities that are defined as healthcare providers. I can send around that link, but that might be helpful.

Andrew Truscott – Accenture - Co-Chair
Yeah. The comment I've heard a lot of the time is that when the term pharmacy is used, what that means is an in-hospital pharmacy who is supplying medications across a few patient settings. A retail pharmacy is not included in that definition. I've heard this time and time again. Anil, you've heard it too. This came from another member of the task force originally.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
And for those online, I just added the PDF link to the chat box if you want to take a look.

Anil K. Jain – IBM Watson Health - Member
Mark, what page did you want us to look at in that document you sent over?

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
I guess I wasn't trying to take a position on the retail pharmacy. I was just saying more for future reference when you're thinking about –

Anil K. Jain – IBM Watson Health - Member
Got it. Okay.

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

Lead
This might be helpful.

Anil K. Jain – IBM Watson Health - Member
Sure. Okay.

Arien Malec – Change Healthcare - Member
Yeah. It does not hurt to clarify that we should probably note that they presumably are already included as pharmacies under the definitions.

Andrew Truscott – Accenture - Co-Chair
Is that a presumption or is that a, "We know that retail pharmacies are explicitly called out?"

Anil K. Jain – IBM Watson Health - Member
Well, it turns out – this is Anil – I just read the first slide of the deck, the link that Mark sent over. It does say that a pharmacy is considered a healthcare provider. But the word retail is not in front of it and I think it does help for us to get that clarified by putting this in there.

Arien Malec – Change Healthcare - Member
I would think pharmacy is a more inclusive term.

Anil K. Jain – IBM Watson Health - Member
I would agree, but…

Arien Malec – Change Healthcare - Member
But the definition of provider that it's linked to is incredibly broad and expansive.

Anil K. Jain – IBM Watson Health - Member
Exactly.

Andrew Truscott – Accenture - Co-Chair
I think that's why retail pharmacy has elected to interpret it saying it's very broad and expansive. They mean in hospital pharmacy. They don't mean us retailers.

Arien Malec – Change Healthcare - Member
Do you bill via Part D?

Andrew Truscott – Accenture - Co-Chair
I'm not arguing the fact, Arien. I believe they are. I heard this from at least three large retail pharmacy organizations.

Arien Malec – Change Healthcare - Member
I think there was an argument back in the day – we should probably just move on – but I

think there's an argument back in the day when you only billed through Part A and Part B that you couldn't include pharmacy, but once you establish Part D, it's hard for anybody to claim that they're not…

Andrew Truscott – Accenture - Co-Chair

I'll tell you what – for information blocking, we think the retail pharmacy should be included, correct?

Arien Malec – Change Healthcare - Member

Yeah. I just would make sure that we state that we believe that they're already included under the definition.

Andrew Truscott – Accenture - Co-Chair

Do we believe that insurance companies who curate medical histories, do we believe that they're already covered?

Arien Malec – Change Healthcare - Member

We do not believe that they're already covered.

Andrew Truscott – Accenture - Co-Chair

Okay. We'll take the word valuable out. Actually, just leave that. We recognize some of these organization types could be considered already covered by the regulators. That doesn't make sense.

John Kansky – Indiana Health Information Exchange - Member

Andy, just a suggestion – could you just clarify regarding retail pharmacy?

Arien Malec – Change Healthcare - Member

Retail pharmacy. I would clarify regarding retail pharmacy, just make the assertion that the task force believes that they're already covered under the definition provided.

John Kansky – Indiana Health Information Exchange - Member

It sounds like – I'm not trying to interpret – it sounds like what you're saying is pharmacy is clearly included in the definition and you include in the task force –

Arien Malec – Change Healthcare - Member

Retail pharmacy. That's right. Yeah.

John Kansky – Indiana Health Information Exchange - Member

Inclusive of that.

Arien Malec – Change Healthcare - Member

And we believe it's desirable to do so.

Andrew Truscott – Accenture - Co-Chair
Yeah. Does that make sense, Arien?

Arien Malec – Change Healthcare - Member
Yes.

Andrew Truscott – Accenture - Co-Chair
These updates are recommendation number ten. I'll give everyone – I think we've considered that to death. Those in favor of making these amendments, please say aye.

Multiple Speakers
Aye.

Andrew Truscott – Accenture - Co-Chair
I could feel the ayes getting wearier.

Arien Malec – Change Healthcare - Member
Exactly. They certainly are.

Andrew Truscott – Accenture - Co-Chair
Those against, please say nay. Any abstentions? Passed. Okay. Let's move on. There are minor markups to recommendation 12, just to remove the term involvement and just make it access, exchange, or use. That's a minor markup. I'm not going to put it to vote unless everyone fancies voting, which I don't think you do. Okay. What we've got highlighted in greens are ones which have already been approved and gone through HITAC.

The next major one to talk about is recommendation 33, which I know you're going to know and love, which is around basic access and value-added access for fees, etc. Arien, you had sent through some additional markups of this. Could you possibly talk us through that and I'll add it into this document?

Arien Malec – Change Healthcare - Member
Sure. Let me just make sure I'm looking at the one that I marked up because that would be useful.

Andrew Truscott – Accenture - Co-Chair
Okay.

Arien Malec – Change Healthcare - Member
This is the one that I marked up. Great. I can't look at my own markup. So, I put basic access with two sub-bullets. Sub-bullet one is the raw data, raw facts of the patient. It's the patient's medical record or designated record set. I made it clear that our reference to patients costing or pricing data use for decision making is as defined by the designated record set, which already includes patient-specific costing or pricing data. So, we're not

asserting a new add to that.

There was a concern raised during the HITAC meeting that as an industry, we don't yet know how to provide perspective through patient cost. It was important not to will it so by means of a definition, which is why this bullet is really referring to the raw data or raw facts. Those raw data or raw facts could be used in the process of driving pricing transparency and it would be desirable to do so, but the intent here is not, as I said, to will into existence a mechanism for doing so that doesn't exist.

And then sub-bullet two is transformation data required to implement standards. So, I didn't change any of this. Value-added access and exchange in use excludes any transformation, alteration, calculation, interpretation, transportation, etc. over and above that necessity to implement standards. I didn't change any of the sub-bullets there.

So, really, we're clarifying the distinction between basic access and value-added access. We're clarifying what's definitional under basic access and basic access will be a term where we'll be applying the pricing recommendations and value-added access, which is pretty much anything else. I will pause to make sure this is understandable. I know we had some struggles in the HIT advisory committee with people just understanding what it was we're actually talking about.

Andrew Truscott – Accenture - Co-Chair

Yeah. You'll also see me struggling getting **[inaudible] [01:18:09]** bullet points, etc. Can you just talk us through law, please?

Arien Malec – Change Healthcare - Member

There are a whole bunch of terms that mean relatively the same thing. I think, Andy, you've talked about source data. I intend the term raw data or raw facts as being basically the set of natural facts that per Supreme Court decision can't have IPR associated with it. A fact is weather is 60 degrees and partly cloudy today. You can't patent or copyright the temperature observation.

In many cases, patient data, we have a whole set of observations that are either covered by the designated record set or are raw data or raw facts. If there's a better term for raw data, raw facts, I'm happy to consider it, but it really is the blood pressure reading is X.

Andrew Truscott – Accenture - Co-Chair

Okay. What's a good way about capturing that.

Steven Lane – Sutter Health - Member

Are you contemplating that genomic data about an individual fits into that raw data, raw facts?

Arien Malec – Change Healthcare - Member

So, it already is part of the designated record set if it's used for decision making. But this is an

area where there may well be other applicable law. So, my understanding – I'm not a HIPAA lawyer, but I've read the regs a bunch of times and talked with many lawyers – is that the designated record set is intended to encompass everything used for decision making about a patient by a covered entity.

As you have patient-specific information that's used for decision making, it becomes part of a a designated record set. So, yes, absolutely. Again, it might be covered by other relevant law.

Andrew Truscott – Accenture - Co-Chair
I am still struggling with the term raw, Arien.

Arien Malec – Change Healthcare - Member
I'm happy to consider, contemplate any other – if anybody has a better term…

Andrew Truscott – Accenture - Co-Chair
Anybody?

Arien Malec – Change Healthcare - Member
I think the designated record set is actually a great term, but I don't think anybody understands what it is who's not a HIPAA lawyer or deeply immersed in this.

Andrew Truscott – Accenture - Co-Chair
I think I heard Anil just say designated record set.

Anil K. Jain – IBM Watson Health - Member
That wasn't me.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
The designated record set to us means something specific. So, I like the use of that. I agree that maybe other people who are not covered entities do not know what it is. So, I like the way it's framed right now.

Andrew Truscott – Accenture - Co-Chair
It's almost like we just say that.

Arien Malec – Change Healthcare - Member
The reason I expanded the definition is the designated record set has a meaning with respect to covered entities. It doesn't' have a meaning with respect to HINs or HIEs. You could say information that is or would be included in the designated record set.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support
So, Arien, this is Morris. Just to clarify designated record set, it's generally under the Privacy

Rule just a group of records maintained by or for a covered entity, just to clarify.

Andrew Truscott – Accenture - Co-Chair
So, it's not explicit in what the content is.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support
It is. I was just scoping it out for you.

Arien Malec – Change Healthcare - Member
That's the meaning with respect to covered entities. It doesn't have a meaning more broadly.

Andrew Truscott – Accenture - Co-Chair
Sorry, whoever is speaking, you are very, very faint.

John Kansky – Indiana Health Information Exchange - Member
It's John and I'm much louder now.

Andrew Truscott – Accenture - Co-Chair
That's better.

John Kansky – Indiana Health Information Exchange - Member
I understand the nuance of the designated record set. It doesn't define a specific set of data like USCDI would because designated record sets are in the eye of the covered entity.

Arien Malec – Change Healthcare - Member
They're not in the eye of the covered entity. So, the designated record set means a group of records maintained by or for a covered entity. That is the medical records and billing records about an individual maintained by or for a covered healthcare provider, the enrollment payment claims adjudication and case for medical management record systems maintained by or for a health plan or – so, part three, used in whole or in part by or for the covered entity to make decisions about an individuals.

John Kansky – Indiana Health Information Exchange - Member
I think that's an extremely helpful definition, but what I'm saying is when the covered entity applies that, it ends up being different specific sets of data. I see your point that it doesn't mean anything when you apply it to an HIE or HIN. I see where we're going. You're saying it's an accepted industry definition and we could say apply it to your circumstances.

Arien Malec – Change Healthcare - Member
The other way of doing this is to use the term record as defined in designated record sets. The term record means any item, collection, or grouping of information that includes protected health information is maintained, collected, used, or disseminated by or for a covered entity.

Andrew Truscott – Accenture - Co-Chair
If you're not a covered entity, then –

Arien Malec – Change Healthcare - Member
I know and understand. That's the reason to use a broader set of definitions because covered entities have meetings only in the context of a covered entity. I'm sorry. Designated record set only has meetings in the context of a covered entity.

The simplest way to address this is to, rather than try to define it, we just punt all the hard work to our friends at ONC and say we think there should be a distinction between basic access and value-added access and basic-basic access would include such things as objective observations, items that are covered that are part of the designated record set for covered entities or similar items that are processed or managed through an HIE.

But really, use that as a subtext and say, "Look, we just think that ONC should make a distinction – basic access that has higher protections associated with it and value-added access to which market rates are determined," and give some helpful placeholders for how to define this term. Ultimately, ONC is going to have to find an operational definition for what it is that we intend. We can do all the work or we can make ONC do all the hard work.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Arien, this is Mark. Just so I understand, given that I'm going to be one of those people that would be working through all this – essentially, what you're saying is that you want the designated record set without the clarifying language about FHIR 4 covered entity. Isn't that essentially what you're saying?

Arien Malec – Change Healthcare - Member
Yeah. I think that's right. But I think the higher point, regardless of the definition, is that the task force, and I believe the committee, believes that there should be a distinction between value-added services and basic access.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Right. Yeah. I'm just trying to understand – at the core of what you're saying is it's really important to understand what basic access means.

Arien Malec – Change Healthcare - Member
Refers to. Exactly. I think the designated record set definition gives you everything you need except for the limitations.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
If the group agrees with that, I would suggest explicitly putting that into your recommendation as the definition or at least noting that in some clear way.

Andrew Truscott – Accenture - Co-Chair
Arien, I've been playing about with drafting as we've been talking. It seems to me that if you're a covered entity, we mean the designated record set, right?

Arien Malec – Change Healthcare - Member
That's right.

Andrew Truscott – Accenture - Co-Chair
Okay. That's where I'll fit that, that first statement in there. If you're not considered a covered entity, what do we think it should be?

Arien Malec – Change Healthcare - Member
It is the data that – I have to go through all my tabs to get back – it's the data – if we're not a provider, if we are a health developer of health information technology, an HIE or HIN, right?

Andrew Truscott – Accenture - Co-Chair
Yeah.

Arien Malec – Change Healthcare - Member
And if it's a payer, then we already have a good definition. We're okay there. Pharmacies are covered entities if they transact for Part D. So, if their entity is not a covered entity, then let's just apply the definition without the restriction of the covered entity.

Andrew Truscott – Accenture - Co-Chair
That's the definition that you gave us previously. But that's got the term raw in it.

Arien Malec – Change Healthcare - Member
It does not have the term raw in it. The definition of the covered entity, I'm saying we suggest applying or ONC might consider applying 164.501, whatever the hell this is.

Andrew Truscott – Accenture - Co-Chair
Someone help me with the drafting. I'm trying to draw this out separately.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support
This is Morris again. Can I ask a quick question?

Arien Malec – Change Healthcare - Member
Sure.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support
Part of the definition of the designated record set for non – I just need some clarification

here. Part of that definition is making decisions about the individual. Are you suggesting that non-covered entities will have the ability to make decisions about the individual? I'm just trying to see how it all fits in. I'm just asking.

Arien Malec – Change Healthcare - Member

It is a great question. This really applies to HIEs or HINs that aren't making decisions, aren't acting as covered entities, but all the data they have is either by definition value-added services or effectively copies of the data that come from the covered entities. This was really intended to cover the copies of the data that come from the covered entities.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support

I think if you clarify that, I think if you add some color to that, I think that would be really helpful considering Mark and I will be looking at these recommendations.

Andrew Truscott – Accenture - Co-Chair

Okay. Given what we've got on the screen right now, guide me on how you want to update this.

Arien Malec – Change Healthcare - Member

I would say the task force recommends that ONC distinguishes between basic access and value-added access exchange and use. The task force suggests that ONC… Yeah.

John Kansky – Indiana Health Information Exchange - Member

Is it basic access or is it access to basic data and the access to value-added data?

Arien Malec – Change Healthcare - Member

Well, it's access to basic data and the use and exchange are generally value-added services unless they're essential in our definition for the functioning of the certified health information technology. So, getting the data to Surescripts – you can't have any prescribing module if you can't get the data to Surescripts.

But general transport, I'm going to help you get the record from point A to point B. I'm going to help you get a lab record from the lab to someplace else, generally is not part of providing basic access. Particularly, a lot of use is value-added capability.

Michael Adcock – Individual - Co-Chair

We have a helpful public comment that we may want to consider here.

Andrew Truscott – Accenture - Co-Chair

I'm sorry.

Michael Adcock – Individual - Co-Chair

There's a helpful public comment that has been submitted.

Andrew Truscott – Accenture - Co-Chair

Okay. I can't see those. Can somebody read them?

Michael Adcock – Individual - Co-Chair

It says the proposed definition of basic access would seem to include clinical notes. Since they are not facts, that doesn't seem consistent with the basic goals of the rule. Notes are part of the designated record set with decision making. Why have the raw clause at all?

Arien Malec – Change Healthcare - Member

I think that's where we're going right now. So, thank you, public commenter. And then I'd say if an entity is not a covered entity, the data is not considered a covered entity, but is making clinical decision making, the same definition without restriction to covered entities. And if the entity is an HIE or HIN, then we're talking about the data that was collected from or managed on behalf of the covered entity, the designated record set information that was collected from and managed on behalf of the covered entity.

Andrew Truscott – Accenture - Co-Chair

Okay. What was the other one?

Arien Malec – Change Healthcare - Member

So, we've got three domains of potential actors or four domains of potential actors. We've got providers and providers are either covered entities or they are covered entity-like. And so, in the case where they're not covered entities because they don't do HIPAA transactions, then we just want to apply, for purposes of information blocking, the designated record set definition to them.

And then we've got the cases of developer health information technology, health information exchange, and health information network. In those cases, what we're talking about is the data managed by or collected from the provider or other actors that is or would fall within the definition of the covered entity, as broadly defined – sorry, designated record set, as broadly defined.

Andrew Truscott – Accenture - Co-Chair

Where is the designated record set and covered entity properly defined? Which CFR?

Arien Malec – Change Healthcare - Member

The CFR is…

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support

45 CFR.

Arien Malec – Change Healthcare - Member

45 CFR 164.501.

Andrew Truscott – Accenture - Co-Chair
Is that happy?

Arien Malec – Change Healthcare - Member
I think Claudia would be pleased that that definition includes billing records, enrollment payment claims adjudication records.

Andrew Truscott – Accenture - Co-Chair
You mean Cynthia.

Arien Malec – Change Healthcare - Member
Cynthia would be, sorry.

Andrew Truscott – Accenture - Co-Chair
Claudia is probably pleased as well. Okay. So, we've got covered entities, which includes payers and providers. If you're a provide actor that's not a covered entity or designated record set – we've got HIE and HIN. What do we do with HIT developers? I don't think we have that issue, do we? They're marked up inside there, the last point.

Arien Malec – Change Healthcare - Member
I would say it's under bullet three, "If an entity is considered HIE/HIN or developer of health information technology, the information is collected on behalf of the covered entity or other…" And then the information that's collected on behalf of the covered entity or non-covered entity provider.

Andrew Truscott – Accenture - Co-Chair
Just provider, just covered entity or non-covered entity.

Arien Malec – Change Healthcare - Member
Well, we don't want to limit to the provider because we also would include payers with the HIE and connecting payers.

Andrew Truscott – Accenture - Co-Chair
Exactly. Yeah, and basic transformation of data required to implement standards – I'm not keen on the term basic here, but I think that might be something for ONC to wade through.

Michael Adcock – Individual - Co-Chair
Just a note – we got another public comment that said, "Might a simpler proposal for basic access be retrieving existing data or a representational transformation of existing data?"

Andrew Truscott – Accenture - Co-Chair
I think the term representing transformation could be tricky. Is that syntactical, semantic, or both? Notwithstanding also the goodness that comes out of USCDI like contextualization, etc.

Part of me is wondering whether we should be hanging this around USCDI definitions as opposed to –

Arien Malec – Change Healthcare - Member

There were many people that would be happy if we hung it around USCDI definitions.

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

I like that. I like that concept.

Andrew Truscott – Accenture - Co-Chair

Like everybody else.

John Kansky – Indiana Health Information Exchange - Member

The problem with hanging it on USCDI is it's not yet sufficiently broad and it's going to take us years to get there.

Arien Malec – Change Healthcare - Member

This is the conundrum that we're in is that the law required access to all information. USCDI is not all information. It doesn't include multiple data classes that I think multiple actors want to make sure get included.

John Kansky – Indiana Health Information Exchange - Member

So, I think hanging it on designated record set is the best compromise we have for now.

Andrew Truscott – Accenture - Co-Chair

I'm making this note here. Do we note that the emerging definition of USCDI may provide a useful way of constraining basic value-added access in the future?

Arien Malec – Change Healthcare - Member

Yeah.

John Kansky – Indiana Health Information Exchange - Member

That's fair.

Michael Adcock – Individual - Co-Chair

Andy, this is just a reminder – we've got public comment in six minutes.

Andrew Truscott – Accenture - Co-Chair

Thank you, sir.

Michael Adcock – Individual - Co-Chair

I would encourage Daniel Carnese to speak up verbally when the public comment session

begins.

Arien Malec – Change Healthcare - Member
I just want to comment internally that when we're going through these deliberations and it's really freakishly hard that we have sympathy for our ONC colleagues.

Andrew Truscott – Accenture - Co-Chair
Don't tell them that.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
We encourage all the sympathy.

Morris Landau – Office of the National Coordinator for Health Information Technology - Back-up/Support
I concur on that one.

Arien Malec – Change Healthcare - Member
Plus, the reality is that it's rare that people get that mad at us and everybody in the world gets mad at our federal –

Andrew Truscott – Accenture - Co-Chair
We just have to try harder. Okay. The task force – I'm just going to put this markup which we've gone through fairly exhaustively now. I know we've all been thinking about it, so, I'm happy to put this to a quick roll call vote. Those in favor of the markup as it's currently sitting, please say aye.

Multiple Speakers
Aye.

Andrew Truscott – Accenture - Co-Chair
Those against, please say nay. Those abstaining, please say abstain. Okay. Thank you very much. Let's try and move through any other – there really weren't many other changes. We removed recommendation 48 because it was just around our thoughts around TEF.

John Kansky – Indiana Health Information Exchange - Member
That was the one – just for everyone's clarification – there was a request for information in the assurances and condition of certification regarding the trusted exchange framework. The recommendation was very similar to the other recommendation in the exceptions section.

Andrew Truscott – Accenture - Co-Chair
It was identical. So, we removed it. Recommendation 52 – here is the markup which failed to get into what we put in front of HITAC. We promised Raj faithfully we would get his sentiments in here and we thought we had already. Here's the markup around fair use

around screen shots.

We just have the understanding that any actor disclosing the screenshots is responsible for communicating that each use is to be put to fair use as opposed to ensuring that each use is put to fair use. Has anyone got any concerns over that markup? I'm not going to put that to a vote because I think we've already voted on that. It's already improved recommendations. I just want to make sure that we reflected things correctly.

I think that might be it. In which case, we can go to public comment right now.

John Kansky – Indiana Health Information Exchange - Member

Andy, before we open up to public comment – we can do it after public comment also – do you want to recap what our plan is between now and Wednesday?

Andrew Truscott – Accenture - Co-Chair

We'll do that after public comment.

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

Thanks, Andy. Operator, can we open the line?

Operator

If you would 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-two if you would like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the * keys. Our first comment comes from Daniel Carnese with Patient Precision. Please proceed with your comment.

Daniel Carnese – Patient Precision - Chief Executive Officer

Good morning, everyone. I appreciate the effort that you all are going through to try to get these definitions. I think the last thing was probably the most important of all of the topics. I think the idea of having basic information be, strictly speaking, a syntactic transformation of the conclusions that have already been made, I think that really gets at the intention of what you're going for.

What we don't want is to have a situation where there is a value-added service, whether it comes from a person or software. This information access is supposed to mandate triggering. So, when we say that, just for example, you have an advanced AI-based service, that is doing something more than providing a representation transformation, a syntactic transformation of the information there. That's what we want to be value-added.

But if an AI program has already made a conclusion, it's already been paid for one way or another, just as a doctor's conclusion has been paid for, then I think it makes sense that once that information has been explicitly inferred, put in the record, that should be part of basic

access because it wouldn't be right to have to pay multiple times for the same inference, whether it's from a person or from software. That's the end of my comment.

Andrew Truscott – Accenture - Co-Chair

That's very helpful. Have we got any other comments?

Operator

There are no further comments at this time.

Andrew Truscott – Accenture - Co-Chair

Okay. Let's discuss that inside the task force. Team, would anybody object to actually capturing in that definition we have of basic access, where we talk about basic transformation of data to actually say basic syntactic transformation of data?

Steven Lane – Sutter Health - Member

I think that's reasonable.

Andrew Truscott – Accenture - Co-Chair

Arien?

Arien Malec – Change Healthcare - Member

All basic transformation of data?

Andrew Truscott – Accenture - Co-Chair

Yeah.

Arien Malec – Change Healthcare - Member

So, any work that I do to map, for example – the conclusion of that is that any work that I do to map, for example –

Andrew Truscott – Accenture - Co-Chair

Semantics, basically.

Arien Malec – Change Healthcare - Member

Yeah. So, it turns out to be kind of hard to map from, let's say, I've got a service right now that maps from NCPDP v. 1 claims into 837 claims. Now, the service does other stuff, but that mapping of NCPDP v. 1 to 837 is a valuable service. It would be deemed a basic service and deemed to be available at no cost if we go with that approach.

Andrew Truscott – Accenture - Co-Chair

Basic syntactic mapping but not semantic. So, let's say I've got a lab interface that has some localized lab terminology being used. The actual syntactic mapping of that lab interface to LOINC would be included in basic, but the semantic terminology translations would be value-

added.

Arien Malec – Change Healthcare - Member

So, what I'm talking about – I don't think that distinction drives the distinction of basic and value-added. I don't believe that all syntactic transformations are basic. The way that we intended to cover this is via the subpart relative to the transformations that required to make it available via standards so that if I maintain my own private medication terminology or use one of the standard medication terminology vendors and I transact for e-prescribing, the transformations required to express our ex-norm and NDC codes need to be included as part of the definition of basic access.

Andrew Truscott – Accenture - Co-Chair

What we're struggling with here is –

Arien Malec – Change Healthcare - Member

But not all standards and transformations. The standards and transformation required to make the certified information technology work.

Andrew Truscott – Accenture - Co-Chair

There's some syntax and semantic – some syntactical transformations are simple and some are complex. Some semantic translations are simple and some are complex. So, it's probably not fair to say that all syntactical are basic and are semantic are value add.

Arien Malec – Change Healthcare - Member

Exactly.

Andrew Truscott – Accenture - Co-Chair

Daniel, do you have any additional comment on that?

John Kansky – Indiana Health Information Exchange - Member

I think he's typing – he said, "Is there a reason to include basic?" "No, I think you've covered it." He just typed.

Andrew Truscott – Accenture - Co-Chair

Basic is important because basic and value add are the two categories where we're saying fees should be considered. If you're basic, then it's basically a cost approach, whereas if it's value-added, then its' more of a market rate-driven approach.

John Kansky – Indiana Health Information Exchange - Member

He said you covered it. I think he's good with it based on the chat.

Andrew Truscott – Accenture - Co-Chair

Well, we haven't made a decision yet. We're still working it out. Right now in our drafting, we haven't got this nuance and I'm not sure how we can reflect the nuance because it is

somewhat subjective around what is simple and what is complicated.

Arien Malec – Change Healthcare - Member
As I said, I think the way that I intended to address this is to say I don't care how simply or complex it is. If you have certified health information technology that's been certified to – or a health information network or health information exchange that's been certified to standards, then it's on you to implement those transformations. That's not an extra cost that you can charge.

Andrew Truscott – Accenture - Co-Chair
But to our points we were making earlier, we might not have certified health IT.

Arien Malec – Change Healthcare - Member
Say that again.

Andrew Truscott – Accenture - Co-Chair
To the points we were making earlier, we might not have certified health IT. It might be health IT, but it might not be certified.

Arien Malec – Change Healthcare - Member
Right. I think our definition contemplates, back to our definition – I think our definition is accommodating that. Let me get my copy of it.

Andrew Truscott – Accenture - Co-Chair
It means we can't rely on certified health IT and therefore complying.

Arien Malec – Change Healthcare - Member
Our definition right now says, "Transformation data required to implement standards (from the core standard list," reasonably required to exchange or implement the intended use of a certified technology. So, you're saying –

Andrew Truscott – Accenture - Co-Chair
And then you've got an example. Yeah. But we've updated based upon Daniel's comment right now – so, it says basic syntactic transformation of data required.

Arien Malec – Change Healthcare - Member
I think we should remove that.

Andrew Truscott – Accenture - Co-Chair
What about this thing, task force?

John Kansky – Indiana Health Information Exchange - Member
I'm not really sure what I'm saying here, but listening to this conversation about syntactical

versus semantic, introducing either of those terms seems to be troublesome.

Andrew Truscott – Accenture - Co-Chair
So, keeping it to basic, which is inclusive, and complex for value add. Then I'm sure Mark and Morris are going to ask us further questions in the future to help them define those out.

Steven Lane – Sutter Health - Member
Right. But in the end, we're making a recommendation to ONC. The more clarification we provide up front, perhaps the less work they have to do, but in the end, they have to get this right and it will go out for public comment and we'll have another crack at it.

Arien Malec – Change Healthcare - Member
It will not go out to public comment.

Steven Lane – Sutter Health - Member
No?

Andrew Truscott – Accenture - Co-Chair
Okay. I think we leave it as it is. I think it's going to come back around to us further to help ONC with this definition and this whole section.

Arien Malec – Change Healthcare - Member
The typical process is NPRM to the final rule. The only path where there would be additional public comment is if they release it as an IFR.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
Just to clarify from ONC, that's right. We have the public comment period now. It's been extended. Once we receive those comments, we review them, assess them, and then update and make a final rule.

Andrew Truscott – Accenture - Co-Chair
Magic. Okay. Task force, thank you very much for your contributions over the last few weeks and months. It has been thoroughly enjoyable, sometimes frustrating for us all, but I think we've actually come back to a series of recommendations which are seeking and really in line with what Cures is looking achieve and will have demonstrable improvements for patients, for those who – to use our own terms, for those purchases and payers around their care and actually for all the participants in the healthcare ecosystem. Has anybody on the task force got any closing comments as we sign off?

Arien Malec – Change Healthcare - Member
No, here, here.

Anil K. Jain – IBM Watson Health - Member

Thank you, guys.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
Thank you so much.

Mark Knee – Office of the National Coordinator for Health Information Technology - Staff Lead
This is Mark from ONC. I just want to say from our perspective, ONC, the amount of work you all put into this, the quality of the recommendations is really much appreciated. On a personal level, I've enjoyed talking to you all very frequently over the last couple of months. So, thank you. As far as timing goes, Andy and Michael and I are going to work on updating the transmittal letter and hopefully get it out soon so the HITAC can review it prior to the votes on Wednesday. So, thanks everyone.

Arien Malec – Change Healthcare - Member
Thank you.

Andrew Truscott – Accenture - Co-Chair
Thanks so much, team. Have a great day.

Sheryl Turney – Anthem Blue Cross Blue Shield - Member
Thank you.

Anil K. Jain – IBM Watson Health - Member
Thanks, everyone.