



**HIT Policy Committee
Interoperability & Health Information Exchange Workgroup
Final Transcript
May 14, 2015**

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon, everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Interoperability and HIE Workgroup. This is a public call, and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking, as this meeting is being transcribed and recorded, and I'll take roll. Micky Tripathi?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative
Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Micky. Chris Lehmann? Arien Malec? Barclay Butler?

Barclay P. Butler, PhD – Director of Health Standards & Interoperability – Department of Defense
Present.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Barclay.

Barclay P. Butler, PhD – Director of Health Standards & Interoperability – Department of Defense Hi.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Barclay. Beth Morrow?

Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership
Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Beth. Brian Ahier?

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yes, I'm here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Brian. Carl Dvorak? Dave Whitlinger? Hal Baker?

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Present.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Hal. Jitin Asnaani?

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

Here—present.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Jitin. John Blair? Kate Kiefert? Kitt Winter?

Kitt Winter, MBA – Director, Health IT Program Office – Social Security Administration

Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Kit. Landen Bain? Larry Garber? Margaret Donahue? Melissa Goldstein? Nancy Orvis? Shelly Spiro?

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

I'm here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Tony Gilman? Hey, Shelly.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Hi.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Tony Gilman?

Tony Gilman – Chief Executive Officer – Texas Health Services Authority

Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Tony. Troy Seagondollar?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Troy. Wes Rishel?

Wes Rishel – Independent Consultant

Here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Wes. And from ONC, do we have Kory Mertz?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

I'm here.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Hi, Kory. All right, back to you, Micky.

Karl

And Michelle, this is Karl, I just joined in a moment late while you were doing roll call.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you, Karl.

Karl

Thanks.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great. Good afternoon. Thanks, everyone, for joining. Today we're gonna go over the comments that we got from the Policy Committee. There were a number of them, and I want to dive right in to see if we can resolve some of the things that we've got back.

We've got, on this call, which is really our only call to resolve some of these issues and get back to the Policy Committee, we've got, there's gonna be a call with the Policy Committee on May 22nd to sort of just hammer out some of these last remaining things that each of the workgroups had and we'll share with you in a minute what comments we have and what things we need to go through on this call today. Next slide, please.

So, the meeting—overall, it went very well, I think, the Policy Committee meeting, and for the most part, we had, as you know, I think, a lot of recommendations in there, and a complex web of things. We've included, at the back of this presentation the actual presentation that we did, so you have all of that for your reference. And you know, and I think, judging by—they didn't take a formal vote, but based on the comments that we got back and the things we were asked to look back at, the vast majority of things that we proposed, I think, are on their way to recommended. You know, it could be but for the final vote, be considered to be recommended. There were a couple of issues that—you know, that we were asked to look at, again, based on people's comments, and then one new issue that we need to look at.

So, these were—you know, sort of the six of them. I think some of them are relatively easy for us to go through. There are two, I think, that are probably gonna stay—well, two, maybe three—that will take a little bit more time. The first one, and this is one we'll spend a little bit more time on, is, we had an extended discussion on our recommendation to not allow the inclusion of “selfies.” So, you know, of all of the things we were proposing, I didn't really expect this one to be one that we ended up spending a lot of time on, but we ended up spending a fair amount of time on it. There were some—and it was hard to sort out, and after I go through this, I'm gonna ask Troy and anyone else who is on the Policy Committee to weigh in with their thoughts, you know, on this as well.

I think it was hard to disentangle from the conversation how much of the questions and comments we're getting back were related to just a little bit of confusion of the scope of, you know, of selfies and, you know, what it means to be on the same EHR, you know, is this about care coordination in general, or is it just a very specific case of people being on the same EHR? There was just confusion there, and it was hard to sort that out—versus others who seem to be genuinely sort of questioning and perhaps opposed to the recommendation that we were making. So I think all of that was flying around, and we want to sort of address the issue, but also do what we can to clarify and hone in on exactly what it is we're talking about so we can communicate that in a better way than we were able to the first time around. So you'll see, we've asked Kory to pull out some of the old language so that we can make sure that we're absolutely crystal clear in what it is we're saying.

With that, I think we are. I think it's a—my personal view is that it's really just a communication issue at the end of the day. There may be a couple of people who disagree with it, but it seemed that the overall sentiment was in favor, you know, once you sort of tease out some of the confusion that was circling around the issue.

The second thing that came up was, you may recall that on measure 3, which was the information reconciliation, we had a recommendation in there that CMS should consider making certain types of exclusions for particular specialties, for example, or certain scopes of practice for which the information reconciliation requirement may not apply. Maybe they're low prescribers, maybe it's other things. We were asked if we might have any additional thoughts on some criteria for determining which specialties should be excluded from measure 3. So, you know, to the extent that there are people on the phone who have some further thoughts on how we might be able to give at least a little bit more guidance on that, I think we can offer that. We don't have to figure the whole thing out; I think that we're just asking for a little bit more specificity, if we had some thoughts.

The third one, which I think is gonna take time—so number one, I think, will take a little bit more, a little time for us to discuss, and number three is gonna take a little time for us to discuss. The Consumer Workgroup recommendation was—and we didn't talk about this in our workgroup, but for those of you who have read through the entire NPRM, you may recall that in the consumer engagement section, there is a requirement that eligible professionals or eligible providers receive and incorporate—and I think, Kory, am I right is it 15 percent?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yes, 15 percent.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, it's for 15 percent of their patients, they have to receive and incorporate information from so-called non-clinical settings, and I'll put that in quotes because the scope of it actually isn't non-clinical settings by any way, definition of that, but that's what they call it. And so basically, it means that a combination of patients and, essentially, non-meaningful use eligible clinical entities, or non-clinical entities, so that would include LTPAC, home health care, physical therapists, anyone else who might be able to send information can send information, and the requirement was that, for 15 percent of your patients, you have to receive and incorporate that, and patients generate information counts toward that 15 percent.

Well, the Consumer Workgroup made a recommendation that said that that be split up into patients and everything else, and they further recommended that, for patients, they want to set a 10 percent requirement for patient generated information—that's not something that we're gonna look at here, although we've been asked to look at it, but it is related to something else. And then what they did is, they said, "For everything else, we think that that ought to be kicked over to objective 7 and the IO Workgroup to weigh in on, you know, how they would recommend incorporating that within sort of the framework." So that's gonna take us a little bit of time because that's new territory for us, but that's what we need to discuss a little bit.

The fourth one was a very specific question related to reconciliations happening prior to the patient visit, and should that count for measure 3. I think that our view would be yes, and maybe we would just need to provide, you know, CMS with some—with the recommendation that they should provide some specificity on that so that people aren't confused on that. We can come back to that in a second and perhaps deal with that one right away.

The fifth one was about how our transfer referrals counted if the patient doesn't show up for the appointment. I think we've already taken care of that in that the, it's already clear that if the—it's based on encounters, so, and that's going back to the specification from Stage 2 that if the patient doesn't show up, it doesn't count. So I think that that one's taken care of. I don't think we need to discuss it any further, unless anyone else would like to.

And then finally, we'll come back to this one, because I think it's a pretty easy one to address, but there was a question related to data segmentation certification and how that might sort of help in this conversation. It was in the selfies conversation, but it was a transition of care, you know, generally. And I think that, specifically, we were waiting for the selfies, but it was a little bit confusing exactly what the question was. I think we have one slide on that that we can discuss. I don't think that there's a whole lot there for us to discuss, if I'm understanding the question correctly, but we can come to that.

So that's, those are the things that came up, you know, small and large things for us to discuss. I guess, let me just see if we can just knock off at least—number five, I think, is knocked off. I don't think that we have to do anything more there. Number four, I think that the right approach on that—and maybe we can actually just go to the next slide, because I think you have this on the next slide, Kory, if I'm not mistaken.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, so our sort of straw responses here—and we'll go through this in greater detail—for number one, for selfies, I think that probably we're, where we would suggest—we meaning Chris and I and the others, again, a straw response for all of you to weigh in on is that we probably want to stick with the current recommendation and just provide some additional clarity and explanation. We have a few slides to talk our way through that.

The specialist exclusion criteria, we can spend a little time talking more about that if people have thoughts, and then number three, I think we want to spend a little bit more time on it. We have some slides for that.

The reconciliation timing—and I guess a straw recommendation here would be that we just request that CMS clarify that reconciliation can be done in advance of the visit and should count for that particular, for that particular episode. There is nothing—Kory did go back and look at stage two—it's vague in stage two, as well. I don't know how that, how people have been handling that, you know, operationally. Maybe Karl or, you know, Brian or some others who were on the ground to can, you know, can sort of provide us with some clarification there. So maybe we should talk about that one first.

Male

Clarifications specifically on what, Micky? I want to make sure—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I'm sorry, yeah, it's number four. It's, there was a question about whether reconciliation would count if it happens in advance of the visit.

Male

It can't—go ahead, _____.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I think we all—I assume we'd all agree that it should count, but, um, but we couldn't find anything in stage two that says it counts, and perhaps we should just tell CMS that they should clarify that.

Male

There's a blizzard of interpretation in some of these regs, but we—we looked at it as, if a visit occurred and the reconciliation was done relevant to that visit, be it the day before or whatever, it still counted.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep.

Wes Rishel – Independent Consultant

Can I ask a question? How was reconciliation done before our visit? What is the input that is used to—to perform the reconciliation? It's against other notes received electronically, or, or—

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

So this is Hal. What'll happen is, the patient will get a discharge med list from the hospital and you have your outpatient med list and you reconcile the two. I think the reason we tie it to a visit is, of course, that reconciliation of meds, which is what we started, tends to be done with the patient, because reconciling the med list without involving the patient doesn't accomplish much, whereas the problem list and others, it's a bit different.

Wes Rishel – Independent Consultant

Yeah, well, that's why I'm asking the question, really, is—I mean, I think the counting algorithm that Karl described is certainly one that's defensible. I just, I just am wondering if a group of unbiased physicians would think that was meeting the overall objective of medicine reconciliation.

Karl

Well, Wes, what happens sometimes, and it's not—this is not just medication reconciliation, right, this is the whole C-CDA hopefully getting reconciled. So, one use case is, you're being pushed to C-CDA for a new patient and you're a specialist, and you're sitting there, you know, the evening before looking at your next day's schedule and you pop open this patient who's brand new to you, and you want to get at least a basic understanding of what your time tomorrow looks like. You might pop that up, and you might say, "Okay, yeah, this all looks good, it's a good set of data, I'm gonna go ahead and load this in and reconcile it into my chart so that tomorrow morning when I start my day, what came in on the C-CDA is, now it fills out the problem list, med list, allergy list. I'll still have my, I may ask the patient if they're taking all those meds religiously and comment on compliance and stuff, but because that reconciliation was done the night before, you know, it's still being done for that encounter or that visit." So—so we, we found that there were a number of situations like that, where it's not—you know, surely, it's in the spirit to count that, and we didn't find situations where somebody would be reconciling stuff for no good reason such that it shouldn't count. So we—you know, our interpretation was that it met the intention.

Male

Yeah.

Wes Rishel – Independent Consultant

Yeah, and I think, and that wouldn't be at the expense of, obviously, involving the patient for the purposes of medication reconciliation specifically, but even in that case, that's a great example that Karl just gave, but there's many more examples as well. And you know, in clinical practice, I think that, you know, best practice would certainly be that we're, we're going to, you know, ask the patient, are they on new medications, and verify the medication reconciliation that actually may have already occurred, and in some cases, you know, I know for family members, you know, we're asked to bring in all the medications. The bottle—they want to actually see the bottles because, you know, sometimes for patient that are on dozens of medications, the patient may not actually be the best source of truth from their own memory.

So, be that as it may, I think that, you know, considering that this is reconciliation for not just medications, but even for medications specifically, probably some—some clarity from CMS that, that this could happen actually prior to the visit, and it would still count. And I think—I think that my interpretation is, it does, but I'd hate to get into a situation a couple of years from now where we have to request an FAQ from CMS to get clarification on something that could be brought into rule making now.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right, so it sounds like, you know, we don't—because again, we don't have to spend a whole lot of time on this. It sounds like we want clarification, and it sounds like, operationally, that's kinda how it's happening anyway, so it would be great if CMS just clarified it.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Micky, this is Shelly Spiro.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

I'd just like to comment on this, too. One of the, under the Medicare Part D program, and one of the call letters for 2014 that CMS did was, under care coordination, was working with pharmacy to do, prior to the annual wellness visit, that the pharmacist would do the medication reconciliation in connection—as part of the comprehensive med review, and then communicate that with the physician as part of their annual wellness visit so that those can also be counted. Where—and we interpreted it as the one prior to the visit but meant as part of that annual wellness visit. See, and that's where the part D program recognized that.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. Okay, great. Actually, that's great to know. That's another—another example where there is sort of a precedent there.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

This is Hal. The one other thing I would add is, the medication list is the only part of the record, I think, that the patient controls the accuracy of, because ultimately, no matter what's prescribed, the patient ultimately decides what they are taking, and so the truthfulness of the med list is the one thing that is really patient controlled.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. Okay, great. So, is there any other—I mean, I think what we can say here, if everyone is in agreement, that CMS really ought to clarify this and we could, you know, sort of just point out that, operationally, it seems like these, you know, that these are being counted as a part of stage two and so it makes all the sense in the world for them just to clarify it.

Okay, great. Why don't we move to the next slide now, and then we can dive into some of the details. Ooh, this is a small, small print slide—hold on. So, let's talk about the selfies question. So, the selfies questions—this was, Kory had pulled out the FAQ language that was used in stage two that established sort of the selfie principle. And why don't we move to the next slide, because I think that's where it has the—you know, the specific language.

So I've highlighted in red the specific language here, which was an answer—ah, wait a minute, so this is, I'm sorry, this is the NPRM facts. Why don't we—why don't we back up for a second.

So this is where, in the, in the FAQ language, it first established that selfies would count, and I'm trying to find the exact language where it actually says—sorry, go ahead.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

It's the bolded language, Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Oh, okay, you've already highlighted it. Sorry, Kory.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah—no, no, no.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, so in the bold language, if the receiving provider already has access to the cert, meaning that they're on the same EHR of the initiating provider of the transition or referral, simply accessing the health information does not count toward meeting this objective. However, if the initiating provider also sends a summary of care document, this transition can be included in the denominator and the numerator, as long as it is counted consistently across the organization. So, for measure one, a summary of care document—now, this is measure one, measure two going back to stage two, so let's not get confused—let's not get confused by that.

So—so basically, what it said is that, if you, that you can exclude those transitions from the, your numerator and denominator, or you can count them, but if you count them, you have to send the C-CDA as if you were sending it to any other entity. But this—this was dealing particularly, specifically with the case where everyone is on the same EHR, right, so the integrated delivery network case.

So our recommendation _____ and the next slide shows the, highlights the text from the NPRM, and it basically says the same thing. They basically say, “We allowed this in stage two, we are now going to—we did it as a part of an FAQ; we are now going to sort of instantiate that.” And so our recommendation was to actually go back and suggest that, no, maybe you shouldn’t allow those. That’s—I think we have that in the next slide, if I'm not mistaken. Oh, okay, so I didn't—I forget which slide _____.

So, so—so what we had recommended was that they not be allowed for the reasons that we discussed. It seems to give a disproportionate, you know, sort of advantage to large, integrated delivery networks, which is where this would—which is where this would occur. That it doesn’t offer anything additional to, to the quality of care, and that, to the extent that we wanna make sure that this kind of care coordination is happening within an integrated delivery network or in the same EHR, that there are better tools for doing that than having people sending e-mails to themselves, and especially, as I think someone noted in the pre-call, than sending multi-page C-CDAs to themselves, which is, you know, probably not the best way for doing that.

So this slide—I'm sorry that Chris wasn’t able to be on the call—this was, this was a slide that Chris added where, you know, it was his sense that, during the Policy Committee discussion, the argument was made that selfies would improve information exchange at the time of referral, and then, as he says, this argument, as a powerful meme, has no supporting evidence. On the contrary, if a receiving physician with access to the patient’s record can’t be trusted to review the patient’s most recent history, there’s even less likelihood that he or she will be able to review the C-CDA. And you know, and as he argues, you know, we should be separating the issue of managing referrals within a delivery system versus sending information to an outside provider.

Let me—let me go to the next slide. I should say that I also did call on Neal Patterson, who is on the Policy Committee and is the CEO of Cerner, and—you know, and then sort of just turned to him and said, “You know, it seems like there are better ways of doing this within an EHR than having this e-mailed to yourself,” and he agreed. You know, he did speak up and say, you know, this is—that he supported, actually, the, our recommendation here to not allow selfies. That’s essentially the argument, that within EHR, there are better ways of doing this.

So, some questions, I think—let me, let me pause here, first off, and see if, you know, Troy, you were there, and if any others were there, if, you know, if I've explained this right, and if you have any further perspective to offer, here.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

Yeah, this is Troy. I agree with you. I mean, what you're stating is spot on as far as what the, the confusion level was. I think what people were, were looking at was, they—you know, in stage two, we were, the purpose and goal of stage two was entirely different than what we're looking at at stage three, and performing selfies within the integrated delivery network where the data is, is readily available, is the point where people were kind of confused about it.

The, if you're on the same EHR system, which is to say, "I'm on an Epic system, and the person that I'm referring the patient to is on an Epic system, but we don't share the same database," then yeah, the C-CDA would be, would be invaluable in order to pass that information on. That would count; that's not truly, you know, a selfie. But if we're both on the same system, I can see the information, they can see the information, and it's, say it's a transfer from one ambulatory provider to another ambulatory provider, that does nothing to enhance interoperability, which is the stage that we're in.

And so that, that big, the grand scheme of sharing information across systems, I think, was the missing link that people didn't capture.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, um—thanks. Thanks, Troy.

Brian Ahier – Director of Standards & Government Affairs – Medicity

So this is Brian. I think, to me, the confusion seemed to be around just Troy's point, and maybe the clarification we can bring is around—you know, the specific language that we want to put in our recommendation on not necessarily, not that you're using the same EHR system or platform, which may not particularly call out what we're talking about, but that the information is available in the same database or the same EHR instance. And I think that's the clarification that, eventually, was, was brought out in the Policy Committee meeting and that maybe we need to include that in our recommendation.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Wes Rishel – Independent Consultant

This is Wes. I want to wait until all the Policy Committee members have shared their recollections, and then I have a question. Hearing no one?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep, go ahead.

Wes Rishel – Independent Consultant

They—hearing the game of telephone from the meeting that I didn't attend here, it strikes me that there must have been some people arguing that the, uh, sending of the CCA created an event which is not very important if this is a referral, because there is an event, the patient's gonna show up. However, if this physician is the primary care physician doing physician care coordination, then—then there is an issue of them knowing something has happened. Now, I think there's probably conflation going on, on five dimensions in that, but, but, but—it does seem that perhaps the question is, is this related to physician care coordination, or is it related to referrals? If it is related to physician care coordination, which has got a big increase in emphasis thanks to, thanks to Medicare, do we, do we need to somehow address that?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, and, and Wes, I think that's a good point, and that's actually on slide eight here is, that's sort of what the first question was getting at. So I think you're right, I think that once we boil down and distill, you know, to the people who are asking, who understood completely what the scope of this was, and who were still asking questions about it, the argument was—and I had a side conversation with one of the Policy Committee members who did understand this, and the argument was exactly what you're suggesting, that, that even though the information is available in the EHR, the clinician, let's say, let's say it's a hospital discharge. The ambulatory clinician does not necessarily know that, that the patient has been discharged, and by pushing the C-CDA to them, that acts as an alerting mechanism about that event, and that will trigger them to then go into the EHR and look at the information that is available in the EHR.

Wes Rishel – Independent Consultant

Yeah, no, I'm skeptical—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Have them look at—

Wes Rishel – Independent Consultant

- I'm skeptical that a selfie generates an event in the in basket of anybody, but, but I guess that depends on how the systems are being implemented at different, different [Cross talk].

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, and that was—that was the argument that was being made.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Well, and this is Hal. You know, there are two different issues here, which is—one is between systems where the documents are meant to transmit information so that care coordination is even possible, because you have no visibility to the other care environment because you don't have the same record. Then the other is triggering the need for care coordination in the absence of a culture of communication where people are sometimes too busy to communicate and coordinate even the big systems.

The CCD document and the HIE methodology is, is a pretty blunt and ineffective tool to accomplish that. It will do it, but it's a lot of work for a pretty simple idea that could probably be handled in a more elegant fashion. But the other part is, if it lets you meet—as I think David Bates said, if it lets you meet the objective, because 90 percent of your referrals are internal to your system, then you may not get good at the referrals outside your system where it is most dangerous.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. I think that's a great point. And, and really, if 90 percent—I mean, you know, there is an exclusion for fewer than 100. Now, granted, for a large system like Partners, you know, 10 percent is, is still probably gonna be over 100. But, that said, I think that there was a sentiment among other people, I think that, exactly what you say, Hal, that if this prevents you from, from figuring out how to do this in the right way, then, then it means you're just not gonna do it, and the case is outside of your system, which is probably where it's most needed.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

[Cross talk] This is Larry Garber. Sorry I was late on the call, but—and regarding Wes’ point, which I respect, and regarding the PCP who’s trying to coordinate care, there are much better ways for me, as a primary care physician, to, to then assess, you know, a referral that took place, you know, or a visit by one of my specialists, you know, instead of getting this, this solid, nonfunctional consolidated CDA document, you know, I’d much rather go look at the med list in my own med list, and the allergies in my own allergy list, and my own, you know, problem list where things are hyperlinked. In other words, you know, the electronic health record is a living, hyperlinked document where this, you know, where the C-CDA is essentially a snapshot, or maybe the table of contents to everything behind it, and it’s much more effective for me to use the tools that are built into my EHR, you know, taking this table of contents and drill down into wherever I need to go, as opposed to receiving some static document that, you know, really doesn’t help me coordinate care any better than, other than just alerting me, and there are better ways to alert myself within the EHR that—than that.

Wes Rishel – Independent Consultant

Right, Larry, I think there’s no doubt that there’s a better mechanism. The question is just, is that requirement to alert a physician of a change—and it may, it may not, it may be that a referral happened, there may be other, other things. But is that a goal that should be monitored through meaningful use or not, and I, I’m suggesting, I guess I’ve come to the point of saying, if, if it wasn’t the intent of—you know, if you trace back through the levels of, of, of goals, objectives, and so forth, if that wasn’t an intent, we shouldn’t try to introduce it.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. I think that’s a great point, Wes, and I think you’re right. That is, you know, sort of the last remaining issue on the table, here, and I guess the argument I would make, and I think Larry—sorry to cut you off, I think you had a comment—but it seems to me that the argument on that ought to be (a) you don’t want to sort of say, “Well, that wasn’t the intent, so we shouldn’t be—you know, it’s sort of non-germane in this discussion.” But also, as we move increasingly into value based purchasing, that’s where the push for that, you know, really starts to come into play, and most appropriately, _____ comes into play there. But Larry, I’m sorry, I think I cut you off.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Yeah, no, I was just gonna say, I think CMS has it covered that the specialist needs to send me some sort of notification because they won’t get, they may not get paid for their visits if they’re not, you know, in coordination with me. So I think, through their E&M coding processes, they, they may have that part covered.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. So, it sounds like—it sounds like we’re in agreement, here, on (a) that we should be, you know, that we should clarify exactly, the narrow use case that we’re talking about here, the very specific use case, and perhaps the recommendation that CMS makes sure that they clarify as well so that we’re talking about people being on the same EHR system and the same database, the same EHR instance where they have the same, ubiquitous access to the information, all—you know, and _____.

Everyone, we're talking about people all having the same access to the information, and that there are essentially three points here. One is that, as an alerting mechanism, it may not be a very good alerting mechanism, and it's not the right way to do it anyway, and it's not the original intent of the measure, so we shouldn't be sort of justifying it on that grounds anyway. And that, second, that it doesn't have any—the clinical information is best gotten through the EHR and not from the documents being sent; and third, that, in excluding these, it does have the positive, you know, aspect that it does force those organizations to be thinking outside of their organizations for whatever level that is, the 10 percent or whatever, to be able to make sure that the care coordination is happening at the edges, as it were.

And in the case where it really is a small number, there always is the exclusion for fewer than 100 transitions referrals on the other side, so for people who find that it really is 99 percent happening internally, it would have an exclusion on the measure, anyway. Are we in agreement on that?

Wes Rishel – Independent Consultant

Yes.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Great. Let's move to the next issue.

I think the consumer one is gonna be, is gonna take us a little while, so let's look at this one. This is the question of the specialists and the exclusion criteria for measure three. So—and again, just recalling what we recommended, we recommended that CMS ask the question, so this was in response to a question. The NPRM, they don't have any exclusions or any special provisions for particular specialties. There is an exclusion for—no, actually, for the med rec, there is no exclusion allowed. Actually, there are literally zero—it doesn't have the low volume exclusion in any way, like it does with transition of care, for example, so there are no exclusions allowed right now.

So, we recommended, and CMS asked the question—should we think about treating different specialties differently, and if so, how should we think about that? We recommended that yes, you do, and we pointed out that there are low prescribers, there are others that have such a narrow scope of specialty that it may not be appropriate for them to be doing information reconciliation on all three of these dimensions, and that they should do that. They—the recommendation from the Policy Committee was that we see if we can take that down perhaps one level lower in terms of providing some guidance or some criteria. So, we don't have to answer, provide a complete answer, that's CMS' job, but to the extent that we have any additional thoughts on this, I think that's, you know, sort of the spirit in which that request was made to us.

Then, and you know, and I—the second bullet is, I would recommend that this be based on objective criteria, that we not try to go down the path of saying, “Well, orthopods, yes, you're all, you know, excluded, [Laughter] and the other specialty, and that specialty”—I think it ought to be more on objective criteria rather than, you know, pointing out particular specialties and getting into that game.

Some—you know, some possibilities, and I think we discussed, I went back and, you know, and listened to what we had discussed before and looked at my notes. Some of the things that we had discussed at the time were perhaps any EPs who have a very low prescription volume, for example, is there's something to say about scope of practice that isn't, you know, calling out particular specialties. You know, third would be that we call out specific specialties—I don't think that makes sense, but I'm happy to have the conversation. And I guess it does—let's note, the measure already includes a proposed exclusion for providers who have less than 100 referrals. Is that true, Kory? I don't think that's—

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, it's in there.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

It is in there? Okay, all right; then that's my mistake. I'm sorry, I thought there was no exclusion for reconciliation. So I guess that is in there if you have fewer than 100 referrals.

Wes Rishel – Independent Consultant

Is that referrals in, or referrals out?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

This would be for referrals in, because you're doing—this is for measure three, which is the reconciliation.

Wes Rishel – Independent Consultant

Okay, and then I'm just curious, how will it distinguish whether the patient self-referred themselves in, unbeknown to the primary care doctor, or whether they did refer themselves in, considering CMS has gotten away from the consultation referral codes.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, that's interesting. Now, now we, we—you may recall, as a part of our recommendations, which no one asked us anything about, we did recommend that they take out, that they take out this never before encountered thing, because—and I think we had this conversation in the workgroup—that you don't have anything to reconcile against, so we had recommended that—except for whatever the patient expresses. So we had recommended taking that out, so if we remain true to that, this would exclude those cases.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Now, Micky, there is, as I recall, I mean, for the reconciliation portion in stage two, there was a stipulation about relevance, so it was, it was based on the provider's interpretation of the relevance of the referral. I mean, is that—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Now, as I recall, that—and I think that carries over to stage three, and someone correct me if I'm wrong, that where they allow discretion for relevance is in essentially how much reconciliation you do, but it's not about whether you're required to do any reconciliation, it's about how much you, you—you need to do, let's say, with the entire med list. I think that's what it was, but I may be wrong on that.

Male

So, Kory, is there—do you have any enlightenment to us on that? Is this a rollover from stage two?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Uh, I'd have to double check. My recollection is the same as Micky's, that it's more focused on the information to be incorporated rather than the instances, but I can pull up the measure and double check.

Male

Because you know, that's—when we discussed this, I mean, we were looking at, you know, the examples of, say, an ophthalmologist reconciling a problem list or reconciling, even, a medication list, there's no relevance to the referral. You know, they would do some portion of that; does that count as reconciliation, if they focus on things that are relevant to the referral request?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. You know—you know what I recommend on this one, if everyone's okay with this? I would suggest that we can get that information from Kory and we take this as an offline activity, because it's a little bit open-ended, and as I said, there's no firm conclusion that we have to come forward with here. They were just asking if we had more thoughts, and it might be something that, if people have a little more time to think about it with the additional information, we can get some framing, you know, sort of thoughts and collect that offline. Because we don't have to—the Policy Committee call isn't 'til a week from tomorrow, so we have a little bit of time, here, but I want to make sure that we get to the consumer conversation, because that's new and it is, you know, somewhat specific. So, is everyone okay with that, actually, if we take this one offline?

Male

Absolutely.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. All right, why don't we do that, then?

Male

There's no other way to do it at this point. I mean, the only alternative is, like you said, I mean, call out each and every specialist, and that's just not feasible.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, and it'll start a war among the societies. [Laughter] Next slide, please.

Male

My armor's wearing thin, so let's be careful.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

[Laughter] Okay, so here we are at the Consumer Workgroup recommendations, and what we have, this was a—this is a table that they provided, and option B was their option here. So, if you recall—and we're looking at measure three on this table. So, for 15 percent of unique patients, either patient generated health data, or data from a non-clinical setting is incorporated in the EHR. That's what the NPRM says right now, and the recommendation that was approved by the Policy Committee was the recommendation from the Consumer Workgroup, which was that the split out PGHD—it's patient generated health data, I think—that you split that out and that you make that a 10 percent requirement for patient generated health data. We may disagree with that, but we actually haven't been asked to comment on that, so let's not comment on that. [Laughter] But the modification, also, was approved, which was essentially to turn it to us. Which was to say, "Hey, move data from—move that part which is about data from a non-clinical setting over to us, to the HIE objectives." So that's what we've been asked to comment on—how we would incorporate that within the recommendations that we have made.

Okay, so that's what we've been asked to comment on. Let's just remember that originally it was 15 percent that includes everything—patient generated health data or non-clinical settings. The Consumer Workgroup is saying they want to have a 10 percent requirement just for patient generated health data, so now we've been asked about the rest, so let's now move to the next slide.

So this is just saying what the definition of non-clinical is. Basically, if you're not an EP or you're not an EH, or a critical access hospital, right? That's it, so it's long term care, home health—everything else would count as non-clinical, but in this case, importantly, patient generated health data would not count, from our perspective, because that's being now treated separately. Next slide, please.

So this one is to remind you of what recommended on measure two, because it does, it is—it is germane in this. So, a couple of the things that are relevant here—so, first off, we recommended, you remember, there was the incorporate measure, just to remind everyone of what that conversation was and what we recommended. Incorporate originally was that you, for 40 percent of unique patients, you had to incorporate information from another setting, and it had to be a C-CDA coming into you. So, one of the things that we recommended first off was lowering the threshold from 40 percent to 25 percent. Just because it was a brand new measure, we thought that 40 percent was too high. We also said that you ought to have some discretion in what to incorporate rather than saying you have to incorporate the full CCDS that comes at you.

We agreed, in allowing active versus passive receipt, meaning that you could either query for it and then it comes back sort of as solicited information coming back to you, or it could just be something that's pushed to you, like for measure one as a part of a transition of care. We—the never before encountered, I don't think, is necessarily germane here, but we recommended allowing the never before encountered and the measure dominator. We allowed, we agreed with allowing the exclusion for information unavailable, which is, I asked for information of an LTPAC provider, let's say. They say, "I don't have a C-CDA to give you," and you say, "Okay, great, that's an exclusion for me."

And then, we also added allowing for queries outside of specific transitions and referral episodes. That is where I'm in a system or I have the ability to query outside of a particular transition and then get something back. That was actually, we got some very positive feedback on that one, so people liked that one. And then we had an exclusion—and this is one that's important here—we recommended allowing an exclusion for transitions or referrals from entities not using certs. So the argument here was—and this, we didn't have a phone discussion on this, we did this over e-mail, but the argument here was that, unlike measure one, where I can push things to people and get credit for it, and all I'd have to do is know that they received it, and what we saw operationally in the real world was that there was a way to bootstrap that for people who didn't have cert. Namely, large providers, for example, were purchasing web mailboxes essentially—direct, capable web mailboxes for a long term care provider, for example, so that you could push a C-CDA to them and they would be able to view it. And there were—you know, operationally, we saw that people were able to bootstrap that on the market and so that's why, with measure one, we said, "That's great, they should continue to do that."

On this one, it's a little bit different, because now I have to be able to receive a C-CDA and, in the vast, vast, vast majority of cases, if that sending provider is not on cert, they're not gonna be able to send me a C-CDA. So that's why we recommended allowing an exclusion for transitions for referral that were coming from entities not using cert. That's important in this conversation, because now we're being asked to weigh in on the question of having some kind of credit in the measure or receiving things from organizations that, by definition, almost by definition are not gonna have cert, unless they have just decided on their own to get cert.

Utilization alerts—the last two aren't germane to this particular conversation. Okay, so I just wanted to remind everyone of what we had recommended. Next slide, please.

So, this is that number seven, which I think is most—you know, most related to this question, which is that allowing the exclusion for entities that are not using cert. Basically, what we said is that the current—and I think I went over this, actually, so I don't think I need to go over it again. So, yeah, it's just the last two bullets.

So the other thing that we did note is that there is exclusion for information unavailable, so if you think about this problem, that I've got a large, a large number of non-clinical—meaning they're not EP or EH—transitions that are coming at me. Most of them are not able to deliver C-CDAs. I could, under the exclusion for information unavailable, use that as a way of getting, you know, getting that out of my denominator, but I would literally have to make the request for every single transition. And what we were recommending was that we allow an exclusion for known entities so that I don't have to ask that long term care provider every single time they send something to me. I know, as the recipient, that long term care provider does not have cert. I know it, they're in my community, so let me figure out the exclusion based on an entity, known entities rather than a transition, but it will be up to a receiving provider to do that. And it will be up to the receiving provider to attest that that sending provider does not have cert, right? So that was basically the argument there. So let's move to the next slide.

So, the request now to us is, how would we incorporate, within measure two, this idea that non-clinical entities, that we have to have some fraction of our, our transitions coming in, that some fraction of them ought to take into account the non-clinical entities that have been left over from—you know, from the Consumer Workgroup. So I think that there are three general approaches we can take to this, and I'm gonna pause and, and open the discussion, here.

So, one would be, you know, sort of what I call the uniform approach, which is basically saying, “Just remove the C-CDA.” You can remove the C-CDA restriction on incoming transitions and just say, “Just count everything. Count whatever comes in.” If it’s a physical therapist and they send you something electronically, and it’s a .pdf, that counts just like the C-CDA that comes from the EP, you know, we’ve got to measure, we’ve got to measure 25 percent, everything counts, and—and then just let the market sort it out.

The second approach would be—now that, what that doesn’t do is, it doesn’t, you know, get at the spirit of what that measure was getting at, which was getting information from non-clinical entities, right? Because you still could meet that requirement if you did it that way without any non-clinical—so-called non-clinical entities.

The second and third approach get at this thing as saying, “Well, the spirit of that was to have these non-clinical entities.” One could be a two-tier kind of approach where you set an overall threshold, and then you have some specific requirements related to non-clinical entities. So, for example, you could say, “I should be receiving something for 35 percent of patients, and then, but—and 10 percentage points of that, so 10 percent of the 35 percent, has to be from non-clinical entities.” And, from those non-clinical entities, it doesn’t have to be a C-CDA, right?

It’s kind of complicated. It’s even complicated to say, but that could be one approach to doing it. The other would be that we could just add a fourth measure that deals specifically with the non-clinical entities, so that says, you require providers to receive and incorporate data during, let’s say, 10 percent—I’m just throwing out a number—of transitional referrals from non-clinical settings. The incoming message doesn’t have to be C-CDA, because most of them aren’t gonna be on cert. It just has to be accessible to the EP within the EHR and then, and then I think, you know, we might want to add that messages from non-clinical settings ought to count against, you know—or messages from non-clinical settings from, you know, measure two. So, let’s say I did get a C-CDA from, from a long term care provider—that ought to be able to count against this 10 percent in this measure, and—and then maybe, you know, we could say the providers would be required to meet three out of four of the measures now rather than making this a requirement. Remember, they only have to meet two out of three of the existing three, so this is a, given the option of meeting three out of four.

I’m sure there are many other ways to look at this—yeah, go ahead.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Yeah, Micky, this is Shelly Spiro.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Question—how would an entity that is using an intermediary or translator work into this? So, as an example, so much of what we do when we’re prescribing is, you know, the intermediary has been certified to make that transmission. Would those count—on behalf of a provider?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

[Cross talk] I mean, as long as you’re getting a C-CDA, a C-CDA that is, according to the specifications, regardless of how it got to you, that you could count that against measure two.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Well, that's a good thing.

Male

So, you—okay, wait a minute. So, we're not suggesting a secure portal, we're suggesting that it could be fax, e-mail, snail mail, pigeon? That seems a little loose.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Well, that—that is what it is now, so if you remember back to what the original measure was, the original measure said 15 percent of what—I need to take in, for 15 percent of my patients, information from non-clinical settings, and it said it can come in any form. It could be .pdfs. That would count toward the 15 percent. I just had to be getting information on 15 percent of the patients.

Male

So there's no way to measure that. I mean, this is going to be an attestation. I'm—I'm just kind of at a loss as to how you measure this.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

This is Larry. I'm at a loss as to why we would even do this. I mean, this is really crazy. You know, we're trying to—you know, you know, incentivize physicians, you know, and hospitals to receive something that, you know, through other measures they've already implemented the ability to receive, and you're incentivizing them to somehow, I don't know, coerce these non-clinical or non-eligible professional, non-eligible hospital to extend us something. You know, we have the capability to do it. The focus should be on incentivizing them. There should be—the government should be, the government should be doing whatever they have to do, whatever levers they've got to incentivize long term post-acute care and other—you know, other pieces that help their system to, to send stuff to us.

You know, this will be completely rebelled by everyone in the health care system, saying, “You're giving us another requirement which we have absolutely no control over.” And we've already done what we need to be able to do. Our door is wide open, our mailbox is wide open—we can't force someone to do something, no matter how much you pay us.

Male

Well, and I think it goes along the lines of saying, “Okay, I've created a secure portal, which I share information with the patients.” And why can't these—I have a problem with the non-clinical definition, by the way, I just, that'll be my comment.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep.

Male

Why are we not giving that same access to non-clinical areas in order to send us information? That we can it can be actually captured electronically and monitored and reported upon. It just doesn't make any sense to me.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, so taking that example just for a second, just so we're understanding this, so let's say we have given, you know, a direct compliant portal to a long term care provider. In this scenario, they—if they sent me a .pdf via that, that would count toward this, in principle. If we went with something that said, "It doesn't have to be a C-CDA, it just has to be something" and they're a non-clinical provider.

Male

Right, I get—yeah. Okay, that, that would be acceptable, I understand that. But what about the other forms—I mean, fax and mail and—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yes, so I mean—Kory, does it have to be electronic? What is the requirement on that, on the 15 percent? Does it have to be transported electronically, is it one of those things that it has to be electronic, but it can be any electronic means?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah, I don't think it got into the specificity on that—on that side.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So it literally could be a fax?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

I—I think so.

Male

Micky—

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Now, you've got to remember, too, you're incorporating this into the HIE objectives now, though, so you should think about what the requirements are from the framework in the HIE objectives, I would say.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right, but it sounds like no one has the appetite to raise the requirement [Laughter] that is coming in.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Micky, this is Hal.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Could you remind us what the denominator of which we're talking 15 percent is.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Fifteen percent of all patients, so 15 percent of unique patients.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Okay, so here's the—here's the difficulty here is that, of the patients I see, only a percentage of them see anybody else during the year. So, say 50 percent see somebody else that year—of the 50 percent that see somebody else this year, a quarter of them, you know, or 50 percent see somebody who's a non-clinical provider. Of those non-clinical providers they see—now we're down to 25 percent of my panel. Of the non-clinical providers they see, only a portion of those have the ability to send me stuff, so we could get down to where I need to get 15 percent out of the 17 percent of my panel sending me stuff, and I have to have a process that's 80 plus percent reliable. So this is the same thing about, you know, 35 percent of patients messaging you. Well, if you've only got 40 percent of your patients signed up on the portal, you have to get over 80 percent of your patients who are on the portal and capable of messaging you to message you.

So this is when we're, I'm worried that the denominator is dramatically outside of the possibility.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right—that's a very good point.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

This is Shelly. I have another question, and maybe this—you know, where pharmacy's involved, in terms of now we're, you know, proposing some of the bidirectional exchange of information such as our exchange and _____ cancel, which would then be coming from a non-eligible provider, would that be considered this type of information, or is that all just a link to the e-prescribing?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

That's a good question. I actually don't know. I think that that would be considered a non-clinical setting. I don't know—Kory, does the language say anything about that? It just says non-clinical settings and it gives a few examples—I didn't see pharmacy on that list. That doesn't mean it's not included, but the list wasn't—you know, wasn't comprehensive.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yeah.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

And—and that goes to the same thing. What if we're talking about, you know, medication reconciliation that the pharmacy is providing, they discuss the meds with the patient and reconcile the med list, has sent it over to the—to the physician for their, you know, for their use. Would that be considered this portion of it? But I'm more interested in the e-prescribing question because our exchange and our _____ questions that are coming back from—coming from the pharmacy to the physician to clarify the prescription.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right. So my guess is that that would count. We can—we can ask that CMS clarify that, but so, so then, but so—let's just take that one off the table so we can ask them to clarify that, and it seems like it would count.

But getting back to this question, then, that a couple of people have raised in different ways—you know, it sounds like, just remember where we are here. There was 15 percent originally required; if you take that 15 percent of unique patients, two-thirds of that has essentially been taken care of by the Consumer Workgroup. That's another way to think about it. Because they said, "Well, peel off the patient generated health data, and make that a 10 percent requirement." So, if you're gonna go back to that 15 percent, well, there's like a 5 percent or one-third of the 15 percent is now left over, and to Hal's point, that could really be, you know, even that could be difficult, and it's a very small percent at that point. And then to Larry's point, saying, "Why are we even getting into this, of segregating these out?"—I mean, does it make sense for us to really say, you know, essentially go along with half of point one, which is to say, just to be allowed, just encouraging people to send stuff, to get whatever they can.

And so one—one way of looking that would be that we recommend removing the C-CDA restriction, because that would open it up to being able to count these so-called non-clinical entities. If we did that, I would suggest that we probably, if we're gonna keep in good spirits with this, suggest raising the recommendation of the threshold from what we had. Because remember, what we said is that we should lower it from 40 percent to 25 percent.

Now, we have an exclusion for the so-called non-clinical entities. We had recommended having an exclusion for those. We could recommend, "Well, let's not have an exclusion for those, then, but remove the C-CDA restriction and raise the threshold a little bit."

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

Micky, this is Shelly. I have another question on this non-clinical setting. Would querying a registry also for, let's say, immunization information, be considered one of these non-clinical settings?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I [Cross talk]—no, I don't know. I assume it would, the clinical information on the patient. That's a good question. We could ask for that clarification, too.

Male

I—I don't think it would, because it's a provider.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Oh—oh, oh, oh. That's a good question. You mean, because it's in response to a query?

Male

Well, no, because it's—so it's, non-clinical means as a setting with any provider who is not an EP eligible hospital or a critical access hospital. So a registry isn't a provider.

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

No, but the—but the public health department that's receiving the information, let's say, from the pharmacy that's provided the immunization, or even the pharmacy that has provided the immunization is now sending it to the physician. But the way that—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, so why don't we ask—why don't we ask for clarifications on these things. I think—I think that makes a lot of sense for us to ask for the clarifications, and these are two really good examples, Shelly, that you brought up.

But—but going back, then, again to this question of, you know, how we want to treat this—first off, do people agree with Larry's point, which is that we shouldn't be segregating these out. You know, thinking of, and getting providers into the mode of saying, "All right, now I have to get a certain percent from non-clinical entities, and then the rest from—from wherever I get them." First of all, how do people feel about that point? Because that separates approach one from approaches two and three.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

This is Hal. I'm very worried about that because I'm trying to think of what percentage of all patients have a contact with a non-clinical provider to even have the possibility of doing it, and I'm very worried about that. I would assume the ONC would at least need to know that.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep.

Male

Yeah, but it's pretty unlikely that, that they would see anybody that's not affiliated with the provider anyway, so that is a difficult proposition.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. Does anyone—would anyone argue for the proposition that we really ought to be, you know, having specific sort of subtargets here for so-called non-clinical settings?

Male

Well, I'll tell you, I would really like to see, you know, the information shared between the providers and these, these defined non-clinical areas.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Male

But I just don't know how that would play out. Without—without a defined method of doing so, it's just all over the map.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right.

Male

And taking that and incorporating it into the medical record, I mean, that really doesn't, it doesn't—I don't know how you would, how you would attest to that, how you would actually do a capture point for that. I don't know how you would do it.

Beth Morrow, JD – Director, Health Initiatives – The Children’s Partnership

Yeah, and this is Beth—I, I'm sitting here trying to figure out how to make the goal of this make sense and I agree that it, it's opening up a serious problem. The aim—I think the aim is, is good and well intentioned, but the way it plays out doesn't, doesn't really make sense to me. And I'm thinking that there are other ways that this can be sort of addressed, like you know, the—the information about members of the care team that's in the C-CDA and, you know, other things like that, that aim at making sure the provider can find this additional relevant information from other settings when it exists, but not presuming that they're gonna force people to send it to them.

Male

Right, right.

R. Hal Baker, MD – Vice President and Chief Information Officer – WellSpan Health

Hal here, again. Would—would setting the denominator as being the patients to whom the eligible provider has needed referrals to a non-clinical provider, and then getting back from 15 percent of those, would that be, perhaps, a different way to do it? Then at least we'd know that everyone in the denominator was possible to be in the numerator.

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

Hi, this is Jitin. I—I think that that is, we are trying to _____ a way of getting accepted this issue that oftentimes a patient could end up in a non-clinical care setting, or have data available in a non-clinical care setting without there actually being a referral in place, and we wouldn't want—we'd want to encourage that that sort of data be shared and not precluded from a measure like this. So I also sit on the same fence that I don't think that it should be a target for a non-clinical care setting data, but I do think that it should be explicitly called out as a legitimate source of data that providers should be encouraged to get data from.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

All right, so if we go down that path and say that it's a legitimate source, then it opens up, do we say it's legitimate only if they send a C-CDA? Because if so, then we're just back in the same world that we are already, and, and we have the exclusion that's allowed if they don't have cert. Or we open it up and we say, “No, the way to open this up is to allow them to send it, you know, anyway. It doesn't have to be a C-CDA, they could send any format.” It raises the question, though, of how would I actually count that? I would have to have some, you know, sort of clunky manual process, perhaps, for how I would essentially be attesting that I received a fax or something. Maybe some of the IT developers on the phone can, can speak to that point.

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

This is—this is Jitin, again. I have one response to that, probably not the authoritative one, but there is one suggestion. I mean, at the, at the most restricted level, it should be C-CDA and any other accepted standard in the industry, so between now and, and meaningful use implementation, _____ the constant acceptance standard or they even, other standards that were previously used. I think that it still should count towards usage, given that these settings had never been part of the meaningful use program before.

That being said, I totally agree that actually, that might itself still be too restricted for those settings.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Yeah, this is Brian. I think Jitin’s approach is definitely the right way to go about it, and probably, simply putting it in the language that, that he said, that other acceptable standards, you know, without requiring the use of certified EHR technology, basically the way it seems now is that if I’m going to do a transition of care and, say, to approach the acute care facility and they don’t have the certified EHR technology in place or the capability of consuming a consolidated CDA, I’m gonna go for an exclusion rather than actually having the exchange that I do count towards meeting the measure.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Mm-hmm, right.

Beth Morrow, JD – Director, Health Initiatives – The Children’s Partnership

But—this is Beth—I, I worry that, that we’re sort of undermining the whole drive towards interoperability if we fiddle too much, unless we place the—well, even if we raise the target so high, it, it really—it’s somewhat counter to the, the goal of what we’ve been working on to date.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right.

Brian Ahier – Director of Standards & Government Affairs – Medicity

Well, but still, you know, incorporating the data into the EHR from a non-clinical setting is important in and of itself, and rather than boil the ocean, let’s try to meet providers where they are. And when I say providers, I’m primarily talking about in these other care settings that have not really benefited from the EHR incentive program.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, so it seems like there are three, there are three, you know, kind of channels that are on the table, here. So one channel would be, if we assume that, let’s just say that we want to say, you know, everyone should count, right? Whoever sends something to me, that should count against my 25 percent or 40 percent, whatever the number’s gonna be, but let’s say, right now, we’re recommending 25 percent—let’s say 25 percent, and we’re saying, “All right, these have been kicked over to us. We’re saying that non-clinical entities, so-called non-clinical entities should count.” There are three ways that the information could conceivably come to me. One would be, you know, the previous measure that, that this was originally in did not specify any electronic means—it didn’t specify electronic means, so it literally could come via snail mail, phone, fax, right?

The second would be the spirit in which all of these measures under objective seven have been, which is to say, it can come via any electronic means. So that would allow, for example, someone sending a .pdf to me, as long as it came electronically, meaning non-fax, non-phone, not speakerware. And then the third would be that it has to be a specific format, that it has to come via any electronic means, but it has to be a C-CDA, right?

So, one approach might be to say, “Everything should count, but we are—but, but, but phone, fax? That shouldn’t count, so let’s take that one off the table.” And then that opens up the question of, do we want to say, “Well, it can be via any electronic means, and we’ll accept .pdf if it comes, if it comes via electronic means,” and there are ways in the EHR system to somewhat automate that, maybe not perfect, but then certainly, if they send a C-CDA, that should count.

What—what do people think about an approach like that?

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

I, I'm inclined to—this is Troy. I'm inclined to go with option two, and the reason that I say that is because, one of the—we don't want to limit innovation, and as long as we say that it comes by electronic means, then it opens the door for, you know, APIs to be developed, secure portals, there can be an agreement made between different business entities about what the key components are necessary between. You can define relevancy. So I'm inclined to go with option two.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay. What, what—and let me just clarify, so what that would suggest, then, is that if we went with our option two, then what we would be—and we're saying that this is opened up to everyone, which it, which it already is. That means that, for my 25 percent, I could, in principle, fill my whole 25 percent with .pdfs that are sent to me electronically. I could not—I wouldn't have to get a single C-CDA, and I can get all .pdfs from long term care providers. I'm just, you know, pointing to a boundary condition, here. That probably is more what happened in the real world, but I just want to point out that if that's the—

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

The reason there are non-EPs and non-EHs, and in this classification of a non-clinical provider or areas because they don't have cert. If they don't have cert, like you pointed out, they don't have a C-CDA.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep.

Troy Seagondollar, RN-BC, MSN, UNAC/UHCP – Regional Technology Nursing Liaison – Informatics Nurse – Kaiser Permanente

So, how would they develop one if they don't have it?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep. How do others—how do others feel about that? So the proposal on the table would be that we say, “Anyone counts, and I am able to accept anything—anything on my side, anything would count that I receive via any electronic means. It doesn't have to be a C-CDA.”

Wes Rishel – Independent Consultant

This is Wes. I generally like the direction that Troy took us. I wonder if there is merit to the consideration of a low criterion—very low criterion—for standard, standards based receipt and a higher criterion for, for the general receipt. This is the, I think, the old, “If they build it, they will come” theory if, in fact, eligible providers and hospitals have to demonstrate accepting the standard thing, even for a small number, then that mechanism becomes available for, for use. If, in fact, a number of skilled nursing facilities and hospices have, have had to build into their workflow transferring information back in any form whatsoever, then, as the market for cost-effective software develops through marketplace economics rather than through, through certification, that that be—that the standard becomes a desirable feature.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right, so—

Wes Rishel – Independent Consultant

And I'm a little weak—a little weak on that last rationale, but nonetheless. [Laughter]

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, but your suggestion, Wes, would be something along the lines of 25 percent via any electronic means, 5 percent of that, 5 percentage points of that needs to be a C-CDA as well, let's say—I'm just throwing out numbers.

Wes Rishel – Independent Consultant

Yeah. I—I think even 5 percent sounds a little high, but, but, but that's—that is, in fact, the direction that I was headed.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. Which would be analogous with—although, although pushed one level up on the maturity curve—with what stage two did with transition of care, if you remember. There was 50, I need to get transitions of care 50 percent of the time, you know, in whatever means I got it, it wasn't even electronic, it could be whatever means I got it, and then 10 percent had to be electronic, or not—I'm sorry, it wasn't receiving, it was sending. I have to send it 50 percent of the time, and then 10 percent I have to send electronically. Push it up one level on the maturity curve, we're saying something like 25 percent has to be electronic, and then 5 percent has to be C-CDA, or whatever that number is. How do other, what do other people think about it?

Wes Rishel – Independent Consultant

Yeah, again, I think we have issues around what the, what the denominator is—is it all patients, or patients that this is at least a possibility it's gonna happen and so forth? But yeah, that's the idea. [Cross talk]

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

This is Shelly—this is Shelly, and I apologize for the noise here, I'm in a public place. But I do want to make a comment in relation to something that I've talked to before, which was the aspect of using an intermediary or a converter of whatever the non-certified entity is sending in, where that would meet with what Wes was talking about, that we could have a small percentage that it would be up to the one who's receiving it to make sure that they were using an intermediary to convert it to its consolidated CDA.

Wes Rishel – Independent Consultant

Yes, so again, it's not—just to be clear, I think with this, you know, with this, the receiving entity does not have to confirm that the sending entity is on any certified anything. As long as they get a C-CDA that's compliant with the specification, whether they got it from the intermediary, or they got it from the original source system, as long as it's compliant when they receive it, that would count toward their C-CDA requirement.

Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership

This is Beth—

Shelly Spiro, RPh, FASCP – Executive Director – Pharmacy Health Information Technology

And by—and by doing that, that would allow the, the receiving entity to at least meet their threshold, but not interrupt the innovation until those other entities, the sending entity, was able to build up their system to meet those requirements that would allow the intermediaries, you know, for a contract intermediary to help.

Beth Morrow, JD – Director, Health Initiatives – The Children’s Partnership

This is Beth. I, I have—I just looked back at the, the slide from the Consumer Workgroup, and I think we should also think about whether we agree with their recommendation to move it to the HIE objective, because if, if, if moving it to the HIE objective is meant to sort of tag it to the notion of interoperability, whereas keeping it where it was in objective six might be more appropriate. I'm not sure whether that's more related to care coordination—it's just about incorporating data into the EHR, and therefore, it's not—you know, the elements that are related to interoperability aren't as important.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, that's certainly a fair point, Beth. I think there's a procedural issue that the Policy Committee already approved it. That doesn't mean that we can't go back and say, "Gee, well, we were kinda railroaded into that." [Laughter] But I think the spirit in which they were thinking about it was that objective six was about patient engagement, so patient generated data ought to be sort of, you know, separated out, and that to the extent that we're talking about non-clinical entities, I think that they were kind of making a statement that that really is about care coordination at some level, and that's why it ought to be thought of in the context of, in the spirit of objective seven.

We—you know, we would say that we don't agree with that, but I think that was, you know, kind of their thinking, there. I don't know if others who were there would agree with that, or Kory, if you have anything to add on that.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

No, I—I would agree with your assessment, that that was their thinking, Micky.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

So, assuming—assuming that we are going to at least, for now, you know, accept the Policy Committee recommendation that this is sort of in our lap, it sounds like where, where I'm hearing that there is a consensus is that we go with the option which is essentially saying, "Our threshold right now is 25 percent. Within the 25 percent, as long as you receive it via any electronic means"—so remember, before the 25 percent was that it had to be a C-CDA and we allowed exclusions for those who couldn't send you a C-CDA. Now what we're saying is that we would have 25 percent that could be sent via any electronic means, and then we have a more targeted sub-requirement, if that's a word, that would say, I'll just throw out a number and see if people respond to this—5 percent of that should be C-CDAs, electronic means and C-CDAs—wherever you get them from. You can get C-CDAs from an LTPAC, you can get them from an EP, an EH—it doesn't matter. How do people feel about that?

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

Micky, this is Jitin. I have a quick question, hopefully not terribly tangential, but as we talk about C-CDAs, are we using the term C-CDAs as sort of a placeholder, as opposed to referring to the formatting standards specified in the standards advisory, which I think would be a more nimble way of referring to whatever format is chosen for sharing such documents.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Well, there—I mean, there is a particular specification that is, you know, that is called out in the NPRM and in the Associated Certification rule, so—and I assume that it's the same one that's pointed to in the standards advisory. Kory [Cross talk].

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

My only suggestion, the only reason I brought that up is because I, I understand—and maybe I misunderstood—but I thought that the standards advisory may be updated more regularly, and that might be the right thing for the NPRM to be pointed towards such that between now and implementation, if there are better improvements, either to the C-CDA itself, or to other things which come along that we've not, we've not forced industry to adopt something which may not actually be the state of the art at that time. This is accepted products.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yep, yep—so we could offer that as a general comment, if people agree with that.

Male

Yeah, I agree with that.

Jitin Asnaani, MBA – Director, Product Innovation – athenahealth

All right, sorry, I didn't mean to derail it too much, I just wanted to be sure we were talking the same way.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. [Cross talk] Although I will point out, just for a second—not to get us completely on a different topic, here, but the standards advisory is not a rule, so I think that—and Kory, I'm sure you were just about to add that point, right? [Laughter]

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yes, and I was just gonna note through, through rule making, you can't point to documents like that that are gonna change. You're gonna just try to incorporate the specific standards that is—

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, right. So let's not go down that path right now. That may be another topic for us, so let's not go down that path right now. Sorry, someone else had a comment?

Male

To that point, I think you can—you can reference the appropriate standard that is within the standards advisory.

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yes, but it—you know, if the standards advisory changes in the future and it's a different standard in there, it would still be whatever was initially pointed to in the rule, but it can lead to something that changes.

Male

Yeah. That's the challenge of rulemaking, right?

Kory Mertz – Challenge Grant Director – Office of the National Coordinator for Health Information Technology

Yep, yep—right. So Micky, [Cross talk] the original question. Sorry to take you off topic.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, so—okay. Yeah, so—so back to the original question. Our original coming into this, our recommendation was that, that 25 percent, so for 25 percent of your patients, you—well, for, I'm sorry, for 25 percent of transitions or referrals that, that, for 25 percent of that, you needed to incorporate a C-CDA. And we also allowed an exclusion—this was our recommendation—we allowed an exclusion for known entities that are not capable of sending a C-CDA. So you may be getting transitions from an LTPAC provider, for example. They can't send—they could send you a .pdf, but they can't send you a C-CDA, so we were saying that the receiving provider ought to be able to take that out of their denominator and their numerator.

So—so that was our original recommendation. The new recommendation would be, in the spirit of saying, "All right, Consumer Workgroup, we'll allow those in, addition we actually will up the requirements in the spirit of interoperability that they can't do phone and fax, they actually will allow them in. But they have to send it via any electronic means, it has to be for 25 percent of the patients, so it's the same 25 percent. Now, it doesn't have to be C-CDAs, it could be anyone sending me anything, as long as it's via electronic means, and then we have a sub-requirement that would be an embedded requirement while 5 percent, 5 percentage points of the 25 percent have to be a C-CDA.

Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership

This is Beth. I'm having the feeling that 25 percent is too low if it's any electronic means, if we were—I mean, I'm having a hard time figuring out what, how widely the exclusion would've applied and, you know, how we translate that here. But in my logic, I would think we would be raising the threshold as we expand it to any electronic means.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, no, I think that—I think that's a good point, but if you take the, in effect, we've made it easier to, to hit the 25 percent by allowing any electronic means, but I would point out that we would be taking off the table, now, the exclusion for those who don't have cert, right, so it's that balancing of the threshold versus the exclusion. You could raise the—raise the threshold, but we have taken away the exclusion.

Beth Morrow, JD – Director, Health Initiatives – The Children's Partnership

Yeah, I—

Male

So, we're getting down to a quarter of the people that could send you something electronically will send you something electronically—and of those that send you something electronically, 20 percent of them will be by CCD format—5 percent of the 25.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah.

Male

That, at least, seems consistent.

Male

Just to be clear, you're saying 5 percent of the denominator, which is one-fifth of the 25 percent.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Yeah, yeah, yeah—right.

Male

Okay, thank you.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Sorry. [Laughter]

Male

As opposed—as opposed to 1.25 percent, which would be the other, other way, right.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Right, yeah. He was, he was saying 20 percent of the 25 percent, so 5 percent of the _____, exactly. [Laughter]

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I'm still—this is Larry. I'm still thinking about, you know, I'm still worried about the 25 percent. In other words, we're talking about people who have no incentive whatsoever financially to implement technology to send me something electronically. In other words, they can't just e-mail me a .pdf, because it's not secure, so they're gonna need to have some sort of secure system and, you know, I can't just give them a portal to log in, because, you know, these poor, you know, physical therapy sites, you know, service 50 different providers—100 different providers that refer to them. So, are they gonna have 100 different portals that they can securely send .pdfs to me? You know, I'm just, I'm just—I'm not feeling good about this one at all. [Cross talk]

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

No, but just to clarify, Larry, remember, we're not saying that you have to get a single one from a so-called non-clinical entity. Before we said you have to get 25 percent C-CDAs, and we're basically saying—and those are probably gonna have to be from EPs, EHs. Now we're saying 25 percent can come from every, from anyone, and it doesn't have to be a C-CDA, but—and maybe you would just fill it all out with the EPs and the EHs who you were gonna get to begin with.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

Oh, I'm sorry—oh, so it can still include the EPs and—okay, I'm [Cross talk].

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Oh, yeah. Yeah, yeah, yeah, right. We're not, the recommendation on the table here is that we not distinguish between EPs, EHs, or non. It's basically, the only distinguishing characteristic is that, of the 25 percent, I need to have 5 percentage points, so that's, the 25 percentage points have to be a C-CDA from anyone.

Lawrence Garber, MD – Internist/Medical Director for Informatics – Reliant Medical Group

I respectfully withdraw my astonishment. [Laughter]

Male

So then, is the statement here that there is no new incentive to reach out to non-eligible providers?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

I don't think—well, I think in some ways you could argue that this actually provides more incentive than we originally had in ours. Now, I don't know, on that consumer measure—that was 15 percent, but it said you can get it anyway, patient generated or from other places. In ours now, we originally were saying that people could exclude those who didn't, who weren't able of sending me a C-CDA. Now we're saying that you can include those, even if they can't send you a C-CDA, as long as they can send it to you electronically. So you could argue that it actually encourages me to get people to send me stuff.

Male

So I'm just thinking about the transition from stage two to stage three, and I don't really remember the specifics well enough, but the way I thought I heard someone state this, we are not changing the requirement in terms of volume to receive information. So, if I qualified under stage two, I don't have to do anything for stage three. Did I misunderstand what was said?

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Um, yeah, I think so. I mean, I think that you do—I mean, this is, remember, this is a measure that is a brand new measure, and I'm just looking at the time. We've run out of time, and I wasn't paying attention to it—but this is measure two, so it's actually, all of this is new. I never had to do anything with respect to receiving information. Measure two here is all sort of green field in that I'm now [Cross talk].

Male

I withdraw my question.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, so let me—what I'm gonna suggest is that I, you know, try to write it up based on what I heard, and I am gonna ask a specific question in the offline, which is Beth's question, because it's a fair question and deserves a little bit more thought from everyone. Which is—and I know it's hard for us to sort of all, in real time, sort of say, "Well, wait a minute, I've included the 20—it's still 25 percent but now everything's included, but now we're taking away the exclusion; how does all that fit together?" You know, Beth's point, which I think is a completely fair one, is that by opening it up to anything that's sent to me via electronic means, doesn't that suggest that we should raise the threshold again, because previously we were saying 25 percent with C-CDAs. The countervailing thing is that we're taking exclusion off the table, but that's a fair question for all of us to wrestle with, you know, "What does that do on net?" So I'll pose that as a question in the offline as well to get us to settle on the numbers.

I will also ask, I think that we'll also ask offline this question of the data segmentation, because it was a question that came up. It's not really clear to me exactly how the data segmentation fits into this, but it was a question that came up, and I don't—we've absolutely run out of time here, so we have to turn it over to public comment, but perhaps we can ask that offline as well.

Let me turn it over to Michelle for the public comment.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Lonny, can you please open the line?

Public Comment

Operator

Yes. If you're listening through your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you're on the telephone and would like to make a public comment, please press *1 at this time.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

We have no public comment.

Micky Tripathi, PhD – President & Chief Executive Officer – Massachusetts eHealth Collaborative

Okay, great. Well, thanks, everyone. It was a real smorgasbord of issues here, and I appreciate everyone's very thoughtful engagement. We'll be in touch offline. Thank you.

Michelle Consolazio, MPA – FACA Lead/Policy Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Have a great night.

Male

Thanks a lot. Bye, all.

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Thanks, guys.