



## Collaboration of the Health IT Policy and Standards Committees

Quality Payment Program Task Force  
Subgroup 1 – Technology Implementation  
Final Transcript  
May 27, 2016

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### Presentation

#### **Operator**

All lines are now bridged.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – 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 and Health IT Standards Committee's Quality Payment Program Task Force and this is a Subgroup of that Task Force focused on Technology, I don't think that's what we called it, sorry. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Cris Ross?

#### **Cris Ross, MBA – Chief Information Officer – Mayo Clinic Here.**

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

**Hi, Chris. Anne Castro? I believe Anne is on.**

#### **Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I am on I have found my mute button.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Anne. Floyd Eisenberg?

#### **Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I am here.

#### **Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Floyd. Justin Fuller?

#### **Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Hello, I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Justin. Ginny Meadows is in London. Mark Savage...I'm sorry and Mark Savage is in London. John Travis?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**  
Here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, John and I thought I heard Paul Tang's voice just as we were getting started but I could be wrong?

**Paul Tang, MD, MS – Vice President & Chief Health Transformation Officer – IBM Watson Health**  
Yes, I'm here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Paul. With that...I'm sorry from ONC we have Gretchen Wyatt, Alex Baker and Beth Myers on the phone. Is there anyone else from ONC on the line? Okay, with that I'll turn it over to you Cris.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Great, thanks, Michelle and thanks everybody who could contribute today. We're a small but hopefully hearty group. I think we're going to want to get to the material quickly but just to begin with I want to thank everyone for their contributions who put together notes, I've got them spread out in front of me and some of the most cogent ones were included in the slide deck and I want to thank Gretchen and the ONC team for that. So, thanks for a good start.

The second piece is, you know, we were all joking a little bit before the call began around a number of things but one of which was the complexity and breadth of this regulation and my only comment as the chair is I'm probably the dumbest person on the call but what I'd like my role to try to be is to try to keep our eyes on the overriding purpose of MACRA which is, you know, to advance and modernize payments for better outcomes.

And it is easy to get caught up in some of the details, some of the technical distinctions and of course we'll do that, but overall if we can kind of keep our eyes pointed a little bit towards the horizon I think we will serve ONC and the country well for doing that.

Then the last piece is I'm sure many people have been reading our own commentary plus public commentary and so on and I think this is a place where one of the things that FACAs can really add to the professionalism of the ONC staff is a little bit of experience in the field and exposure to these problems in real life and we've got a nice mix of people on the phone who represent those different view-points and I hope that we can balance aspiration with feasibility, what can we really achieve under the timelines that are laid out in front of us with the goal ahead of trying to advance and modernize payments for better outcomes.

So, I hope...I'm going to ask for forgiveness in advance, if from time to time I try to bring us back to those questions of aspiration and feasibility and on the "yes, but how does this help us get closer to the

MACRA goals” I hope you’ll forgive me. Many of you are going to know way more than I will around many of the details associated with this although hopefully we can all learn from each other but let’s see what we can do. We have a limited number of calls and we’ll try to be as efficient as possible. That’s really all I wanted to say Michelle and Gretchen from an opening stand-point.

So, I think what it looks like we’re doing next on the agenda and we’re two minutes ahead of time is to get to an overview of the Subgroup comment themes from Gretchen and I’ll just say for my purposes I’m really interested Gretchen in however you want to guide us. I’ve got the PowerPoint open but I’ve also got the consolidated notes that everyone put together and I think it is, you know, at least for me it’s useful to see the synthesis as well as much of the detail and I would expect that we probably will be jumping back and forth between those documents to some degree. But Gretchen could I turn it over to you and can you present...

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Thanks, Cris, happy to do so and with Paul Tang on the line as well I’ll probably refer back to him and have him sort of give us more context from the call earlier today because there was some overlap with some of the comments from there with some of the things that are in that combined document that Cris was mentioning. So, I think that the themes are starting to percolate to the top already.

I have my document here as well so I’m going to be cheating and doing the same thing, but if we could move to the next, to, let’s see I think the fourth slide, so moving into like the questions so that we can just refresh everybody’s mind of what it is that we are going to be focusing on.

So, these, let’s see, question one is...well, let’s go back one if we could just so that everybody can see the three questions that we’re going to be focused on. So, the first one is sort of a level setting for the overall program as well as within the advancing care information category. How health IT can be in...how folks can be incented to use health IT to achieve these large high priority goals. Did we get it right? Are there areas that we need to advance things a little bit more and then as we were talking about, was it earlier this week or last week, about can this also help with that group reporting option? So, how can certified health IT get us into that space as well?

Second question is digging down a little bit deeper, you know, what is it that needs to be clarified to the specific policies especially around CQMs and some of those other third-party entities other than certified EHRs so that we can move the program further into true value-based care and this is where I think I might ask Paul to sort of summarize some of the comments that we had earlier this afternoon which sort of overlapped in this area as well.

And then the final one is the long-term, where does the program need to go in the future and how can health IT facilitate that advancement both for individuals within the MIPS Program and with APMs and overall for the nation to move more towards the value-based care.

Lots and lots of really good feedback from everybody, it was really impressive to see all of this. So, you know, when we get into the themes, you know, and I would guess that everybody would be able to sort of refer back to some of their comments and sort of riff on some of those.

So, if I mistake anything please know that I was just trying to get everything together to help stir the conversation. Let's go into the next slide if we could which is the first question.

As Cris said this is sort of just a summary of some of the top level comments that sort of percolated between everybody making sure that within the overall program making it expressly clear how health IT is expected to facilitate eligible clinicians movement through these programs. I think a lot of commenters thought that there needed to be a better job on that so I wanted to make sure that we got that correct and then also, how the composite scoring really is going to help move that needle as we had spoken about last week.

There were a lot questions about how exactly things are differentiated between the various categories and is there truly a need to explain that better. I think that that's where just the earlier policy questions might be...what we had talked about with policies being unclear. I think that making sure that we identify how health IT can support some of these policies will make it a little bit easier for the clinicians and I think that's what the comments were talking about as well.

And much like within the Meaningful Use Program incenting those who are very new to this whole concept either into quality measurement in general or to the use of certified health IT there needs to be really sharp delineation on how that's going to occur so that no one gets left behind.

And then moving into the group reporting discussion really making sure that folks know before they even make the decision whether they want to be individuals or group reporters what the implications are, you know, especially as they start looking at how they need to align their practices and the measures that they select so that they can shoot for some of those performance bonuses within MIPS or within APMs and making sure that there is clear transparency on how this whole program is going to work and how things are going to be evolving in the future both within the reporting processes, the policies themselves and how new technology requirements are going to be implemented within the program.

So, I think that's probably the best summary but I definitely...Anne gave us some really good comments and unfortunately Ginny not being on the line, she gave us some excellent work as well. So, folks that had commented if you could sort of expand upon on some of these comments it would really help I think clarify what I had pulled here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Anne or John, or anyone else, would anyone like to...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

I might...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Break the ice?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, this is John kind of a little bit jumping in the middle and that's almost inevitable, on the group reporting, you know, I think while conceptually it may be easy to say I think it's very important to be clear how mechanically group reporting is going to work in terms of those things that are clinical

workflow based, those things that are more, you know, under the Meaningful Use Program would have been yes/no types of attestation, basis of measurement and what really is the methodology to apply there.

It might not seem like it makes a real practical difference but the group dynamic as to what they choose to do may vary based on if that's going to just be straight up across the group or a compilation of individual performances rolled up to a group, but we're pretty certain groups are going to want to be able to evaluate at both levels to make the determination of what they want to do in terms of how they report their measures under ACI or under, you know, the quality measure domain of the composite measure.

One of the challenges I think we actually highlighted that in what we submitted is the timing of things that you're going to have to make your decision about how you report based on the earliest program requirement you might face for making that decision and specifically around GPRO participation for quality measures you're going to have to determine if you want to report as a group by June 30<sup>th</sup> and that forces your hand relative to everything else and that's really a shame, if I can put it that way, because it's going to be...you're not going to have the intelligence necessarily unless you have a real good handle on things internally to know is it more advantageous to report as a group or as individuals.

You might have your lagers within your group that can be, you know, masked reporting as a group. You might have some very strong reporting as individuals that would result in their scoring more performance points under the ACI category, reporting as individuals, and that kind of calculus is going to be key when it comes to especially earning the performance points in the ACI category.

So, I'm a little concerned that in essence you may have to declare yourself as a group by midyear of a performance period and you may not have the intelligence in place to really make an informed decision that quickly if that makes sense.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, so, John, this is Cris, if I could just ask then, is this just inherent in the question of having to think about reporting as a group or are there particular attributes that make that selection to report as a group or not more challenging? Is there anything we would suggest changing or improving...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

I...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So it's more straightforward?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, I don't know under the statute whether for the original authorizing statute for the GPRO Program or for MACRA if there is an ability to have flexibility to allow for frankly a later declaration of reporting as a group versus reporting as individuals. I realize that there are practical limits on that administratively for CMS, but it is a tough thing.

The biggest impact is going to again be to weigh whether or not I report as individuals or as a group for ACI in order not so much to get to the base level if you remember the definition of that dimension.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

But for the performance points it really could make a differential to my upside opportunity to have a higher level of payment adjustment. You know if I've got some really weak performers I want to know that because I may err on the side of reporting as a group and I might not get the performance points for some individuals but if I have really strong individuals everybody is generally doing reasonably well, but, you know, there are certain individuals who are really carrying the ball they may stand out more under an individual reporting model that would help the group earn performance points ironically because it still is the whole of the group, you know, at a practice level being evaluated that way.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, if you don't mind me continuing to ask you the question and I imagine that Floyd and Anne, and others will have things to say about this too. So, if we can't help...in helping them make a better choice up front. Are there things that we would recommend to make the bad consequences of the wrong choice less onerous, if that makes sense? So maybe we can't improve their ability to predict but gosh I think we'd want to...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Avoid the unintended consequences if someone reports...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

The wrong way that they're stuck, right?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Ironically one of the points of flexibility people have under the current regimen is that they're not necessarily held to the same decision reporting quality measures through GPRO as a group and Meaningful Use. There is not a consequence of the decision having to be made the same way.

Maybe there is something like that here where I'm not held firmly by my decision for reporting the quality measures as necessarily dictating what I would do to report the ACI domain that's one thing that could be done.

So, I could judge whether or not I want...really the area I need more time on is ACI and so, you know, if it were not so tightly coupled that I could make a different decision potentially for ACI and report as individuals if it were more advantageous for me to do it that way for performance point purposes that would be one thing to look into, don't make it a preordained thing that crosses those two domains. I don't know if the statute dictates that, I don't think it does. I think that's a choice CMS has for how they administer the program.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Justin, Floyd, Anne I'm curious do you have some thoughts on that?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Yes.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd, there is actually a potential hidden...with the measures that even today might make a difference in whether you report individually or GPRO. The way the measures are designed is they...many of them is defining a denominator based on certain encounters or actions that occur and there are some providers who are trying to report but they don't perform those types of services so they can't get anyone in the denominator even though they actually perform the numerator services and for that reason the way the measures are designed they actually can't report as individuals and have negative impact compared to if they reported as a group they would get the value of those activities.

So, I think under one, designing measures that could address both individual and group but also understanding which measures might be problematic may help drive people into reporting and making those decisions upfront.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Yeah, this is...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, how would you recommend we modify our approach Floyd to get to that objective? I think...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Well, one is...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Internally but...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

One is I think CMS looks at measure design, they have to take into account individual reporting by most...many of them, I can't say most but many of them are designed for the primary care physician and others are reporting under these programs who are not the primary care physician so it becomes challenging for them to get people in the denominator and report on those measures...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

The...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Design...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Sorry. Floyd, maybe you agree I'd say one of those where that is especially true is secure messaging where a primary care physician is going to be especially now looking at CPC+ they're going to be very

active communicating to the patient a procedure-based specialty, yeah, they might be but there is also a good chance that it's, you know, I see you and we're done...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

And your back to the care of your primary care physician and secure messaging is one like that. Arguably patient education might be one like that although you could say...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Well...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

About the procedure, but just those...and in a multispecialty group that's going to also be true...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Why don't we...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Where it is advantageous to be grouped and not individual.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Why wouldn't we put a general recommendation that says that caution, a caution statement on the, you know, flexibility is there but the burden is on the selector as to which measures are chosen based on the setting of, you know, the care setting whether it's a PCMH-like or an ACO-like, or a value-based, you know, that, you know, as to whether or not an individual or a group should be used, you know, a generalized education statement within the rule just to make sure people understand that instead of...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, just sort of a word to the wise kind of thing Anne?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Yes, yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, okay, I got it.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I think that's generally understood just from my experience when we go out and negotiate with our providers we have detailed conversations about the measures that are brought to play and they're written into the contract specifically, the denominators are identified, the numerators and the who is eligible, who is not just so there is no questions, but a word to the wise I think is the kind of thing that you'd want to put in there.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's an interesting note.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

So, this is Justin Fuller, I had a similar thing that I was going to bring up and I'm glad we're talking about this. I was talking with a colleague of mine who is an economist and he understands a lot of these numbers quite a lot better than I do as a clinician, but he brought up a similar issue.

So, rather than the discussion we're having now where we're talking about I as a provider want to understand, you know, whether I'm going to have a higher performance score as an individual or as a group. He brought up the issue of, you know, the MIPS Program versus the APM and one of the things he brought up and he and I might have missed it so I'm relying on you guys to point me in the right direction, he kind of brought up the idea, okay, if I work in an organization and I've got 600 providers given the way that the incentives and the penalties work in MIPS versus sort of the flat approach in APM he said that he saw a risk in that you could basically take all of your really great providers and put them in the MIPS Program sort of to be a ringer and just clean house and then leave everybody else in APM because it would be a wash. So, I just thought I'd bring that up as well. Go ahead?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, I was just...this is Cris...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Justin that's an interesting comment I wonder if that's possible to do.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Well, I think it's all possible...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

And you've got to keep in mind that there are a lot of providers who are employed by hospital systems so there are a bunch of organizations that have a bunch of business units that are deciding this and it's not a bunch of physicians who are doing the decision-making about where they're going to be.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Yeah that's right.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

And a bunch of SIMs being created around the country and if you look at the trend there is going to be more employed physicians in MACRA, I mean, I've read more and more about MACRA pushing physicians out of individual employment anyway. So, these decisions aren't going to be made at an individual level very often anyway.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Yeah, yes.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

And I want to point out something else that I heard from my association just in the last day or two as I started to get, you know, like the gallon of water education on this, and that is that participation in private APMs also counts towards Medicare APMs. So, that isn't very clear in the MACRA bill.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Anne, this is Gretchen, the other payer APMs isn't going to happen for a couple of years so that's something that won't be implemented with the first performance year of 2017.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I know, but the first performance year of 2017 is an education building process moving forward and that's part of what the comments that I put in, you know, so if we can get to agree that an education statement, you know, regarding the individual or the group, you know, participation, you know, you really need to look at the measures and what they were actually related to and whether if you're part of a PHIN or if you're an employee of a large hospital system, you know, you've got a lot of homework you've got to do.

And if we...I'm going to move to the part about the general notion that MACRA has an opportunity to build momentum towards interoperability if it helps pull other payers along and even though two years down the road other payers, APMs, you know, have an influence on APMs in MACRA, I still say this is the first shining star idea that moves towards some form of interoperability opportunity and I don't see a lot of...I would like to see more mentioning of other payers in this or the opportunity other payers have.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Well, this is John, you know, maybe it's a conspicuous place to...it's not going to hit everybody it's only going to hit 5000 practices but that's exactly the design of CPC+.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Right.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah and that's the kind of thing that...because my understanding there is that the whole practice in essence that would participate in that is really going to see maybe not all but a very significant number of their commercial and state Medicaid fee-for-service and self-funded employer types of plans do likewise and...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Exactly.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

The timing.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

The oncology pilot, we're in it and our process is to follow exactly what Medicare is going to do unless there is a good reason why we shouldn't and we're debating right now whether we're getting in the CPC+ because we already have the PCMHs, but we're not doing it the same and the question now is why aren't we?

So, we need to, you know, start converting over and what that allows us to do is instead of having a customized interface with every provider in our state we can begin to start piggybacking on the CMS interface so that it reduces cost for us and it reduces cost for our providers and we can all start having a volume cost-effective efficient mechanism for gathering that data for those metrics.

Do you see what I'm saying? It's an opportunity...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

That I think is so huge right now. I'd hate to miss it. And I'm a little frustrated...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Anne...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

We only have a month for the comments.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

And I'm trying to rally the entire Blue Cross Association and get them going on this and AHIP, you know, to gather their comments in the same vein, but I don't...thirty days isn't a lot to finally get that one thing that might actually trigger that interoperability point on the private side that will make happen what for six years we've been trying to do.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, Anne, this is Cris, this is exactly why I was hoping you'd join this workgroup; this is sort of better than I had hoped.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Well, I've got it all...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I guess...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I can see it but it's 30 days to get it all out there and to get...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, no...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

MACRA on board.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, I guess what we might want to do would be to ask Gretchen and the rest of the ONC staff to see if there is a way that we can at least as a placeholder as you're pursuing whatever you can, you know, pursue, maybe two things, one of which is noting that, you know, a representative, the payer community notes that there is a possibility here that this could positively influence practice beyond CMS and that we should be cognizant of those opportunities. I just put words in your mouth, you'd say it better.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

No, you have hit it. We're spending billions of dollars to do something that we can save administrative dollars.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So what could we put in here...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

It's significant.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

What could we put in here to simply encourage CMS as it develops both regulation but down the road, you know, specific implementation or programs and procedures to be aware of what you're talking about? I think if you had a suggestion about language which says, you know, we would like ONC to be cognizant of x, y, and z, we could achieve...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Okay, I have a write up.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

At least some of what you're talking about.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Just because it's not exactly what you asked me to do I want to send you a write up that I had my Blue Cross Association Team write up because when you made the assignment I talked to them about it and they gave me...they were writing comments to your RFI...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

The RFI...their comments and when they answered it I said, wait a minute, we're on the same track here. So, I had a conversation with them with what I wanted to tell you guys...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's good.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

So they changed their comments with the blending of what I was thinking with what they were thinking and they've rewritten them and I want to just send them to you. Now they don't line up with your template and that's what I want you to help me bridge that with.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

I'm sure we'll do fine.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I think all the rest of the answers to the template are exactly spot on from all the rest of the people and you know I'm not clinical so I think all of that is very valid and I don't want to derail this process at all.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No that's good.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I just want to interject commentary about the payer process.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's good. Actually I wonder Floyd if I could put you on the spot, just from your long history in quality reporting I know it is not directly related to private payer exclusively anyway I'd just love to hear your reactions to Anne's comments?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I actually...I had a short stint working on the payer side as well and I...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, okay, yeah.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

It's a while ago, but I think that's ideal. I know one of the things that always comes up in evaluating quality is what the private insurers look for and the way they manage should be similar and actually use the same mechanisms as what CMS is doing not to say that...I mean, each should learn from the other, but no, I would agree. I think from a provider side it makes sense that there is one mechanism and one way to evaluate yourself instead of multiple. So, I think those comments are right on I would fully agree.

It's also easier on the measure side rather than trying to measure one aspect of care slightly differently for everybody it just creates a lot of noise and a lot of difficulty when many providers and I've talked to hospitals as well as provider systems where they're trying to evaluate their care and they also have what their reporting and frankly many of them tell me the reporting isn't good enough to tell them they're providing good care so they have their own measures for that.

So, the more we can align the quality of the measures and increase that an approve it across I think that would be ideal.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Good.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

And I appreciate that observation because it is my theory that if we aligned payers and providers for just the payment mechanism and for the quality measurement we would save so much money on just that interaction that we could then concentrate on that care coordination much more effectively. We would not be distracted because right now we're trying to solve for everything.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Right and frankly what measures...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

All it...every...go ahead.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Really looking for is effectiveness of care coordination as far as providing patient outcomes so the more we can get the coordination to happen and that's not just sharing documents that have content but it's actually looking at care goals and target outcomes and when they should happen and who is doing it and identifying the right rules to manage it, the more that happens then we're achieving quality care. So, I would agree completely with what you just said.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Yeah and so to that end, I know my comments that I gave to you were the skinniest of everybody's and we need to go back to the agenda, I totally agree, I will on the side send you what I really want to say and maybe Cris you can help me figure out where that actually...what kind of feedback that really means.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

We'll work together.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Because I really...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Well, Anne, I will say mine were skinnier than yours...I had the opportunity to submit but I can do so over the weekend now that we've had the conversation, thank you.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Okay.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I'll send that. Go ahead?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

And this is Justin, I was just going to say as a nurse I appreciate the comments because you've given me more to think about in 15 minutes than I would have so thanks.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Thank you, I've been trying to get this to work together. I almost have a tear in my eye.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This is, again, back to the sort of aspirational and practical I think, you know, you've kind of hit a little bit of both as you've said.

So, we kind of dove down into one question on question one which is the attribute around the group reporting. Does anyone want to comment further on that part of question one or should we move over to the other part of question one related around whether, you know, this is providing adequate incentives? Any additional comments on group reporting? I think John you headed us off on that direction, thank you.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Anything else on that subject? Hearing none I guess Gretchen maybe I could turn back to you for just a minute. Are there some attributes of the comments that you got back or parts of question one that you would like to point us at for further discussion?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Well, let me take a step back. And from the comments one thing that became clear was that the vision was rather self-evident within the NPRM that this is truly where we're trying to get towards, the value-based purchasing and that there are incentives for certified health IT that are sprinkled throughout and so I think people recognize that and the reduction of burden and the flexibility are good things that we should, you know, be pleased to see, but that the level of that detail of how this is going to work still needs to be flushed out. I would say that is kind of the crux of the comments here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

All right, yeah, it felt like a lot of the comments, this is Cris, were as much about concerns about burden as much as inadequacy of incentives. Is that a fair comment?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Yes, yes and I would say even with the comments, similar comments in the policy section the same thing, you know, is this truly going to reduce burden when there are all these various areas within MIPS that we're going to need to be reporting on, what is it that we focus on to make sure that we get a good, you know, overall composite score, what's the glide path for us to get towards, you know, higher composite scores and is there an area that we need to focus on first, especially for new entrants into this world of value-based reimbursement.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, before we go into the new entrance which I think is perfectly fair, I wonder if we could go to, if anyone has a consolidation of written comments, it's on the middle of page two, the fairly long paragraph and I think this might have come from John Travis, but it begins with "there is plenty of incentive in the design of the MIPS and APM Program, etcetera" and the point is made in the middle of that paragraph about not causing disruption or discouragement to ECs under MACRA and I thought this sentence was particularly important "specifically, care should be taken not to introduce significant change particularly to any basis of measurement of "use" or quality measures in the early years of the program from what have been familiar points of reference under MU and PQRS. Measurement of "use" has already changed no less than three times now for 2017 use."

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, let me...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

And so I think that's really cogent. Is that you John?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yes it most certainly was, you know, and what I'm counting there is original Stage 2 was what we knew as the law of the land until...it seems a lot longer ago but really it was only just last fall that modified Stage 2 came out and changed 2017 and then now we have MACRA/MIPS/ACI which changes it yet a third time that's how I get my three.

You know so we haven't seen yet, necessarily, specific measure titles and descriptions for numerator and denominator statements, we assume that they'll be what was there for modified Stage 2 for the same things that have survived into the ACI Program, we need that to be the case, you know, because it's not like people have been idle until this happened they've been gearing up, they're in modified Stage 2 right now, you know, for them to absorb change is almost unfathomable to me right now between now and next year for the first performance period of MIPS/ACI and I dare say kind of the same thing holds for quality measurement.

You know the dynamic thing they've really got to be paying attention to is what they're going to do for the CPIA part of the composite measure of MIPS that's where there is dynamism and they've got to really be paying attention to what they might do and many of those things are very problematic if they're not going to be in an APM, you know, or a medical home that would qualify under the innovation center so if they're not in CPC+ they've got some pretty significant work to go do to figure out what they'll do for CPIA as it is.

So, let them have some stability in a couple of the areas that they've got familiarity and rhythm to and then you can gear up with adequate lead time, I was also the source of the comment of the measured introduction of change over the life of the program, it's a 5-year program effect, well longer than that, I'm confusing it right now with CPC+ which I'm also dealing a lot with for Cerner, but it's got a life to it that will allow for change to happen to ACI and quality measurement over time.

I think it's just going to be very raw if there's a lot of dynamism to areas that they probably have been assuming would just start with where they've left off under prior programs at least in 2017, maybe

arguably in 2018, and as a performance period then begin staging things in to introduce change after that as a general principle.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

This is Beth, that's a really good point. I do think that CMS maybe needs to clarify a little further. They did put in a couple of sentences around the objectives and measures where they stated that they did intend to maintain the same measure specifications for the MIPS/ACI category as were previously finalized in the 2015 EHR Incentive Program where we've had the Mod 2 and Stage 3 measures in it. So, this was the second time we've heard this question though so I think that there is very clearly more clarification that these are not, you know, different than those measures, they're presented in a different way and scored in a different way...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

But it's still the same numerator, denominator structure and it's absolutely the same certification requirement I think that's really, really important for developer especially and for providers who are concerned about their technology that, you know, you have 2017 to do either the Mod version or the Stage 3 version and you can use either 2014 edition or 2015 edition but this is the second time we've heard this question so I think that's a really good clarification point that we need to provide.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah and then I...and Beth, you know, certainly in our day jobs we've...you know we would come up with a lot of questions, but we, I think as a principle too we'd suggest kind of the part of it about a measured introduction of change.

We know change is going to happen, it's desirable, it should happen, there is a discipline to the lead time for doing it and that extends to quality measures as well. We're a bit used to that in PQRS with eMeasures but kind of towards where the next question or the, you know, second area of focus for our group goes, there is measured discipline of introducing new measurement requirements because they do beget arguably new certification requirements and new adoption requirements. So, that's always something we want to be taking heed of as a principle I suggest to not...

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

Yeah that's...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Overwhelm the participants, because they're going to be a lot of dynamic elements to this program again in that CPIA category where really, to be honest, I think CMS hopes that some of the really good creatives stuff happens like consumer engagement through non-face-to-face visit methods and making better use of outreach and addressing disparities things like that which now that we have the non-discrimination healthcare final rule out people are going to be thinking about that for, you know,

minority communities and communities that are representing disabled individuals that could be areas for CPIA activities.

I'd rather, as a practice, I think...if I'm going to have a limited amount of energy to spend on change in the early years of the program really want to be able to try to focus there and have stability for myself out of the operational side of things if you will.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, John, with all due respect for the vendor community, the people who are going to really take this in the teeth are going to be the providers.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, my question would be for you to put on your hat of your customers and maybe I can impose on Justin, it feels to me as though we will be able to get much more support for the difficult things that need to happen to advance us if we can make some of the negative consequences of change less.

I would love it if we could come up with one or two, or three solid recommendations about, please don't do this because it will make life really hard for providers. Is that an unreasonable thing for us to try and aspire to? Specifically around this issue about don't change the measures midcourse. I'm curious if people on the call think I'm crazy or if not if you have some suggestions around what are some practical things we can recommend?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

So, Cris, this is Justin, so to answer the first part of your question I absolutely think it's a good idea, you know, again as a nurse, you know, I've dealt hand-in-hand with the doctors who are going through those sorts of things so I think the way I'm sort of interpreting it is, you know, to develop an olive branch approach to start with because everybody is so frustrated with the constant volume of change. I think that this goes a long way towards being a ball, you know, as far as getting some buy in so I agree with that completely.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And this is Floyd, I think I'd differentiate a little bit between the measures and the eQMs, but I think stability is really important because constant change is very disruptive I agree. I think there is also some consideration on the eQm side where a lot of them tend...because they need to meet full review of reliability and validity, and I understand we're looking for results that are meaningful but in many cases so far we've been dealing with process issues because they are the easier ones to evaluate.

Perhaps going back to what we were talking about with Anne before, to improve interoperability and get information, make sure you can capture information about patient reported outcomes and getting the information in, perhaps there could be an ease up on some of the eQMs and have just a few that would address the issues of the fact you can capture patient reported outcomes, you can use it and use it to treat them even if they're not...do that even if you're not getting fully valid outcome measurement but just get started with a less rigorous approach so we're not exactly looking at the first year or two in

performance improvement but just making sure that people are doing the activities that are needed for care coordination. I know that's a little bit vague but hopefully it helps.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, that definitely helps. Is there anyone able or willing to take the next step to figure out how to make that actionable in the form of some more specific type of recommendations? What you just said Justin is fine, it's great and I think ONC staff will be able to make good use of that. But are there more...any additional concrete recommendations we could make?

If not I guess my question would be, Gretchen and Beth turning back to you, are there additional questions we want to dive into on question one that you would point us to based on the comments? We're about halfway through our time and I feel like we should move to question two and the group question.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I think from the written comments I can pull some suggestions together for the group to assess as far as...and then, you know, try to prioritize which ones should rise to the top. I guess the only question is, you know, not just the interoperability but we really didn't discuss much about the care coordination and don't know if we need to do so. I think we can capture that in some of the other questions that we've got on the table.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Any comments on care coordination from the team? Okay, shall we move to the second question? And Gretchen can you walk us through question two common themes?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Okay, this is one where I think I'm going to count on my fellow staff members to help me with this...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Great.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Because this is one where we really do need as much feedback as possible. This is getting towards, again, what we were just talking about as far as the eQMs and because there is so much flexibility within the MIPS Program here where there are various ways that folks can report in this area for the quality category trying to make sure that it incents people the right way so that they don't just choose the easiest measures to report instead of start to challenge themselves, how can we move folks more into the electronic process instead of just claims-based and what is the structure thinking in the future that we, as ONC, would need to do in the certification process to make that a little bit easier.

And I think another question is knowing that QCDRs have this rich source of information is there a way that the whole program can take advantage of that as well?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So, this is Floyd, can I start with a comment here?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Absolutely.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I think QCDRs are a great way to actually look at quality and I have no issue there. The concern is that's not necessarily an indication that EHRs or electronic data is being used effectively because in some cases they may be taking electronic data but in many cases it's the QCDR managers don't necessarily trust the data coming directly out of the EHR so they require some sort of abstraction to get the data into their registry. So, it does look at quality but it's not necessarily indicating interoperability. So, it's a different thing. As that moves forward that would be terrific.

I think what I was talking about with the eQMs is many of them are highly detailed, attempted to be precise and...necessarily need to implement. I think a reduction in the number of eQMs and potentially a reduction in the rigor of precision maybe helpful to help people start using...letting the eQMs show that they're starting to use needed functions of the electronic software to manage care. For instance, patient reported outcome evaluation tools, assessments that provide data that is structured and can be reused but that keep it simple and to a small degree to get people started rather than try to be broad and very comprehensive.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I totally agree. I totally agree. And can we use the, I keep forgetting the term, but the clinical measure development plan to get to more, a smaller number but a higher quality clinical measure process.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah the quality measure development plan?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Right, right that's already in play and maybe the timing is a little bad on that since it does them in November.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That's a good question. There's also in the public comments we had, I don't know whose note this was, it's on page 5 of the document, the third bullet point, QCDRs, I'm a little confused over when and how QCDRs must comply with the certification and measure development criteria already in place.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

So, this is Beth, I can answer a little bit of that based on what is...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

Currently in the proposed rule but I actually think this is a really good conversation as Gretchen mentioned I was really hoping to get quite a bit of detail in this area because it is really pertinent to some of the things that we're looking at both for recommendations for this rule but also for a long-term plan that sort of can be done in partnership, I apologize there's a helicopter going over my house right now, but that can be done in partnership with that measure development strategy.

So, in the current proposed rule eQMs, electronic clinical quality measures, are not required. There is a bonus point structure that's layered on top of your quality reporting. So you get your quality reporting score based on your performance for the measure and then for each of the six measures that you are reporting, if you do an electronic clinical quality measure end-to-end you get a bonus point. So, right now the way CMS has that proposed that end-to-end reporting isn't limited to just a certification criterion and this is a really important distinction.

ONC's certification criteria are measure specific. So the only ones that can actually be tested and certified are the ones that are included in that list of CMS eQMs. So if there is a pool for a broader electronic clinical quality measure that might be produced by a QCDR CMS was trying to allow that to also earn a bonus point largely to try and incentivize that. They did propose that it would have to be end-to-end electronic so that would mean that you couldn't have an abstraction in the middle that interrupted the data flow but you could view it in a format that might not have been specific to the certification criteria.

So, that's what they are currently proposing. So, I think that really plays into this conversation so that is why I wanted to sort of clarify that's where they currently are because I think this is a really interesting space and for us at ONC this is something we're constantly thinking about as we try and improve the testing procedures, as we look at, you know, how does our certification support the next round of eQMs that CMS develops and adds. So, any sort of input on things to think about for that would be extremely helpful.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Okay, so can I...I would...here's my thought, let's keep everything the way you have it, if they play the way you've already got it but create an incentive, and a sweet one, if they use really good measures and they are all electronic, but they're a limited group and really make it worth their while so that it actually goes towards increasing interoperability meaning, you know, it's the ones that are the most meaningful towards the specialty and it's a much smaller group, and that it's the ones that get them the most benefit, and that will make all the vendors want to do them, it will make all the providers want to work on them, and it will make all the payers want to work on those first, and it will make all the value-based benefits move towards those, and it will make all those lazy providers want to work on them, and that's where the incentive really is instead of giving everybody total permission to be lazy.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

All right, so speaking as a lazy provider I think we'll get on it.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I'm sorry, I'm not...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No, Anne, it's perfectly fine, no, I totally get it, I'm taking it in the spirit in which it's intended. I think that makes sense. I mean, I want to support what you're saying and I probably shouldn't do it with humor, but there is so much that we have to do that part of the issue is how do we make sure that the signal to noise ratio is strong enough that we actually get the outcomes we want and I think what's being discussed here makes sense.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So, I...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I think if you're trying to get 10,000 little outcomes...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

It's what's...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Say that's a good outcome period.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, so this if Floyd...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Parsimony is good isn't it if Floyd?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, it is but I think there's a compromise that might help that work a little bit better. The fact that there has to be a complete transmission of the data to the QCDR to make that a valid measure, when you get into the nitty-gritty of some of these measures many QCDRs send data and they evaluate the measure based on the data they've received rather than you sending the measure and a result to the QCDR, they do their own analysis on their end based on what you sent.

But to get to the robustness of some of the measures requires information about certain things like exceptions that are specific to one patient or certain exclusions. So, I think perhaps in the early days, in the early year or two of making this happen, there is still quality by making sure the really important information does transmit even if some of it might be abstracted or if the measure itself were less, a little less robust, a little less perfect, but at least it allows that the right information is traveling to the QCDR that has the significant value and that's the information that really gives...really tells you there is an outcome and then perfect it over time making sure the rest of the information comes electronically.

I just think it may be easier if we could do it a little more incrementally than all at once even for a small number of measures just as a thought.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I would agree with that too. I mean...

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, it's that getting to 100% that makes it difficult as opposed to getting to the best performance you can and you're evaluated along with everybody else and that's more what QCDRs do. But I think it's really helpful to try to...some of that noise comes from the need for perfection.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, does someone want to take a pass at sort of a consensus opinion or recommendation on this subject? I'm not hearing too many brave volunteers.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Floyd had it almost.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, I think so.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Well, yeah, I think the issue is we do...I think what we're agreeing on is we support use of QCDRs, we think it's important to limit, to the most important...the few most important things for specialties. So, for instance if we're talking cardiology it's perhaps the ACC registry, American College of Cardiology as one example, rheumatology has a registry, OMERACT, and how do we...or process and how do we look at the most important things that CMS or other insurers would consider, but try to focus on and, this is hard to define, what are the most significant elements that would indicate you're really looking at outcomes and you're looking at information coming from patients to help drive that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And only incrementally over time building the additional detail needed to manage the full measure. So, I don't know if that answered it or not.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Yeah...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No that's good, I guess to my...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

It did.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Go ahead Anne?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

No, I said it did.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, so my only question would be, this may sound like a stupid question, how do we...how should the individual, you know, best and highest measures for each practice type be defined?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Well that's why I...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So what's the measures for cardiology...yeah, I'm sorry, go ahead Floyd?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I think for that we can actually suggest that the individual specialty group would help define that.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah. Does everyone agree with that?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

It makes sense.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, it makes sense to me I think as well. All right what other topics under question two do we want to address this afternoon? Gretchen, Beth what do you see where you think ONC could use some feedback?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Well that's where I'm reading through stuff right now and...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Trying to make sure how best we can get to this. I think there was one question as far as like for the certification for various things and I'm trying...that's what I'm trying to find, somebody had said, instead of just waiting and doing it all in one bolus effort to do it as things become more ripe and ready to be brought to the market and I'm trying to find that comment and I can't...unfortunately I can't. So, instead

of like having like, you know, one large package of the certification in addition to do a little less addition based and I think that gets us into our next question...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Instead of here, but I think it might be helpful as far, you know, as we start looking at, as Floyd was saying, not thinking so much about technologically how this is going to work, think again what's the end goal and then apply that.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

The other...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, I think the comment is on the bottom of page 7.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, when I think about this and I look at the question, if we're saying that how...the information has to get there electronically but can get there, in a sense, any way that's possible. I guess that's maybe okay for a certain specialty that only deals with a certain specialty registry but if any practice has to deal with more than one registry and there are multiple mechanisms it's going to become very complicated for providers to manage that.

So, there needs to...as much as standards...there can be too many standards and having no standards can be even worse or can be just as bad I should say. So, is there a way that we can make some recommendations about some basic standards that should be used to share data if we're saying it's electronic?

I realize things like...something like FHIR with HL7's interoperability is still very new but at least to try to address something and I know EHRs are required to use CDA but I know issues that I've heard with that with structured content.

I guess is there some way we can try to address some standards for how information flows between the EHR and the QCDR.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well there are some comments in here about a...

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Hello?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Hello?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Hello?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

I'm still here.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Yeah, me too.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Did we lose Cris?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

We might have.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Why don't we put in words...

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Yes...

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

That says that we need to escalate standards on the measure level whether that's through HL7 or any means.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

I like that approach.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Yeah and maybe FHIR will come along. I think there's some early work on that but let's don't commit to a particular standard but just escalate any standard activity but at the measure level.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Yeah, I like that idea because I don't know that we want to specify one or the other at this point.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Right it's too early.

**Alison Gary – Project Manager – Altarum Institute**

**And, yes, we did lose Cris's line so...**

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

This is Cris, I just rejoined, my cell decided to hang up I apologize. Did you all do good without me?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We were worried. We weren't sure what to do at first.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Keep going, keep going.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

We followed the standard rule of meeting etiquette that is anybody who is not there gets assigned all the work.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, all right. So, when I hung up there was a question about submitting data, did that get advanced?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I advanced it I said let's put in words that say we need to work on standards at the measure level through whatever means is available.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah. There were comments in here about the ability to do electronic reporting but there's some challenges associated with this. Whoever wrote those comments do you want to speak up to that? I'm looking at the comments in the middle of page six. Not relevant?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

It wasn't me.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

If it wasn't people...maybe it was...that might have been Ginny is that possible?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Oh, it could have been, all right, that's fair, okay. Should we move onto a different point?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I don't think that they were Ginny's comments but I'm trying to find out exactly who they were but we'll track that down and...

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

I think John Travis has a lot of static on his line as well so he is muted so it could have been him as well.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Okay. All right, so, is there anything else within question two that we should be focused on? I think, you know, I can work with Beth and try to make sure that we've captured the top three issues to bring back to the group.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Okay, should we advance onto question three then Cris?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, let's do it.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Okay. All right, so this sort of the catchment for everything else. Next slide for question three. This is the one that the whole group was asked. So, as the program evolves over time what are some of the capabilities that certified health IT could use to facilitate the advancement of the program whether that's within the CPIA inventory or for specific requirements and functionalities for APMs and how best can this be applied?

So, this is really a catch-all area for everything else. So, we got some pretty good feedback here and Justin was talking about both the CPIA category and resource use and gave a really good example of how resource use aligns with the choosing wisely campaign, gets at not just cost containment but are you really moving towards quality and maybe the algorithms need to be changed to make sure that you're not leaning too far in the barbell one way or the other.

And then within CPIA this could be a great place to find the repository of information that applies both to MIPS and to APMs in the future where you could use it as a test bed to find out, you know, how exactly you can implement data sources and use them effectively to really improve quality and engage with patients effectively.

So, with that I would love for Justin to weigh in a little bit more on how he thinks that maybe health IT can facilitate this or some areas that we might want to put in a parking lot for the future and maybe not necessarily within the comments for the NPRM.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Sure, yeah, the resource use item that I brought up was really like...you captured it very, very succinctly much more than I did in the three paragraphs that I wrote, but, you know, step therapy or imaging studies specifically is one that I know that providers have a difficult time with, you know, when a provider has an idea of trying to arrive at a diagnosis or trying to arrive at a proper treatment plan, you know, a lot of times the algorithm sort of forces them into additional resource allocation that they might not do and of course a lot of that is because they're trying to, you know, get a provider to choose a less expensive option to start with, with the hopes that option is going to provide the diagnosis or the treatment that they need.

But, you know, I think, especially with some of the providers that are here on the call, that's not always the case, you know, a lot of times you still end up stepping through all of those processes and I guess what my suggestion was is that, you know, not to necessarily get rid of the algorithm concept but when a provider arrives at a decision point let them choose...let's say we're going to talk about statins, if the

provider chooses one statin and it turns out to work then they get incentives because they did just choose one source of resource. If they end up going through four or five different statin therapies, you know, maybe there's a different way that you approach it.

But forcing providers to go through an algorithm without having the ability to choose I think is a big dissatisfier so Cris maybe one of the things, going back to your previous question that you asked about, is what are the things that we might be able to do, you know, that would be one I would suggest is if there is a way to change the algorithmic approach to allow providers that authority and autonomy that they thought that they were going to have when they came out of medical school and still incent them when they really are demonstrating that they are trying to reduce resource utilization and then penalizing them when it doesn't look like they're demonstrating or making any effort. Does that make sense?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

It makes sense to me. Comments from others?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

This is Gretchen...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, let me...

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Cris, could I ask a question here?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

And it's really because I'm completely oblivious, but within the discussion in the NPRM the clinical decision support tools that could be utilized, there is really no mention of them of course within resource use because it's all going to be scored off of claims, but moving forward is this an area where technology could help assess how best to apply the resource use a little bit better?

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, actually your question is similar to one that I was going to ask so let me throw out my question and we'll maybe compare the two your question maybe better than mine.

My question was, you know, the question begins with as certified health IT capabilities evolve over time, there's a little bit of a tendency to maybe predict or to force where we think those capabilities might evolve and in some instances that makes sense, in other instances it's the case that the market is going to evolve in ways that we can't of course see yet, but presumably will evolve in directions that are positive and we want to have the ability to incorporate some of those positive developments.

So, I would be interested in people commenting on your question, Gretchen, and also on the point of should we try to be directive or is this a place where we want to let innovation and the market and scientific advance lead the way, and advise ONC to figure...try and provide some advice and thought on how to incorporate those over time, incorporate the things we can't even see yet.

Maybe people think those questions aren't related at all and just want to pick one or the other too. Did we just muddy the waters too much or does someone want to offer an opinion about the issues, the question I just raised? Or have we just worn everybody out at the end of the week?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, this is John, Cris and if there's too much noise on the line I'll go back on mute, but, you know, I think in particular and this was some of our comments the CPIA domain offers really almost a unique program structure to much of what we've seen before that it could be a test bed for innovation in a way that doesn't necessarily require certification, at least not at the outset, but kind of validate, I don't know what the word is, validate, test, prove, you know, it's almost like a mini-CMMI dimension to say, let's, you know, for example the idea of providing compliance monitoring tools to support...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Did we just lose John?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Maybe we did, I'm still here.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Doggone-it it keeps...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

There he is. There's John.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah, I get...am I able to be heard?

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Yes.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Okay.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, you're good, thank you.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

All right, well what I was saying was the CPIA domain, I don't know if any of what I said was heard but the walls in my office, but the CPIA domain provides almost an incubator category for testing out what the role of HIT might be without necessarily mandating it to be certified capability at least not at the outset and let me give you an example and I'm correlating again to CPC+.

CPC+ has a bunch of HIT technical enhancement requirements, it probably could have benefitted from having something like CPIA pre-existed. So, for example their self-management requirements that go with comprehensive care for some of the practice requirements and the technology requirements and some of the things listed for CPIA are much the same thing being able to initiate program improvements or practice capabilities to support self-management of patients with chronic disease or even for, you know, monitoring medication therapy doing MTM.

It would seem like there is a real good opportunity there to correlate HIT capabilities to CPIA activities and maybe use that a bit as it could be almost like a guidance framework for the kinds of capabilities to look for that would be relevant to the CPIA activity, you know, self-management you could have, again, medication therapy monitoring, you could have formulary, not formulary, but drug utilization monitoring, you could have patient generated health data coming through telemetry that isn't necessarily explicitly linked to certified capability. You could almost think of a lot of things.

And part of our suggestion was it almost might be worthwhile developing, from a CMS perspective, a little more depth of guidance or framing around the kinds of technical capabilities that could support the activities that are noted in the proposed rule. I think that would be real useful. Folks could certainly be very ad hoc as to how a practice tries to go about them or it could be fairly structured.

It also, over time might be a place where things that just aren't feasible go to die, you know, or they never get hatched because it's just not a good...not everything needs to be automated through HIT, you know, but it is a place where you could use some...to do some experimentation that wouldn't be a huge risk and if it doesn't prove out, you know, you don't progress it beyond that. If it proves out it might be an area where you begin to look for places to apply standards or places to develop certification requirements if they should be broadly generalizable and they're real useful across programs.

The other way to play it is that could be a place where ideas grow to maturity that other programs may eventually adopt and especially if HIT criteria develops that becomes informative for the development of those criteria that other programs may find use for and I could find 10 things that I could correlate between CPC+ at least and the list of CPIA activities, you know, hindsight is always 20/20.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

So, John, how much of that would you embed in regulation and how much of that would you embed in, you know, just non-regulatory directives from ONC for the market?

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

I think earlier on much more the latter category. I mean, the thought just occurred to me.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

It's almost a functional version of the interoperability advisory, you know, as just a...trying for a metaphor there of something that ONC has done that is not regulatory. It might predict regulation but it's not regulatory and I'd want to take care with it that you don't overdue the point of it informing regulation as its main explicit purpose.

I think it's much more along the line of providing a place for collaboration on testing out what may work for good innovative HIT that isn't even necessarily strictly for a federal purpose either especially back to our point that Anne was making of collaboration across payer markets or payer books of business for a provider. The idea here is you're wanting to march improvement on a steady pace across a broad front not just Medicare and that could be a great proving ground for it.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Well, this is...that is really appealing to me John. I think one of the issues is going to be that often times, you know, ONC is in a really critical public role and will appreciate, in many instances, us making recommendations about where it should happen it's not through regulation.

I'd be curious to get other people's feedback on John's comments? I know I'm interested in the, if that makes sense, do we have guidance about where we should look for where that kind of development would naturally occur. Anybody want to comment? Well, we may have a little bit of Friday afternoon before a long weekend loss of energy and I'm feeling it too so I can appreciate it in my colleagues.

I would argue that I think what John was just talking about makes a whole lot of sense. The question in my mind is, you know, do we want to point to a natural place where that should occur? I don't think its places like standards development organizations. I don't know if we, you know, think...if we can identify some other kind of venue in which we would expect that to evolve.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Cris one thought is while they didn't exactly say how to solve it, I noticed something had to inform CMS in its development of the HIT technical enhancements for CPC+ it didn't just come to be in and of themselves. Maybe it's worth asking what informed that because now they are presuming that those are going to be capabilities that will exist in HIT and if you go look at them they include some things that are pretty interesting but I don't know the process that stood behind them if that was all lessons learned out of the first five years of CPC or if there was a collaborative effort that informed that which went on between professional societies for primary care, you know, like the AAFP, who is very strong, I could almost see...this isn't an accusation, I could almost see the hand of AAFP behind some of it and they're very active for HIT.

So, it would be interesting to know where did that develop because that might be a lesson to apply for similar efforts. So, if it was out of a professional society collaboration with CMS or if was out of a lessons learned from the CMMI program for the first five years of CPC it would be interesting to know that.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

This is Beth, we can put a pin...

**Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology**

This...

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

In that one and we can try and find that out from our CMS colleagues as well.

**Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology**

Yeah, this is Alex with ONC I'll just...knowing a little bit about the process, because we at ONC did collaborate on that, is that those additional capabilities for track 2 really started with the CMMI experience, you know, obviously since that was a model there wasn't a lot of public collaboration process since they're not able to do that with an open dialogue. So, that was really going back to what the clinical team there felt and also, you know, some things that ONC felt would be important to develop in that venue.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Got it. I think others were going to comment too? Speak up.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Well, Cris, this is John, I would have to say...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Maybe...

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

I would highly question that, you know, AAFP or people like Dr. Kibbe would not have some fairly strong opinions of that kind.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, yes.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

So there is not a shortage of sources is all I'm saying, I'm not trying to...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

No that's right after being friends with David Kibbe and others in that area for the last 10 years or so I totally agree and I think it's very, very helpful.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Yeah.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Very helpful. Yeah, I'd hope that Steve Waldren might have been able to join us for some of that for that reason or someone from ACP but I think we have someone from ACP on the other workgroup if I

remember right, other half of the workgroup. All right this is a good conversation. Any additional thoughts or comments on this?

All right, at risk of running the well completely dry Gretchen or others from ONC are there other points on question three or anybody else in the workgroup want to aim us at additional questions associated with this third question?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

I'll let Beth and Alex add anything that they think, but, no, I think this is pretty...this is really helpful and I'm going to go back and listen to the recording again and check over my notes just to make sure that I've got everything set but this has been phenomenal.

**Elisabeth Myers, MBA – Office of E-Health Standards and Services – Centers for Medicare & Medicaid Services**

Yeah, this is Beth, the only thing that...I would have the exact same comment this has been a really great conversation and we really appreciate all of your insight and thought that you've all put into this, it's really good stuff happening here.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Is there anything that was left...where we left a blank or you feel like you'd like to get some additional view-point or last call?

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

I just sent my other thing that I talked about, I sent it to the distribution list to the whole meeting so it should be in everybody's inbox.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

The thing I was talking about earlier.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes, thanks, Anne, that was really helpful. Did it back to everybody? It looked like it got to ONC staff and I think to me, I don't know if it got to the other workgroup members maybe we can do that distribution now.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

It just went to ONC staff and you Cris.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Okay.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

But you can forward it.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

We can copy all the members.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

If you could forward it that would be great.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yes, we can Anne, thanks.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yeah, Anne it's a really nice document, I think it's really, really helpful. Okay, so what's our next steps?

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Next we need to come up with a summary of what's been said here and circulate it to the group to make sure that we're good to go with that and next week, just so that everybody remembers, we have another full Task Force call on Friday the 3<sup>rd</sup> so we'll need to summarize everything and come up with the draft recommendations for everybody to look at by Friday to present to the Joint meeting the following week on the 8<sup>th</sup> I believe.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

That sounds great. So, people should be looking for documents from you with a summary of comments, correct, and we're aiming towards the 8<sup>th</sup> and then the 23<sup>rd</sup>.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Correct, that's where...well, we're going to present...

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Yes.

**Gretchen Wyatt, MA – Senior Strategic Advisor, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology**

Draft comments or draft recommendations on the 8<sup>th</sup> and then finalize them from the feedback, but definitely there is going to be back and forth with folks over the course of next week to make sure that we're presenting the ideas correctly so that we don't waste too much time next Friday.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Good. Any other questions or comments about next steps? If not maybe we should go to public comment and we can end a little bit early. Michelle, should we go to public comment? Did we lose Michelle?

## Public Comment

**Jaclyn Fontanella – Digital Project Manager – Altarum Institute**

Sure we can open the lines. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press \*1 at this time.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

So, while we wait for public comment I just want to thank everybody for all your contributions especially in such a short turnaround. I hope you all have an awesome holiday weekend, it's well deserved, and we'll come back refreshed to start working more on these comments. So, Jaclyn is there public comment?

**Jaclyn Fontanella – Digital Project Manager – Altarum Institute**

No, there are no comments at this time.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, thank you everybody.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thanks, Michelle.

**Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology**

Thank you.

**Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina**

Thank you.

**Cris Ross, MBA – Chief Information Officer – Mayo Clinic**

Thanks, everybody.

**Justin Fuller, RN, MSN – Program Lead, Clinical Informatics – Bon Secours Health System, Inc.**

Thank you.

**John Travis, FHFMA, CPA – Vice President & Regulatory Solution Strategist – Cerner Corporation**

Bye-bye.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Bye.