

**HIT Policy Committee  
Information Exchange Workgroup  
Transcript  
March 26, 2013**

**Presentation**

**MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good morning, everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's information exchange workgroup. This is a public call, and there is time for public comment built into the agenda, and the call is also being recorded, so please make sure you identify yourself when speaking. I'll now go through the roll call. Micky Tripathi?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Micky. Peter DeVault?

**Peter DeVault – Epic – Director of Interoperability**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Peter. Jeff Donnell?

**Jeff Donnell – NoMoreClipboard**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Jeff. However has their computer speakers on, if you can just mute them or put your phone on mute, because we're getting the echo. Larry Garber? Dave Goetz?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Dave. Did I mention Jonah Frohlich? James Golden? Charles Kennedy? Ted Kremer?

**Ted Kremer – Cal eConnect**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Ted. We're still getting the echo. Does anyone have their computer speakers on? Okay. Arien Malec? Deven McGraw? Stephanie Reel? Christopher Ross? Steven Stack? Chris Tashjian? John Teichrow? Amy Zimmerman? Tim Cromwell? Jessica Kahn? And any ONC staff members on the line, if you could please identify yourselves?

**Kory Mertz – Office of the National Coordinator**

Kory Mertz.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Cory.

**Hunt Blair – Office of the National Coordinator**

Hunt Blair.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Hunt. Okay. With that, I'll turn it back to you, Micky.

### **Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Great. Thanks, everyone, and thanks, workgroup members, for joining, and any members of the public who are listening in as well. This is the information exchange workgroup of the HIT Policy Committee, and today, we're going to take up the consideration of the various elements of the request for information from CMS and ONC regarding HIE and interoperability. What we laid out as sort of a tentative work plan at the last meeting was to consider this I think in five topic areas, which we'll walk through here in a second, and we've I think set as the work plan to talk about two of them today, and then we have three more that we'll discuss in our next call on Thursday, with an eye toward synthesizing all of that for presentation at the Policy Committee meeting in Washington next week, on Wednesday. So why don't we advance the slide, so we can walk through a little bit of the agenda, and then dive into the questions? Next slide, please.

So in terms of – as I said, in terms of our work plan here, we're – we have five categories that we want to talk about: payments, treatment of ineligible, ineligible meaning from a meaningful use perspective, that we'll take up today, and then at the next call we'll talk about potential state actions, we'll talk about infrastructure opportunities that – as sort of a lever for being able to further HIE and interoperability, and then finally, we'll consider labs and CLIA regulations. I'm sure a lot of other topics will come up in the course of this conversation, but again, we'll try to address it through these five categories. Next slide.

So here is kind of the response framework. I think I've already gone over this, so we'll just consider these five, and then I'm going to turn it over to Kory to walk us through the details of the slides. I'm not in the best position to speak very much because of the location I'm at right now. So let me just turn it over. Kory, if I could turn it over to you, and you can read through some of the questions that I think are coming up.

### **Kory Mertz – Office of the National Coordinator**

Yeah. Sure. If we can jump to the next slide. So before we hit those questions, I just wanted to go over quickly again the kind of five potential levers, kind of again at a high level bucketing category that we talked about on the last call. So, you know, regulation. That could be federal regulations of various types. Or the various payment levers that are available. Certification, either through meaningful use or, you know, ONC certainly has the authority to establish certification beyond just meaningful use. State actions, and then reporting and public reporting.

So – and I think this category is one we added after the fact. Micky recommended it, really in that vein of transparency, you know, making information available and helping people understand kind of the state of the market. So some of those types of actions are the other kind of lever that we want to make sure everybody's keeping in mind. So we're going to try to use these five as part of the bucketing when we think through the various – you know, kind of the payment bucket, the, you know, infrastructure bucket, those pieces. So this is – again, you know, these are just high level. I'm sure there'll be things that maybe fall outside of these, but these are one way we're trying to kind of focus in on thinking as we walk through these different areas. So next slide, please.

So these are the four questions that were teed up in the RFI around payment. So, you know, I think it can just be helpful to take a look at these and, you know, remember these as we are about to dive into this conversation around payment and what changes we should – you know, what potential changes we could recommend to help really drive things forward around HIE. So, again, these are the ones we crafted. I certainly don't think we need to read through these, but just wanted to put these up so everybody had a chance to take a look at them again quick. So next slide, please.

So this is just kind of what we teed up, and we'll just talk through this quick, and then I think really open it up for discussion. But some of the levers I think we can keep in mind, particularly with payments, are, you know, there's various requirements to participate in programs that CMS has, so we can think about how to leverage those requirements to drive participation in health information exchange. You know, I think we've certainly seen levers such as incentive payments through the meaningful use program. There's certainly a number of other programs we could think about to drive that sort of participation in health information exchange.

You know, and obviously, the flip side of that is avoiding the disincentives, which you also see in the meaningful use program. But I think you could also see both these types of, you know, incentives or disincentive levers in ACOs and some of the other various payment programs that CMS has. So again, just thinking about these as different levers you could apply to the various programs that are out there.

The federal purchasing requirement is, you know, one that I believe Arien brought up on our last call, mentioning, well, what about other federal agencies, such as DOD, VA, IHS, and others, thinking about, you know, what could they be doing to help drive HIE as well. And then I think the last thing that came up on the last call was this idea of could there be new, you know, codes or incentives added around care coordination payments. So for instance, in medical home models, we do add a specific code for, you know, higher levels of care coordination. You know, you'd have to go through certain process steps to be able to meet that mark, and then you could get that increased reimbursement level as a result of that.

And then just a couple of levers that were specifically raised in the RFI, again, was the CMS conditions of participation for hospitals or requirements for skilled nursing facilities and nursing facilities to get reimbursement, requirements to encourage HIE in ACOs, and thinking about new CMMI care and payment models. You know, they've got a lot of activities coming out of the Innovation Center right now. One thing they potentially proposed in the RFI was should there be requirements around having an HIE strategy for applicants, and then, you know, what sort of monitoring would you put in place after that?

And then, you know, the last one is just really focused in on HIE requirements and expectations and new care models, you know, be it ACOs, the dual eligible work, and a number of the other things that are coming out of CMS right now.

So really just wanted to tee that up as kind of a high level framing and some ideas to get people thinking. And at this point, I think we really want to open it up to a conversation about what are – what are the right items we want to put forward as a recommendation to the Policy Committee to then recommend to ONC and CMS, to use payment policy to drive HIE forward?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Thanks, Kory.

**Kory Mertz – Office of the National Coordinator**

Mm-hmm.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Just to – does it make sense for us to think of, you know, a couple of buckets? One would be, you know, sort of extension tweaking of existing payment models, so we have Pioneer ACO, we have shared savings, we have those, and then things that might be, you know, sort of genuinely new or – you know, that aren't there right now, like the care coordination payment you're talking about, and perhaps some other CMMI kinds of things? And I don't know what exists with federal purchasing requirements already, but that could either be tweaking or new.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. Hi. This is Dave Goetz. And one of the questions I think I had in thinking about all the different – either the SIM grants or the CPCI, the initiatives, or others, are those set in stone in terms of the ability to have a requirement inside those that there be some sort of, you know, point to point or whatever exchange engaged? Or, I mean, in other – can you go back and include that as the – I know with the SIM grants, they – the contracts are probably still under negotiation, so that might be open. But I think CPCI, a lot – those – a lot of those have been, you know, finalized.

**Kory Mertz – Office of the National Coordinator**

Yeah. I mean, the further – obviously, Dave, the further down a program you get, the harder it is to make any changes like that, and it's certainly much easier to do that at the outset. So, you know, it might be easiest to just kind of craft a general recommendation around what we – you know, what you guys think should be in those types of programs moving forward, and then maybe you could say, you know, as possible, apply it to existing. But I – you know, just working on the state HIE program and others here at ONC, I know, you know, once something's in place, it's much harder to make some of those modifications. But it can be possible, but it's just much harder.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Or do you think the SIM grants are too far out the door already?

**Hunt Blair – Office of the National Coordinator**

So this is Hunt. The SIM grants for the testing states, the testing states have basically the spring and summer to put forward their – I'm not remembering the exact phrase that's used, but it's basically an implementation work plan. So there's an opportunity there. And then the design stage, there's also opportunity there in terms of being able to make some recommendations about expectations.

And then I think in terms of CP – the medical home ...

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right.

**Hunt Blair – Office of the National Coordinator**

Those and the other CMMI programs, remember that one of the great features of those is that as they're evolved potentially from their experimental phase, if you will, if they prove out, then the Secretary has the authority to turn them into ongoing programs. And so even though some of those are already out the gate in terms of them being leveraged and becoming more ongoing strategies for payment reform and just payment – and transformation, then there's still opportunity there. So part of what we're looking for is what are the things, as Kory was saying, broadly that would help encourage broader adoption and utilization of HIE across that range of programs?

So I don't think – I think it's – for some of the specific programs, the horse has left the barn, but I don't think that – I think there are more horses –

**Kory Mertz – Office of the National Coordinator**

Right.

**Hunt Blair – Office of the National Coordinator**

– to be trotted out.

[Laughter]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

So both of those are multi-payer initiatives also, so one way to think about those is the inclusion of what the other payers could be asked to participate in. But I remain unclear as to whether Medicare can or would participate in anything that would be a particular add-on. But when you think about the need for what happens at transitions between acute care and SNFs, that they're paying for the first 21 days, and you'd think they'd want that to go well, right? I'm – has no one ever figured out a way to kind of encourage Medicare policy to do anything at that point?

**Hunt Blair – Office of the National Coordinator**

Well, I think that's part of – part of the point of this RFI, is to provide feedback along those lines.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right. Okay.

**Hunt Blair – Office of the National Coordinator**

You know, I will say that, you know, the history of CMS and Medicare in the modern era, if you will, is that there's been a lot more willingness to find – to find ways to enable things. I mean, even before ACA passed, Medicare found the statutory authority to implement the multi-payer advanced primary care demo, for instance, which on the surface, they didn't – you know, at first blush, they weren't sure that they had a way to do it, but because John Blum wanted to do it, they found a way. So I think that that's – that the scope of the request here is, you know, give us your best thinking about what could or should happen, and I think that this is, you know, to frame – to frame those things.

And in terms of multi-payer, I just note that one of the – that there's some interesting opportunities there, because as we are beginning to look at the reality of how that's going to play out for the SIM testing states, the notion in states larger than my home state, Vermont, that you're going to have statewide multi-payer, is probably not – not the reality in Pennsylvania, for instance –

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right.

**Hunt Blair – Office of the National Coordinator**

Kind of a market, you know, vastly different in different corners of the state, and that's going to be the case in lots of states. So I think that even there, there are opportunities for, as these programs roll forward, having – I think – I think one of the favorite words that everybody is using a lot around CMMI and ONC these days is iterative. So I wouldn't rule things out just because they have to be phased or iteratively introduced.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. So this is Micky. If we're going to talk about just maybe one specific question to help us parse some of this out, thinking of whether it's, you know, the SIM grants or CPCI or any of these other programs, Pioneer ACO, even though that's already out the gate, I realize, and then shared savings things, what do we think as a group about A, adding anything related to interoperability to try to future there, and to the extent that we think that we want to add something, what do we think about, you know, sort of the balance between what we might think of as process measures versus outcome? You know, is there any appetite for saying that we should build into those the kinds of process measures like you have in, you know, in meaningful use, that they should do X percent of this, that, or the other thing? Or do we want to focus more on adding things that might be more finely tuned outcome measures that you could only accomplish with interoperability? So that would be one angle.

And then the other is is there more a technology certification angle to this, to just say that the furtherance of certification – of the certification process for technology should be geared toward those things that we think ought to be happening more sort of assertively and in a more pointed way in some of these programs, these ACL programs? So sort of broadening it beyond meaningful use.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

You have to assume everybody participating in those programs is qualified for meaningful use, but that may be a wrong assumption, right? I mean, that may not be correct, but I don't know how you'd be – do a practice improvement initiative and not be qualified for meaningful use, but I guess it's possible.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. So that would suggest the question of is meaningful use enough? Is whatever is in the – in meaningful use pushing toward – that pushes toward interoperability enough to enable what they need to accomplish in these other programs, and if not, would we recommend adding further requirements focused on that?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

So what I keep coming back to in the language, and I'm sorry, I'll shut up and let other people talk, but I keep coming back to the concept of transitions, and – as expressed in the RFI, as kind of the most meaningful – seemingly the most meaningful, you know, focal point. Is there some way to – and this gets to your question of process versus outcomes, Micky. How would – what would we say is a difference in process and outcomes measures in the transition between, again, back to post-acute and nursing facility? So what is it that would be an outcome versus a process in that?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Well, I'll jump in. So, you know, I mean, again, a process one would be more along the lines of the meaningful use type of things that would – you know, perhaps could specifically think about different dimensions that it could extend to. So you could specifically say that – you know, I'm not recommending this. I'm just suggesting it as, you know, one type of process measure. You know, X percent of transitions of care to, you know, SNF or LTC have to be electronic and according to, you know, a particular transport content standard, for example. That would be sort of a process one, as opposed to something more specifically focused on, you know, readmissions or some other type of outcomes that you – would be difficult to accomplish without having underlying interoperability infrastructure to support it.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Okay. I'm sorry. I'm a little – I'm going to – anybody else want to step in here and throw anything on this – on this trail? If not, I'll continue to kind of riff on the idea. So – because if we in fact have the penalties that now attach to readmissions, you know, will people act in their own best interest, so to speak, to – and will they do it in a way that meets some, as you alluded to, standardized communication, both in transport and format, and would that be useful as a way to provide guidance to people as a way that, you know, then gives them the benefit of meeting or reducing readmission rates? But because it's done in a standardized method across multiple payers, across, you know, regions or states, it has a – it's more impactful. Does that make any sense?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. I think it does. I don't know whether it's more impactful because it's broader or because it's deeper.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Well, they could try to do both, right?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. Yeah.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I mean, I think both in terms of the depth of the content and the breadth of the reach by having it become almost a standard of care. Again, back to that phraseology that was used.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

In the RFI. We need more coffee this morning.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. I just have to step away just for 30 seconds. I'll be right back. Thanks.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

If people are doing episodes of care as part of a, again, one of their payment reform initiatives, should transmission of a summary at the end of an episode back to the relevant receiving place, whether it's a primary caregiver in terms of an acute care incident, or if it's a behavioral health, you know, stabilization stay in a mental health facility, you know, at the – each – any of – at the end of each of any of these episodes, should it be recommended that there be a – some sort of requirement set for the transmission of the summary at that point? There may –

**Micky Tripathi – Massachusetts eHealth Collaborative**

I'm sorry. I'm back.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

No, that's fine. I was just – there's a lot of people out there working on episodes of care.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And so should we recommend that that be – as part of any of the construction and approval of any episode of care, it would include the transmission, and not put a percentage on it. It would just be – you know, I mean, I don't know whether it should include. Maybe – I don't know. That's easy for me to say. But should include some – a transmission of summary of care to the – and care coordination plan to – you know, if necessary, to the receiving entity, whether if it's an acute care, like a knee or a hip or whatever, it goes back to the primary care physician, who's, you know, part of the patient-centered medical home, or whether it's in a health home, it's for someone who's, you know, SPMI, they've – and they've had a stabilization event. It goes back to the coordinator of the – for the health home model.

But it – if you're going to have any kind of episodic development, it seems to me that ought to be part of kind of – before you can consider it a successful episode.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. And then – so I guess, you know, we'd love others to jump in if they have thoughts there, but it seems like the question is what does meaningful use enable, and then what are we adding incrementally on top of that, if I'm understanding it correctly. Because some of what you're saying meaningful use would enable.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Well, it enables, but it doesn't – but it's very general, right?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And so if in fact at this point in time we have people constructing these different payment reform models, what can we include in that construction that drives interoperability?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. Do other people have thoughts on this, and whether we need to do this, because that's still, you know, certainly an open question. One could argue that meaningful use enables it, and they've got, you know, some payment reform incentives out there, and maybe they can, you know, pick that up and run with it.

**Arien Malec – RelayHealth Clinical Solutions**

By the way, just to note, this is Arien. I've joined the call.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Oh, great. Hi, Arien. So Arien, we're just talking about – we're sort of on the first part, about payment, and I think a general question that we've been thinking about is, you know, as we think about, you know, some of the payment – the existing – some of the existing payment reform models, like Pioneer ACO and others, and then as well, looking forward to the SIM grants that, you know, are a little bit more fluid right now, so there's a little bit more opportunity to bake some stuff in, perhaps, you know, what's the balance between saying that, you know, meaningful has created enough incentive and enable – and technology enablement to allow them to run with it, or we think that we could, you know, further advance in a more focused and aggressive way HIE and interoperability generally through, you know, sort of incorporation of some set of perhaps process or outcome measures in those particular payment reform models or experiments.

And that in general is kind of what we've been considering. Is, you know, is it enough already, or if not, what are the kinds of things that we might suggest to further enable it? And Dave had just suggested something related to perhaps episodes of care that would sort of take the transitions of care requirements from meaningful use and more sharply focus them on episodes of care.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah, and we suggested in the last call also the notion of could you consider working that you do on a transition as helping you to qualify for – and if you service program higher levels, ENM coding as another potential alternative, you know, meaningful use is soon going to become a penalty. And I guess the question is, is that, you know – is that – that was what Congress intended? Is that where we end up, or is there a role for CMS to use payment levers to further incent?

And I would – I would more in favor of payment policies that paid for either outcomes, or as I suggested, payment policies that recognize the work and labor involved and cognitive work involved in transitions, over payment policy that directly rewarded specific technology adoption or technology use.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I think I know what you mean by that, Arien, but do you want to be a little more specific? When you say technology, do you mean DIRECT explicitly, or –

**Arien Malec – RelayHealth Clinical Solutions**

Yeah, so – or well, yeah, that's not what I meant. So rather than, for example, specifically paying for the sending or receiving of a summary of care document, make the payment policy reward the cognitive work involved in, for example, reconciling medications, reconciling problems, reconciling allergies, performing other work, either at the beginning or at the end of the transition of care. You know, JACO – there's levers in JACO that are more accreditation, but for ambulatory care providers, there aren't those current levers either in terms of accreditation or in terms of – you know, you can't qualify for a level five billing code on the basis of the cognitive work that you do in a transition, and that might be something to consider.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. So you're talking about sort of more advanced process measures, then? It's not quite an outcome measure, but –

**Arien Malec – RelayHealth Clinical Solutions**

Correct. It's –

**Micky Tripathi – Massachusetts eHealth Collaborative**

– a simplistic process measure?

**Arien Malec – RelayHealth Clinical Solutions**

Right. It's a current – it's basically taking the current fee for service model and recognizing other work that is involved in those fee for service ENM codes.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Can it be a ladder? You know, in other words, it starts with a small amount for something simple, but if in fact, you know, what is transmitted includes that cognitive effort, that extra perspective on patient status really is what you're getting at, right?

**Arien Malec – RelayHealth Clinical Solutions**

Yeah.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Medication therapy management, as one, you know – something that's done kind of comprehensively and then transmitted back to the – I mean, let's face it. A lot of people show up in the hospital because all their meds have started interacting poorly, right?

**Arien Malec – RelayHealth Clinical Solutions**

Correct. And again, that would be – that would be an example of cognitive work that would be associated with a transition, but where you're paying for the work in a fee for service world as opposed to paying for the outcome in a – in an advanced payment models world.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. So I was just going to get to that. This would apply, then, to those who are still in the basic fee for service? This would not apply to those who are in some of these advanced payment models right now?

**Arien Malec – RelayHealth Clinical Solutions**

Right. That's –

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

... example? Yeah.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

So – yeah. So that example, just to follow that one down, so someone had done a comprehensive reconciliation of prescription drug usage and made recommendations, and then as part – and then transmitted that to primary care doctors, care coordination team, patient, family, you know, as part of that process. And that's what you're paying for, right?

**Arien Malec – RelayHealth Clinical Solutions**

Yep.

**Micky Tripathi – Massachusetts eHealth Collaborative**

What are some other examples of that kind of cognitive work? Med reconciliation is one.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. That's right. So there's med, you know, med allergy – there's problem list reconciliation. There is plan of care reconciliation, and this may overlap into just flat out paying for certain care coordination activities.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I know a physician who says that he gets paid to clip a diabetic's toes, but gets paid nothing for managing a complex diabetic's – diabetes patient.

**Arien Malec – RelayHealth Clinical Solutions**

Exactly.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Not to be too graphic on the phone call.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. It's early. Particularly out on the West Coast, Arien.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. It's really early for Arien. Okay. So I think that's – I think that's sort of a great category, what are the things – recognizing that most of, you know, Medicare right now is fee for service, with some, you know, specific examples of moving into value-based purchasing, but that seems like a good set of things for fee for service world. Are there other thoughts? Perhaps specifically related to the advanced payment model world? Or do we feel like, you know, there's enough outcome enabled – outcome pushed there and risk sharing there that – and enough of, you know, sort of a jump start from what meaningful use incents and enables, that that'll be enough?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

You know, we all thought – sorry, I'm not going to kvetch here, but, you know, I guess –

**Micky Tripathi – Massachusetts eHealth Collaborative**

But go ahead.

[Laughter]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

But, you know, there's been this assumption that kind of by laying out some of these broad ideas, that people would get it and start doing it, and we've been disappointed on that score, right, for a lot of different reasons. So, I mean, that's why – I mean, I think about, again, back – I think the cognitive idea is great, Arien. I think that's exactly what you do want to occur. I just worry that if we make transmission implicit, or any of this implicit in any way, that people just, you know, they don't get it.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. I guess my perspective now is we're building this on top of meaningful use, at least on top of the EHR capabilities that they have access to, and, you know, they can qualify on paper, but it'll be manual, laborious, or they can qualify using their EHR technology and HIE capabilities.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So that's interesting, though, Dave. I'd like to just push on that for a second, because – and it may be that I'm just in a highly perverse market here in Massachusetts, because at least what we've seen is ACO enablement has advanced more aggressively on the commercial side than it has on the public side, and particularly with Blue Cross AQC contracts, which have been out there now on the market and cover well over 50 percent of patients and providers in the market, and Blue Cross is over 50 percent of the commercial market in general. So that's really pushed it. And at least from what we're seeing, there is a lot of focus on HIE from a bottom up perspective, as organizations take on risk and start to enable technologies to better help them manage that risk. But as I said, that – it may just be a very perverse market that we have here, and would love to know –

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I think had an advanced – I won't say perverse, but I think it's advanced. I do think – I do think – and I do think there are things that are possible in a place with both the medical and intellectual fire power of, you know, Eastern Massachusetts, that are not plausible in rural West Tennessee, you know.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. So it –

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Or is obvious.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. But does advanced mean that we just need to let it mature on its own? Or that more is needed in other places?

**Arien Malec – RelayHealth Clinical Solutions**

This – yeah, this is Arien. That's my perspective as well. We're seeing the same kinds of trends, not in Massachusetts. We're seeing the buying pace for and adoption pace for HIE accelerate ... advanced utilization, at least some percentage of patients are going to be at some level of risk. And that's, as you note, primarily driven more by the commercials than it is by the public payers, although there is some move to be an MSSP that we're seeing.

And those kinds of moves tend to come with them, as I noted, the adoption of HIE technology. So I've got the same perspective that you do, that the move to advanced payment models is accompanied by the move to adopt HIE, and it's not just confined to strange places like Massachusetts and California.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Which are very strange places.

**Arien Malec – RelayHealth Clinical Solutions**

Which are very strange places.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

But to Dave's point, is there – ... and is there a reason to think there may be sort of a rural/urban split, or that there may be – you know, again, is this really just about, you know, just the market just needs a little more time, or there are some significant barriers in certain strata that we would want to consider formally? And if not, we can just say that we think, you know, that with some tweaks to – as we already talked about, perhaps for the fee for service side of this, and as – given that there's going to be a tail of that for quite a long time, and from what we've seen in the advanced payment models, that they actually are, you know, significant drivers – the payment model itself is a significant driver of the enablement of HIE technologies, and the corresponding processes that one would build on top of that to accomplish what we're trying to accomplish with respect to interoperability?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Okay. Without being restrictive, okay, and I understand, you know, this is kind of – this is this dance we've been in now for a long time, right? And so I get all that. But is there a way that does not constrain what is occurring in the more advanced areas, but provides channels for people to follow in the – as these things roll out, that in fact then enable – I'm trying to figure how we enable the cognitive work, okay? Because again, coming back to that concept, and how we do those things that in fact drive that process, which is what we've all been about for a very long time, and yet we've had all these things that have – the connectivity underneath by whatever means has not been there to encourage that to happen.

Again, payment models are kind of a great way to do it. I'm just trying to figure out if there's not some way to build this in, you know, to these different cognitive pieces, but do it in a way that provides guidance to people as to how they can do it. When they're out there really just trying to figure out, okay, I see this – I see this train coming at me. I've got to figure out how I run fast enough to catch up and get on the train, because I think there's a lot of people out there like that.

And when I think of – when I think of Medicaid providers, again, back to that – to that role, and I think of, you know, a lot of them mentioned in the RFI about long-term care facilities, behavioral health, those poor community mental health clinics that are out there have QHCs. They're in much – they're in a little better shape, because community mental health centers have largely been dependent upon state funds. And so, you know, I mean, as I think about those people who we have to have – if we're going to have, you know, a health home model, or – that works, you've got to have all those people in here.

So what is it that we would kind of provide any guidance to that would – that would help drive this forward? I'm sorry. I'm just – I'm just thinking about those guys.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No, I think that's right on point. So I wonder, is that an argument that almost gets us to the next question as well, which is to say that there are certain things that would need to be done in the fee for service world, because there's a tail of that that's going to be there for a long time, and – but from what we're seeing, the advanced payment models, to the extent that they can be expanded, both in terms of who they cover – in terms of breadth of what they cover, but also who they cover, could be a part of the key here? In terms of who they cover, Dave, it would be, you know, adding those types of organizations who have been underserved up until now.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Mm-hmm.

**Micky Tripathi – Massachusetts eHealth Collaborative**

What do people think about – so basically saying that advanced payment – the advanced payment model seems to work. First off, we agree with that. And second is just a recommendation to be as aggressive as possible in expanding that model.

**Arien Malec – RelayHealth Clinical Solutions**

I would agree – this is Arien. I would agree with that. I'd also note that there's a certain observation that I'm seeing, which is people are lost in the details of those payment models, and they're lost in the mechanics of those payment models. So they're trying to figure out – they're optimizing for the particular outcomes reporting. And so work that CMS does to harmonize outcomes measures, harmonize quality measures across the programs, would help people focus less on the mechanics of the program and more on the quality goal that you're attaining. I'd also add that it's important for CMS to work with commercial payers to make sure that there's alignment of those to the extent possible across programs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I think that's a great point. I don't know if any of you've seen it, or maybe you're offering it, but there are now vendors, including EHR vendors, who offer as a commercial consulting engagement, we will help you align your incentives. You pay us, and we'll come in and we'll tell you, here, you've got these 18 different incentives. We'll tell you how to line all that up, and, you know, we charge \$100.00 an hour for that.

**Arien Malec – RelayHealth Clinical Solutions**

What's the opposite of market failure?

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

But I think it speaks to your point, right, that there are just too many details, and it's a real need. People can't figure it out. And they feel like they're leaving money on the table.

**Arien Malec – RelayHealth Clinical Solutions**

Right. And so if you did harmonize, you'd basically set goal posts and say, just go achieve the goal post and there'll be some program that works for you, as opposed to the other way around, which is, all right, I'm going to pick a program, I'm going to do risk arbitrage to figure out which program I should pick, and then I'll narrowly work on the measures for that program.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. I think that's actually a great perspective and a great – you know, a couple of great recommendations there, from a policy and approach perspective. Is there anything else to say on the payment model question? I mean, I know that – you know, there's like a ton of detail, but it feels like we're at – it feels to me like we're at the appropriate level here of talking about what seems to work and what doesn't, what might then be sort of areas of emphasis, and then, you know, encourage CMS to think about the different levers and different things they can do to make those models easier to actually implement on the ground.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Can I ask a process question?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Mm-hmm.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

So we are – you know, we have this call today, we have our call Thursday, and then Kory gets the joyful task I assume again of trying to make sense of our hash, and –

**Micky Tripathi – Massachusetts eHealth Collaborative**

At least as much as I can push off to him.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right. Right. Exactly.

[Laughter]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And then you get to present that to the Policy Committee next week. Is that – is that the plan?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Since I can't push that one off to him, I –

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. Exactly. Yeah. Yeah.

[Laughter]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Well, your car could still be in the shop. But – then what is the Policy Committee's intent with this? I just wasn't ever clear on that.

**Kory Mertz – Office of the National Coordinator**

Oh, well, I – this is Kory. You know, I think it'll be the standard process of transmitting those recommendations to HHS and, you know, putting them in as a response to the RFI.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Okay. So they will – are they – and there were no other groups, if I remember right, working on this particular RFI at this point?

**Kory Mertz – Office of the National Coordinator**

Correct.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

But – so – but then the full committee will take it, do its thing, and then – and then have it in, what, the 22nd is the due date, right? April 22nd?

**Kory Mertz – Office of the National Coordinator**

I – it's right around that. I don't remember the exact date.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yep. Yep. Okay. Sorry. Just – I just wanted to be sure I understood what our –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. Right.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

– whole process was. Thanks.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Given that we're only going to have two calls to focus on this, let's only get 30 minutes in the agenda, Kory.

**Kory Mertz – Office of the National Coordinator**

Yeah. No. That's –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Don't put me down for 90 minutes, please.

**Kory Mertz – Office of the National Coordinator**

No. That's all we got. We got 30 minutes. Don't worry.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

... kill me.

**MacKenzie Robertson – Office of the National Coordinator**

Hi. Sorry. This is MacKenzie. I hung up instead of taking myself off mute, so I just missed the vital conversation that just happened. So I don't know if there were any questions to me, but I just heard Kory saying that there are 30 minutes on the agenda. This is just intended for once you present to the Policy Committee, these are just comments that we're submitting to the RFI. So the Policy Committee will probably deliberate and ask some questions, and then we can transmit them to ONC as comments on the RFI.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Perfect.

**MacKenzie Robertson – Office of the National Coordinator**

So do you think 30 minutes will be enough?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yes.

**MacKenzie Robertson – Office of the National Coordinator**

Okay. Good.

**Kory Mertz – Office of the National Coordinator**

Yes. He doesn't want ...

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. So it sounds like at least with respect to the payment model question, what I've got, and please tell me if – you know, if – any other refinements here, and then we'll put this on a paper, and then obviously give everyone else another shot at it. But I think what I got so far is that what we, you know, seem to be seeing is that the advanced payment models seem to be pretty effective enablers of more advanced HIE capabilities, and then a couple of points related to that.

One is there is still a significant fee for service tail out there, and we probably still therefore want to address that, and, you know, and then one – part of the idea is Arien's idea of the cognitive work being compensated in some way through higher ENM codes, or there could be a variety of other ways to do that. But better aligning the fee for service world toward – this is one thing with the – with the tweaking of the existing tools that they have.

And then as we think about the advanced payment model, then, thinking about ways that that can be broadened, both in terms of its depth and in terms of its breadth, to a broader set of payers, as well as to the broader part of the healthcare delivery system overall, and how to make the advanced payment models easier so that people can navigate – can implement them easier with respect to the programs themselves, and figuring out what those are, but in conjunction with all the other programs that they have, whether it's meaningful use or any of the other incentive payment models, so that – and I think ... specific ideas of how they could do that, harmonizing measures and what have you, and we can start to detail some of those out.

**Arien Malec – RelayHealth Clinical Solutions**

Yep.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Is that a reflection of where we are right now?

**Arien Malec – RelayHealth Clinical Solutions**

I think that's exactly right. And I just also note that the making it easier also implies focus more on the quality outcomes than on the program mechanics. So to the extent that we can set clear goalposts across programs, we get people more aligned on hitting the goalposts, which naturally involves use of technology and information exchange.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. That's a good point. And some of it actually gets into this, you know, this idea of deeming, right?

**Arien Malec – RelayHealth Clinical Solutions**

Correct.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And from what I've seen, everyone loves when you use that word, so I'll make sure to use it.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. I was going to say, you lost me on that one. What's the – what are we deeming?

[Crosstalk]

**Arien Malec – RelayHealth Clinical Solutions**

Yeah, deeming is the notion that if providers are achieving the outcome measure, that you deem achievement of the process measure. Also the notion – I think it also incorporates the notion that you can qualify for multiple programs with the same – potentially the same measure.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Okay. Yeah. That makes a lot of sense, the second one in particular. One of the things that just occurs to me, and again, I'll just toss this out, but – and I don't know that there's any way to really measure this, but how do we know that at a transition, it's actually comprehended and understood on the receiving end? I guess that's just – I'll just toss that out, but I'll – and leave that alone. But I –

[Crosstalk]

**Arien Malec – RelayHealth Clinical Solutions**

Again, I guess my perspective on that is if we – if the notion of paying for cognitive work gets in, we just assume that doctors are going to be good doctors, right? They're going to – they're going to do the appropriate work.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. That would be for the –

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

But the pharmacy – the pharmacy at the nursing facility makes the adjustments to the medication therapies because they've received this, you know, very careful analytic report from the facility where they sent to detox off the drugs they were on.

**Arien Malec – RelayHealth Clinical Solutions**

Oh, yeah. Well, we – that is another point. I didn't – we haven't talked MTM, but we really should.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. That's a big one.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Talked shat?

**Arien Malec – RelayHealth Clinical Solutions**

MTM, medication therapy management. So CMS already includes – boy, there's Five Star, there's MTM. CMS already includes a set of quality outcomes for Part D focused on pharmacy and focused on PBMs, qualified payers under Part D, PDPs. And that's actually driving some level of adoption of cognitive work in pharmacies. I think the view on the ground is that it's not enough to shift – to push it over the line in terms of more full pharmacist incorporate into care planning processes. So we might want to comment on accelerating levers that CMS has in part D.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And aren't they going to expand those requirements here soon? isn't there – isn't there something that's going to be more of a general – or maybe it's a definition or qual – of what those requirements will be on the STARS piece.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. On the STARS piece.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

So certainly duals will fall into that category, right? Involve the state programs. Sorry. I'll stop riffing here.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, no, this is good.

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Because again, we don't have to spell out the details, but I think just, you know, putting a highlight on a particular area that there are potentially a number of levers it seems to me it's kind of our job.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. That's right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Is there anything else on this before we move specifically to the question of the ineligible? I mean, I think we've already bled into that topic a little bit.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Well, pharmacists would be an ineligible, wouldn't they?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

... MTM thing. They enter – they – they're the ones who, for the ambulatory, certainly, are the ones who end up implementing the medication therapy management or counsel – even counseling with the – you know, with the – with the patient, right?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And saying, you know, this is what has been recommended for you, or this is – you know, we're trying to – trying to balance these things. I don't think they get paid for that, right?

**Arien Malec – RelayHealth Clinical Solutions**

They do get paid for that under some programs.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right.

**Arien Malec – RelayHealth Clinical Solutions**

Under the MTM – under MTM programs. And so –

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Does it vary by the program, I guess? Or – I mean, I guess you could –

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

They may just do it on their own without having been paid for it, too, right?

**Arien Malec – RelayHealth Clinical Solutions**

Right. And there's – yeah. There's just – there's some infrastructure issues that occur, which is pharmacists are set up to bill for the MCCP B1 codes, and you get MTM billing under 837s. And there's just – there's some structural impediments to broader pharmacy participation in MTM.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

That seems like a shame, kind of. I mean, isn't that kind of the natural –

**Arien Malec – RelayHealth Clinical Solutions**

Well, yeah. So the broader perspective that I have is we do work with, for example, with military treatment facilities as part of their medical home model, incorporate pharmacists as a part of the care team. And what they've found is that, you know, pharmacists are kind of like – they're sort of – they're an in between role between say an NP and an MD, and for – if you've got – if you've got a good pharmacist to patient ratio, there are some patients that really benefit from the level of planning that pharmacists can do. So, you know, they're the right tool for the job if you need to manage a complex set of medications. They're kind of expensive if you want to do them – use them for ordinary care management activities. There's at least some evidence that if you look at the Kaiser models and you look at DOD models, when you take the payer out of the mix, or you take fee for service out of the mix, you get the natural models that involve pharmacists and care delivery.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Would that not be the tendency of payment reform, too?

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. Yeah. If you go – if you go all the way in the direction – if you push all the levers, you're going to get there at the end of the day.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

At the end of the day, we're all dead.

**Arien Malec – RelayHealth Clinical Solutions**

That could be.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

So – but what does that suggest – in terms of – does that suggest any specific recommendations?

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. So are there ways that we could align MTM and STARS programs' models –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Arien Malec – RelayHealth Clinical Solutions**

– that recognize the role of information exchange, in particular, the ability to transmit and receive – send and receive a consolidated CDA or harmonized to meaningful use consolidated CDA? I think there's potential work that CMS could do to harmonize the medication plan, the MAP, medication action plan. Everybody's got a slightly different word for it.

So the MAP in an MTM context is really just a plan of care that's medication focused. We've got the – again, just going on the dual eligibles, or the ineligibles category, we've got the MDS, and I think we've already made comments in terms of harmonizing the MDS to the consolidated CDA, or harmonized with meaningful use document measures, and work that could be done – that could be promoted by ONC, for example, to harmonize the plan of care requirements for future stages of meaningful use to enable a plan of care that's constructed in, for example, a pharmacy or a long-term care facility, to be transmitted to and received by a meaningful use eligible care provider.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I'm sorry. I'm having a brain flash. MDS in that – in this context means –

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. So I'm mixing programs. MDS is the – is the required data sheet that long-term care facilities –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right, right, right. Right, right. Got it. Sorry.

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

... is the data set.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Got it. And OASIS is the one that's done for –

**Arien Malec – RelayHealth Clinical Solutions**

Home health.

**Micky Tripathi – Massachusetts eHealth Collaborative**

– home health. Right. Got it. Got it. Thank you. Sorry.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right. So in general, these two things that Arien had just mentioned, they would allow a more automated way of making a more comprehensive plan of care.

**Arien Malec – RelayHealth Clinical Solutions**

Exactly. So I did an MTM program in Wisconsin, or assisted in an MTM program in Wisconsin a few years ago, something like that, and the big problem that we had in that program was that pharmacists were great at creating the medication action plan, and then it was send it via fax to the provider. And that was – that was kind of unsatisfying. So DIRECT helps with the transmission piece, but there's no good way right now to format that medication action plan as a plan of care and send it to the provider.

So to the extent that we could have MTM and STARS programs aligned with the transition of care measures for meaningful use, that would be helpful. And to the extent that we could solve the standards issues related to normalization of a plan of care and align those for stage three, that would also be useful. And then our previous comments relating to the long-term care and home health alignment.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. I think that's great. Any other thoughts in this area? I think that's pretty good, you know, a solid set of recommendations to give some guidance. So we've already gone down the path of ineligibles. Are there other categories of ineligibles? We've really – you know, we've hit a little bit on pharmacists. We've hit a little bit on LTC and home health.

**Arien Malec – RelayHealth Clinical Solutions**

We're going to get to lab, right, later?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Lab we're going to do next time. Right.

**Kory Mertz – Office of the National Coordinator**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And we can talk about it a little now, if we feel like, you know, there's nothing else to say in any other categories.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

No, no, no. I've got two, behavior –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Go ahead.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

– and develop – the behavioral and developmental disabilities.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Go.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Just, again, back to those areas. The – if you're going to do a health home, you're going to have to coordinate across that, across those different entities. So I throw that open as categories. I don't know that I have a particular answer at this point. But they are certainly in dire need, and have a need for segregated, because of the PHI protection issues, have need for segregated, you know, ability to exchange information. Right? Because it's got to be going to the – a more limited set of providers, and it has to be constrained about being generally available.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Micky, this is Amy, and I just recently joined, so I've been just trying to get a feel for the conversation. Can you define what you mean – what you're talking about with ineligibles?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. Those –

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

I came into the conversation. I didn't want to disrupt the conversation. I was trying to get a hang of what you were trying to go for with that, but –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Sure. Yeah. Yeah. Definitely not a pejorative term. It means those providers who are not able to directly receive a meaningful use incentive.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Okay. All right. So ineligible for MU?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

And we're – and the conversation is how to drive HIE for those where there's – where they're ineligible for meaningful use?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yes.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Okay. I just wanted the context. Thank you.

**Arien Malec – RelayHealth Clinical Solutions**

By the way, I just want to note, our previous comments related to fee for service, and our previous comments relating to quality and alignment of quality programs would also apply in this areas as well.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. So is there anything specific with these that we haven't touched on?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I just wanted to be sure to note that home health would be in the same category, actually.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. I put the under LT – or along with LTC, but I agree.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right, right, right. I mean –

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Go ahead.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I mean, I'm just trying to call them out as people that – I haven't got an answer right now. I've got to say, I'm kind of groping a little.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Well, it sounds like we're – you know, part of it is what are the things you can do, and then who would they apply to, so it is important to call out and get on the map, at least, who we're talking about here. So we have pharmacists, LTC, home health, behavioral health, and developmental disability providers.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Mm-hmm.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Is there a term of art for that?

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

It might be long-term services and support. That's how Medicaid refers to some of the more home and community-based service providers.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I think of DD as a little separate, just because they have a lot of very different therapies that are paid for usually state only, because they're not acute-based, and that – but that fit into, again, an overall plan of management in a health home. Kind of, again, back to a health home context as opposed to a patient-centered medical home. So it's really about building that care coordination plan.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay. They're – oh, just one final thing. Are there any standardized types of care plans or other, you know, sort of artifacts that are used in behavioral health or with development disabilities that we want to call out? You know, similar to the MTM and MDS OASIS? If not, that's fine.

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

I don't think there's a federal standard, because these are all state programs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

States are going to have their own kind of methodology around that.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

That will – you know, some of that will be around the payment model that they have.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

And most of those are not – they are full fee for service. They've not been really shoved under managed care as much.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Behavioral some, but DD, not so much.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Thanks. I can ask Larry Garber to – he knows a lot about these types of programs, I think.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So Micky, again, I apologize for coming into the conversation late. I don't know if this – it applies in this category or some others. One of the things that is beginning to come up a lot, and it impacts HIE, but from a slightly different perspective, is sort of the ability to have – and again, if it doesn't fit in here, tell me, and we'll figure out where it fits in. The ability to have – to allow individuals, either patients themselves or providers, to fill out standardized questionnaires and tools, whether it's development screening, whether it's substance abuse, or, you know, any form of substance abuse tools, and then have them analyzed in an algorithm, and then whether they go into – you know, part of – embedded in the EHR and/or then shared with others that are relevant.

So what made me think about that is you were talking about MDS and other sort of systems or names of care plans or tools, but there are – so that's come up in our state in a couple of different instances, and I don't know if that – where that would fit in, but I'm just sort of throwing that out, as I thought of the tool.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So is that about having a more standardized tool across all care settings? Is that what –

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

It's standardized – well, there are – there are different standardized tools. It may not be across all care settings, but there are standardized tools that individuals need to fill out, like questionnaires that are then – you know, that are then scored to – you know, for screening of different situations, developmental screening, alcohol and substance abuse screening, you know, different kinds of things like that. And then they may be shared from there.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So I don't – so I was actually talking about the tool, but that may be more sort of a specific EHR and not an HIE – I'm trying to think is it more of an EHR, an HIE, or both.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Well, I think –

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

It does relate to transitions of care. For instance, there's – you know, there's an RFP out right now around trying to do some stuff around something called expert screening treatment and whatever around alcohol and substance abuse. And again, a lot of these – and even with development screening, it's about, in an electronic world, not having people have to administer these standardized screening tools to determine, is something at risk for something, to then refer them for treatment, refer them – or refer them for further testing, and to do that in paper when the rest of the world is elect – you know, when the office has already moved electronic.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So that may not fit in here. I mean, it may be ... and I don't want to take us off topic. But when you were asking about standardized things, it just came to mind as something I know we're dealing with in two different instances in our state.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No. I wonder, Amy, if this would fall into something we were talking about before you joined, which is a basic recommendation about using – enabling payment for what Arien I think nicely called cognitive work that right now is uncompensated in fee for service. And it seems like this might be in that category of the kinds of things that are uncompensated now, but definitely contribute toward better care, and therefore, with either higher ENM codes or whatever, you know, you could imagine being able to have a fee for service model at least paying for work related to that that would presumably result in better outcomes, and would presumably provide incentives for people to have these things be more automated and interoperable.

**Arien Malec – RelayHealth Clinical Solutions**

And I think what Amy's also noting is that to the extent that those – that those standard assessments – to the extent that they're mandated by or encouraged by CMS or by Medicaid, could be aligned with meaningful use associated transition of care standards.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Arien Malec – RelayHealth Clinical Solutions**

So if you could – if you could include the output of an assessment as a section in a consolidated CDA, you could actually transmit it electronically.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Right. That would be great. And then – so that's one issue. That's more of the transfer of the stuff. You know, we've had discussions, even if it – if you can put it in there, you know, would someone want to actually see the tool itself? Then there's making the tool just electronic, right? So it's both. So I think it could fit in there, and again, I just want to throw it out. I – because I know I came into the conversation late, and I'm – just wanted – it just hit me and I just didn't know where it fit, so –

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

No, I think it's great.

**Arien Malec – RelayHealth Clinical Solutions**

You often have programmatic rules that require the use of a federal – federally approved form, and this kind of thing, right, that make it difficult to make the transitions electronic.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. That's a good general category for us.

**Arien Malec – RelayHealth Clinical Solutions**

Yes.

**Micky Tripathi – Massachusetts eHealth Collaborative**

One of those seemingly no-brainer kind of recommendations that is not happening. Okay. Let's see. All right. So back to where we were. I think we were down at the end of ineligibles. I think we had kind of wrapped up the behavioral health, developmental disability. Now we have the LTC home health pharmacist. Are there any others for – I think this was – actually, we got two hours for this call, so we have another 45 minutes, so we could actually move into labs, if that makes sense to everyone, as sort of the other category of ineligibles that we had put in the work plan for the next call, but if people are prepared to talk about that, we can certainly take that up now, unless there are any others in the ineligible category, or any other thoughts on the payment – general payment topic that we started with on this call.

Okay. Should we turn to labs? All right. How are we going to get labs done?

**Arien Malec – RelayHealth Clinical Solutions**

Well, the obvious one is to align recommendations under CLIA with the meaningful use objectives. So right now, the CLIA guidance – I'm going to back up. CLIA requires – CLIA, the Clinical Lab Improvement Act, administered by CMS, oftentimes involves accreditation by states, but many of the states and state inspectors are paid for by CMS. In order to receive accreditation, there's a whole set of activities that labs need to conform with. Among those is verifying the accuracy, the clinical accuracy, of laboratory data that's sent to providers that historically has been requiring that – the print version of the lab contains required display elements.

In the transition to the electronic world, those same requirements hold, and the lab is required to verify that the EHR – the EHR that it's sending to is able to display the CLIA required display elements appropriately in the EHR. And based on the way that the rules are defined, each lab is required to do verification – which can take the place of taking screen shots and verifying it by the lab personnel, each lab is responsible for verifying that output on the first instance of each EHR that they send to, and then from then on verifying transmission of the data to each additional instance of the EHR.

And this is regardless of what standards the EHR supports. Now the CLIA guidance says something vague to the effect of use of standards may facilitate the lab's obligation, but there's no recognition that if the lab transmits in the meaningful use recognized standard, the so-called LRI spec, and the EHR is meaningful use certified, that there's an expectation that the lab has met its obligations under CLIA. And so creation of a safe harbor in those cases would greatly facilitate connecting up and reduce a significant amount of the cost associated with connecting up labs. Because it's a compliance issue, labs tend to – they take their compliance efforts under CLIA very seriously, and so you tend to have lengthy QA times when getting the connection is pretty easy; getting that connection approved for use to put into production ends up taking quite a bit of time, and you're not able to reuse a lot of the good work that's been done EHR to EHR and lab to lab.

So the – sorry, that's a long background. And the recommendation would be to establish a safe harbor for labs that transmit using the ONC recognized standard to EHRs that have been certified to receive that standard.

**Micky Tripathi – Massachusetts eHealth Collaborative**

So on the transition side – this is Micky. On the transition side, if you're a hospital lab, you would be certified through the meaningful use process, assuming you choose that as a menu set.

**Arien Malec – RelayHealth Clinical Solutions**

Assuming you choose that as a menu set. Correct.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And so this would extend that to the commercial lab side?

**Arien Malec – RelayHealth Clinical Solutions**

That's correct. So it would also – if you're a hospital lab, you can get certified, but you still have the requirement under CLIA, even though you're sending a certified standard to an EHR that can receive a certified standard, you're still required to do the verification.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. At each – at the first instance of each EHR. Right.

**Arien Malec – RelayHealth Clinical Solutions**

Correct. So we could also comment that you could, for commercial labs, you could reuse the existing certification that exists for – under meaningful use for hospital labs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Other comments on this one? Given what a big recognized gap this is, it seems like a pretty sensible approach to it, and something that's within CMS's authority. Any objections? Okay. We'll include it. Thanks, Arien. That's a good one.

**Arien Malec – RelayHealth Clinical Solutions**

Yep.

**Micky Tripathi – Massachusetts eHealth Collaborative**

I know you just thought of that off the top of your head, yeah?

**Arien Malec – RelayHealth Clinical Solutions**

Just off the top of my head. I haven't been thinking about this for a long time and –

**Micky Tripathi – Massachusetts eHealth Collaborative**

For years.

[Laughter]

**Arien Malec – RelayHealth Clinical Solutions**

Haven't had discussions with folks in CMS, in the CLIA organization, or anything, on this exact topic.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Arien Malec – RelayHealth Clinical Solutions**

Or anything.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Are there – is there anything else really with the labs? I mean, I think we could certainly say something about – I mean, I think, you know, it was our workgroup that was instrumental in getting the hospital lab delivery requirement into meaningful use. It's now a menu set item. It certainly wouldn't hurt to make that – you know, suggest that that ought to be as aggressively applied as possible, as we anticipate stage three.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah. Agreed. It was also defined, and this was probably not appropriate for this RFI, it was defined as – I don't know exactly the mechanics for how it got defined this way. It was defined in response toward electronic order, and I actually think that lifting that restriction would increase the likelihood that EHRs could receive the incentive, or the menu incentive.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay. Just so I understand, Arien, it's – the requirement is they do an actual verification on the first instance of each EHR, and then verifying transmission for each other instance? What does that mean?

**Arien Malec – RelayHealth Clinical Solutions**

So you need to – again, let's pick, you know, EHR X.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Arien Malec – RelayHealth Clinical Solutions**

You know, EHR brand X. I'm a lab. Regardless of whether other labs in my community have already connected to EHR brand X – so oftentimes, for example, Quest and LabCorp will have built-in connections for EHR brand X. Regardless of whether that work's already been done, the first time that I connect to EHR brand X, I need to do – I need to get the – I need to set up my connection, and then I need to have the provider of EHR brand X, using EHR brand X, to print screen shots of the received labs, and usually I do chemistries and microbiology and, you know, just try to do enough of a representative of the kinds of labs that I sent so that I have good compliance.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Mm-hmm.

**Arien Malec – RelayHealth Clinical Solutions**

I get screen shots. I verify the screen shots against the required display elements, and that's a – that's an extensive process. The next instance of EHR brand X, as long as it's the same version of EHR brand X that I connect to in the community, I can – I can accept that previous work as a given, but I also need to send a test transaction and verify that there's additional work that I need to do to make sure that the lab is being sent safely, securely, privately, and with high reliability, to each EHR instance. That tends not to be a significant impediment. It's really that first-time testing that tends to be the –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Right.

**Arien Malec – RelayHealth Clinical Solutions**

– the larger roadblock.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Yeah. I was just wondering how you were defining instance. So it's a version –

**Arien Malec – RelayHealth Clinical Solutions**

It's – no, it's a literal instance. So if it's, you know, Dr. Smith uses EHR brand X, and Dr. Jones uses EHR brand X, and they're not the same instance, then I do the full requirements for EHR brand X the first time for Dr. Smith, and then for Dr. Jones, I just make sure that they can receive it and verify the transmission. Now if EHR brand X is a significantly different version for Dr. Jones, and they've, you know – and it's different enough that it potentially materially bears on my CLIA compliance, then I may do the full cycle again for Dr. Jones.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Are there technical definitions for what would constitute a new version, or is this art –

**Arien Malec – RelayHealth Clinical Solutions**

No, it's in the – it's in the – you know, would it – would it affect the display of the CLIA required display elements, etcetera?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Okay. Classical – you know, compliance folks are – it's a risk that the lab needs to take for compliance, and compliance folks and risk don't really go together.

**Arien Malec – RelayHealth Clinical Solutions**

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Is there anything else in the lab category? There's none that I can think of. And this was – I mean, the big one seems to be how do you get commercial labs into this, and this seems like a pretty effective way to do it. Okay. So at this point, we actually still have 30 minutes, and so we could either end early or we could pluck off one of the other remaining categories from what we're going to do on the next call.

[Crosstalk]

**Arien Malec – RelayHealth Clinical Solutions**

I would vote for going forth and then starting later on the next call.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, you would.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah, I would.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No, I think that's – I think that's totally fine. Is that okay with everyone else?

**Hunt Blair – Office of the National Coordinator**

Sure.

**Micky Tripathi – Massachusetts eHealth Collaborative**

As a favor to our West Coast friend Arien?

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

It's okay with me.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Since Jonah bailed on us, you know.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Yeah. Jonah's still in bed. So what's next on our list here? We don't have slides for it, but I think we ought to be able to proceed ahead anyway.

**Kory Mertz – Office of the National Coordinator**

Well, either states or infrastructure.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. So states, the idea was are there specific state-level actions that could be encouraged, if not regulated?

**M**

Well, one thing I think the group – and I think that's what the conversation was before. I think one thing I would encourage us to keep in mind with this RFI is that this is going to HHS, so we should be thinking about what sorts of, you know, leeways or additional things – you know, what can HHS do to help enable states to do this? Not necessarily – you know, if we tell – if we send a comment in that, you know, states should do X, Y, and Z in their state employee health plan, I'm not sure what we as HHS are going to do with that per se.

But if it's, you know, something around additional Medicaid authority or things like that, I think it'll be more – something that we can take and run with as an agency. So just something to keep in mind. But, you know, again, obviously you can go down whatever path you want on that. I just think pieces that HHS can take action on will be most useful for this process.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Arien Malec – RelayHealth Clinical Solutions**

One obvious one in that category that's aligned with our previous comments is using CMS's authority to issue waivers for things like Oregon's program or other kinds of advanced payment model programs for Medicaid, and to the extent possible, align the quality outcomes of those Medicaid programs with those for Medicare, as well as potential commercial programs.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. I would also say, and I think this is happening a lot, but I would put it in a formal recommendation to continue to promote it, which is when there are RFPs coming out or funding coming out, you know, putting in components that promote, support HIE, you know, in any aspect. I mean, that's very general. We can get more specific. But making it a component – you know, there's a component in SIM. There's, you know, a couple of things that have come out. And so they're already doing that, but I think it's good to continue to promote and state that that, you know, can help be a driver, and that funds through either grants or through whatever new payment models can be used to support that movement, that effort.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. Yeah, that's kind of a meta-comment for almost everything we're talking about, right?

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yes.

**Arien Malec – RelayHealth Clinical Solutions**

Is there a way those requirements could be better structured to make them even more helpful in driving this?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Is that a question to Amy?

**Arien Malec – RelayHealth Clinical Solutions**

Yeah.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

You know, there may be, and I just haven't had a chance to really dig in or to speak to our Medicaid folks. I actually met with our Medicaid medical director this morning, but we – that's why I was late. We were meeting on something else. And I said to her, you know, I need you to take a look at this and give me some ideas, but I just haven't gotten to it.

And, you know, I think one of the – there's just so many things going on in so many different arenas right now, that at least on the state side, I think the way we're all feeling, at least where I am, is everyone is completely overwhelmed. I'm sure that's not different for anyone on the phone. And so trying to, you know, really pay attention and provide the feedback where it's needed, it's just been hard to keep up on the timeframes that we need to keep up with. You know, especially where, you know, we're trying – you know, where states are – and I'm not just speaking for Rhode Island, I don't think, you know. There's SIM, there's Trailblazers, there's all these initiatives that are sort of coming together.

And so I just need to – I don't know that I have any more specifics right now, but I certainly hope to get them.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Okay. You know – this is Dave. I think about the MITA Maturity Framework as a type of model for that, right? Where in fact, you know, you're supposed to show how you're going to move up that majority model, and how – and to consider that in the formulation of kind of all your plans, so that it is cross-cutting. Maybe a similar formulation that is not prescriptive, right? I mean, I don't think we know enough to be prescriptive, but we do want to make sure that the contemplation is there. Maybe that's a way to approach it.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. I mean, I think that's fine. I think that there's some, you know, existing already expectation that MITA needs to be embedded in a lot of the stuff at CMS around systems –

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

But I mean a MITA-like model for HIE, for the –

[Crosstalk]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

That, you know, that kind of constructs what a maturity model would look like for the exchange of information, not just as we – as we talked about earlier, Amy, I know you – but we talked at – one of Arien's great ideas was the idea of building this around cognitive work that requires that – as part of the communication of that cognitive work, the use of exchange. And so, you know, to me that's kind of a very useful framework to think through how, you know, you make sure people have answered that as part of any – of these processes that they're going through.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Mm-hmm. Yeah. No. That makes sense. I mean, certainly, that sort of approach is also – you know, if you're going to go for an IUPD for HIE 9010, you have to address it in that regard, too, so –

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Mm-hmm.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Are there other categories of state action to think about? Or other areas? And public health is presumably all CDC, or does HHS have a hook in there? I mean, HHS does ...

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So ... is certainly –

[Crosstalk]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. We're talking about HHS. Right.

**Arien Malec – RelayHealth Clinical Solutions**

Right. One of the biggest areas, and this is – this is obviously a tricky one for HHS, one of the biggest areas that would facilitate information exchange is encouraging harmonization of privacy and security requirements across states, despite the fact that HIPAA does give states broad leeway for additional restrictions, I think we're seeing that additional – significant additional requirements above HIPAA create additional complexity for the nationwide approach to information exchange. And so to the extent that HHS can use its convening authority to encourage harmonization, that would be fabulous.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. I would echo that. You know, I was recently at a meeting on public health and learning health systems, and this issue around sort of preemption based on privacy and security, you know, came up again. And I'm not sure that we'll ever really have federal preemption. But even the discussion about is HIPAA the flooring or the ceil came – ceiling or floor – I mean, I think that – so I don't know how the – other than preemption, I'm not sure how you're going to get harmonization.

**Arien Malec – RelayHealth Clinical Solutions**

Well, you can get – yeah. So I think preemption requires Congress. So HHS really can't do much there. But I do think HHS can use its convening authority to look at the variation and then assess if the variation enhances or impedes information exchange, and potentially use some of its influence to create guidance that might be helpful to state legislatures that are contemplating legislation in this area.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. So, you know, again, I don't know how many people – and this is – you know, it was a number of years ago, the whole HISPC, Health Information, Privacy, and Security Collaborative, but the work that came out of there, which was funded – I don't know if it was – I don't remember if it was AHRQ or HHS funded. Well, it was HHS funded in some way, shape, or form – really shows that there's dramatic variation, and it does impeded.

So I'm not sure that actually if – and I don't think that has really changed. I'm not sure – suggesting that we need to relook at the variations – I mean, we could do that. We could recommend –

**Arien Malec – RelayHealth Clinical Solutions**

But it's gotten worse.

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

... time. I think still the variation is huge, and it doesn't –

**Micky Tripathi – Massachusetts eHealth Collaborative**

I think the idea would be to use the convening authority to take the next step towards finding areas for harmonization.

**Arien Malec – RelayHealth Clinical Solutions**

Correct. And also potentially use, for example, the ULC approach, Uniform Law Commission approach, to create model legislation.

**Micky Tripathi – Massachusetts eHealth Collaborative**

That's interesting.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. I – again, I don't want to – I think some of that was done through HISPC, so – or maybe even referring – taking lessons learned from HISPC, and – you know, like I just don't think we should make recommendations in a vacuum, when four years ago tons of work was done in this area.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No, I was thinking HISPC, too, Amy. I guess one thought that occurred to me, though, was that it was four years ago, and it may be that the market is much more mature and has more of an appetite now, for it, now that more people are seeing the real obstacles as they try to implement this stuff, whereas four years ago it was really academic for – you know, for a lot of people.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Well, the market may be there, but I – and to the extent that the market then are voters, and, you know, affect legislatures, maybe. But this isn't really a market – this is a legislative-driven initiative, and not a market-driven kind of thing, as I see it, in terms of the laws, and the variation in the laws. So I'm okay with recommending it. I just feel like we should – in a recommendation, we should at least say, you know, look at those recommendations from HISPC and decide what needs to be relooked at. I just think that we'd be kind of foolish to like ignore that that happened.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No, no, no. I agree.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

If we want to go further and say it's four years later or however many years later – maybe it's even more. I don't know. I don't remember specifically.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

But I just – I guess what I'm saying is I think we should acknowledge that there was a lot of work done in this area, and that it may be time to relook at certain – to pull out those recommendations from the different subgroups and, you know, see what needs to be addressed, or we could try to do that as a workgroup or something. But I agree ... I just don't think we should – I think we need to leverage what we learned from that and go the next step, whether it's reassess certain areas or try to drive forward in certain areas.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. No. I think that's a fair point. So we'll do that. And I think that, you know, the thing that I think always strikes me in this area is everyone recognizes how important it is, but the recommendations are always very tepid, because we don't really – don't really know how to advance it.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So, you know, I will – the next call – remind me when the next call is, because I don't have my calendar in front of me.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Thursday.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Thursday. Okay. So I will try to do some work between now and then on more state – I wasn't prepared to really address that, and I haven't had a chance to really look at the stuff. So we can continue to brainstorm, but I hope we can come back to this on Thursday, and I'll try to do a little bit more work between now and then, and thinking.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. We're still going to –

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

... state levers overall, not just the privacy and security stuff.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. Okay. That'd be great. So is there – I had mentioned public health. Is there anything in public health that we want to say? I know there's this whole huge area.

**Arien Malec – RelayHealth Clinical Solutions**

I mean, public health, the biggest issue is the lack of – again, it's a convening role.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Arien Malec – RelayHealth Clinical Solutions**

The biggest issue is the – is the variability across states in terms of standards supported, in terms of transmission supported, that makes it difficult to uniformly plug EHR technology into state infrastructures. So, you know, CDC is already doing work in this area, but encouraging HHS to continue that work to make sure that we have sort of cross-state plug compatible units.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Because even right now, as I understand it, there's still a lot of allowed variation, even though they're – right? Wasn't there – I forget what it was. It was lab reporting or something that they sort of said, well, here's the standard ... and local –

**Arien Malec – RelayHealth Clinical Solutions**

There's a standard. It's imposed on the EHR vendors and the providers, but not imposed on the states. And so, for example, in immunization, there's this happy accident that many states use the Wisconsin Immunization Registry Technology for their immunization registries, but California still uses CARE, I believe it's called, which accepts FAT files, not even HL7. So you've got this – you've got this enormous variation in capabilities for basic things like immunization registries, or for reportable labs and the like, which makes it – you'd love to be able to do, for example, universal access to immunization registries, to look up immunization status by patient, but the variation across states makes that difficult to do in a uniform way. Likewise for lab, likewise for – likewise for syndromic surveillance.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

You know, the other thing, and again, it may be different in different states around public health. Part of the challenge is that there are multiple different system within public health, per se. I think this is what you were saying a minute ago. And so multiple different systems within public health that the data have to go to, and coming from many different EHRs, unless there's an HIE in the area that aggregates and can send.

So somehow thinking about how to promote, you know, like a single access point of data getting sent – data that the health department can have. And again, that's going to be variations in different states based on state law. So it gets back to that. What's the health – you know, what public health can have, and trying to think of a streamlined way to get it to the door of public health, and then – so that public health doesn't have to connect to every individual –

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

And then the bidirectionality, which I know there's a lot more work going on, and in fact next week, you know, as part of the HIE grantees' meeting, there's an additional session on Thursday afternoon around bidirectional flow of data for immunization registries, where public health folks specifically from states have been invited to join if they're not already in the meeting. So there's work there, but – and again, I don't have specific recommendations, but trying to get data out of public health as much as into public health I think is important.

**Micky Tripathi – Massachusetts eHealth Collaborative**

How much of the public health problem is related to lack of resources? And I know everyone has lack of resources. It just struck me in going through this that lack of resources seemed to be particularly ... Amy, you're not allowed to answer, because you have self-interest.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

I'll be quiet. But notice I didn't put that in my comments.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. I did notice.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

I was trying to be careful.

**Arien Malec – RelayHealth Clinical Solutions**

Clearly, my California example, the lack of resources is a huge issue.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah.

**Arien Malec – RelayHealth Clinical Solutions**

It's not because the – you know, we had – we had Jonah. We had some pretty good leadership, and I'm sure still have pretty good leadership in California. But when you're California, you go to the absolute must have things that state government can provide, and public health unfortunately doesn't make that list.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Yeah. And while I would just – and I would be hesitant to, you know, say more resources as a recommendation, you know, certainly generally, because it's not a very helpful suggestion, this seems like one that every dollar would have a very high payoff.

**Arien Malec – RelayHealth Clinical Solutions**

Right. To the extent – and it would be specifically for harmonizing standards supported and transmission supported across states.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. Would that be helpful, Amy?

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. Certainly the standards are an issue. I mean, the funding is an issue, and again, I think it's – you know, part of this is the good and the bad. Funding is very categorical. I think CDC and others have gotten better about trying to blend it, and again, put in things to say it needs to be – you know, to promote EHRs and HIE, but we're not there yet.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Clearly not there yet.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Okay. So just recapping here on the state action thing, we talked about CMS authority for waivers for local – well, state-developed advanced payment models. Let's see. We talked a little bit about perhaps adopting some kind of framework for incorporation of HIE as components in any programs. This is almost more of a – you know, sort of a higher level comment, and, you know, perhaps something like the MITA Maturity Framework, again, not speaking specifically of MITA, but something like that that speaks to what majority and interoperability means, so that people have an understanding of that as they're building programs. We talked about privacy, and we just talked about public health. Any other areas? It seems like the most obvious ones.

Well, the only other category we have is then the infrastructure one. Is that right, Kory?

**Kory Mertz – Office of the National Coordinator**

Yep. Yep.

**Micky Tripathi – Massachusetts eHealth Collaborative**

And to just queue that up, we have 15 minutes left, the idea there was, you know, is that another lever? So by infrastructure, meaning infrastructure that's already been created by HHS and is used perhaps for other purposes, could it be repurposed or used as a lever to more specifically enable HIE, and by – you know, by reducing some kind of barrier to entry, or by enabling certain types of nationwide capabilities that are too hard to build from scratch from the bottom up?

We had talked about this when we were talking about provider directories, you know, maybe a year or a year and a half ago in this workgroup, and, you know, one of the ideas that came up at the time but that never went anywhere was, you know, that CMS obviously ... and other – and now with meaningful use, they have very large provider directories, albeit geared to another purpose. But, you know, that could – is there a possibility for the creation of a nationwide provider directory capability, for example, that builds on that? And that'd be just one example of an infrastructure capability. What do people think about either that or any other types of leveraging of infrastructure that is used today?

**Arien Malec – RelayHealth Clinical Solutions**

And is the notion that CMS would stand that up, or is the notion that CMS would publish that as open data? Or –

**Micky Tripathi – Massachusetts eHealth Collaborative**

That would be the question. It seems like the latter would be the –

**Arien Malec – RelayHealth Clinical Solutions**

Correct.

**Micky Tripathi – Massachusetts eHealth Collaborative**

The better approach. And I know at one time, you know, when we were earlier considering, Carl Dvorak, who was on before Peter DeVault, had the suggestion of, you know, making data available in the simplest possible way. You know, take the Blue Button approach of –

**Arien Malec – RelayHealth Clinical Solutions**

Correct.

**Micky Tripathi – Massachusetts eHealth Collaborative**

– you know, simple, text, ASCII file, download, that any vendor could then incorporate in whatever way made sense to them.

**Arien Malec – RelayHealth Clinical Solutions**

That's the direction that I was going as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Arien Malec – RelayHealth Clinical Solutions**

So we would encourage CMS to continue with the open data approach by publishing, for example, NPI data, for publishing meaningful use registration data, in ways that would be helpful for efforts such as provider director.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

You know, Micky, I'm going to just sort of – I don't know how this fits with sort of more of a national provider directory, but I know at least in our state and a number of other – and that this is beginning to happen in other states, we're actually trying to think about like creating an authoritative statewide provider directory, because when you actually think about what's going on in payment reform, insurance exchange, and HIE, while they're all slightly different use cases, there's probably at least 80 percent overlap in the data that's needed. And it's more than just sort of Direct addresses kinds of things.

And so, you know, we're really doing some work here around trying to figure out how to establish some sort of statewide, quote, authoritative provider directory that can be through web services or whatever access by a host of different services ... claims databases, health information exchange, Medicaid, HIE – those are probably our biggest ones. Licensure. You know, there's a number of ones in public health and stuff. So that in and of itself is a humongous project, a task of thinking about.

I don't know how – I'm trying to think about how we – so thinking about just doing that on a statewide – because I've been spending a fair bit of time doing that recently, and then thinking about how to do that on a national level, I'm wondering if it makes more sense to think about, again, on the state side, how to promote, include, support, fund, finance, drive that, and then somehow have those be able to be accessed or leveraged.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

This is Dave. I'm trying to constrain myself.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

Don't – Dave, you're among friends. Go ahead.

[Laughter]

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

But actually, you know, we do a lot of work around that, Amy. I'll be glad to talk to you about that offline. I don't think it's really appropriate for me to bring it up here. But, you know, we serve as provider directory sources for nine out of ten health plans now. We have a pretty fair data set. So – but I'll stop there.

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

No, and I know there are a lot of commercial products, and we're affiliate – you know, we work with some as well. Not – but everything has its own – we can talk offline. Everything has its own use case, and they're all slightly different. So for instance – but anyway, one – Micky brought up the provider directory. I was trying to think about how do we – does that – how does that help – I mean, I think it does help drive health information exchange, and then what's a productive recommendation around that? And I don't know whether just doing it – I don't know whether we can just do it at the national level and have it work for all the use cases that ... so I was trying to bring it down a little bit more to a more concrete, practical, doable level.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yep. Sorry. I'll talk to you later.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Okay.

[Laughter]

**Micky Tripathi – Massachusetts eHealth Collaborative**

From a national policy perspective, it seems like they're trying to elevate the level of some of this.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yeah. I know. I'm sorry.

**Micky Tripathi – Massachusetts eHealth Collaborative**

No, from – it seems like there are two issues. One is is that something that we think that HHS should encourage, robust level directories or not, and then two is to the extent that they are going to exist, can HHS play a role in the harmonization of them?

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Right.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Any thoughts on either of those questions? Dave would certainly like to encourage them, I know.

**Dave Goetz – OptumInsight – Vice President, State Government Solutions**

Yes. I got ideas.

**Micky Tripathi – Massachusetts eHealth Collaborative**

You got ideas.

**Jeff Donnell – NoMoreClipboard**

Well, this is Jeff Donnell. I would also like to encourage them, and encourage that harmonization. I know we're doing a lot of work around patient engagement and health information exchanges, and as we work with a number of different states, this is a major topic in all of those discussions. And the HIEs I know are really struggling with, you know, putting together their own directories of provider – for example, provider Direct addresses. And so I think we would see a lot of support at the HIE level for this kind of activity.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Now one way could be through this – through a convening authority, but there are more specific levers. I mean, the 9010 – the Medicaid 9010 HIE program that Amy referred to earlier, I mean, that's real money that's being given to states. So you could build programmatic requirements, talking about harmonization of state level directory in a much more formalized way, a much more directive way.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. Please don't take my comments as anti. I was just trying to – you know, I'm fully supportive. I think we need to do this work. It's just a matter of at what level and how to make it doable.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah, yeah. Would it be – I mean, we always come back to the problem there are no standards, and the Standards Committee up until now has not wanted to anoint any standards, because they're so immature. So if we were going to talk about something that's more directive, we would have to be able to give them something to – something directive to implement.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

The point is, though, that everyone's still going to build one, because they need it. All ... claims database needs it, especially as we get into the quality work, and so do the health information exchanges, and so do the insurance exchanges. So the problem is everyone's building one. They're just not going to be the same, and not be able to talk to each other.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Mm-hmm. Mm-hmm. Yeah. Okay. Well, so for right now, we just keep on here the harmonization of state level directories, and then have as, you know, one level – one lever is always the convening authority, but the other is the 9010 FFS subsidies for statewide HIE.

**Arien Malec – RelayHealth Clinical Solutions**

And then, you know, there's a not inconsiderable amount of money that's going into state insurance exchanges as well.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yes.

**Arien Malec – RelayHealth Clinical Solutions**

And in any state, CMS or HHS is actually building those exchanges.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. That's a great point.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Right. And the question there is for those exchanges – for those provider directories in the exchanges, and this, we're still trying to get more information, even in our own state with our vendor that's doing this work, you know, are they ... and flexible that they could be broadened for other use cases and exposed to other databases. Is that the right place to put one or make it available, or is it narrowly focused on just the use case around what the exchange needs around providers affiliated to plans?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So, you know, again, I mean, you know, one of the things that is important, at least in Rhode Island, and I think it's going to be important in any of the reimbursement quality – the quality work and the reimbursement payment reform, is how do you take – how do you align individual physicians to practices to other entities? Because unless you're looking at – as you start to move into ACOs, bundled payments, different practices, and you want to look at quality and cost across a – however you define a practice setting or some sublevel, other than a specific individual provider, you're going to need to be able to group them and look at this information across different settings, whether it's patient-centered medical home settings or some other model. And in order to do that, you have to be able to affiliate individuals to whatever, I'm going to put, quote, practice level affiliation or hospital, and, you know, there are many ones. Many. I mean, I don't – I'm sure all of you are well aware of this.

But at that is – from a payment reform, driving – and quality perspective, it's going to be essential to be able to know who practices where and have good quality data. And that's just – if it exists in some other state, I mean, I know there are commercial products out there, and they have some effort at this, but there are still shortcomings with that, no offense to anyone on the phone. So it's still a big challenge, and I think it's going to be critical to underpinning of this work.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. I agree.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

And that's not in – that is not currently where I believe insurance exchanges are going, and that's why I was raising that. So that's part of our goal, too, in terms of how we think about this.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. Yep. I think that's a great –

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Even the semantics, the nomenclature, and how people are tagging things. You know, just the mapping, as we think about this, and what's a practice, or what's some level of affiliation of administering care, for lack of a better term?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Right. I think – I think those are all great points. So I noticed – I just noticed that we're actually at 11:28. Time certainly flies, especially when it's 6:00 in the morning or whatever it is for Arien. So a couple of thoughts here. One, this has been a great conversation, and I think we got a tremendous amount accomplished, with some real good approaches and some pretty – you know, some concrete things that seem to me to strike the right balance of being specific enough that they can point in the direction, but general enough that they don't get us mired in too many details.

So we also covered at least the topic – I think there's probably more to discuss on the infrastructure side, and we only talked about provider directories. I suspect that there's more. So one suggestion would be that we keep the call on Thursday, we start later – we start later, so start a half hour later, and in the meantime, I can work with Kory on putting together sort of the draft for the HITPC presentation, and we can use the time to finish up wherever we are in infrastructure and state level – state levers, if there are any that Amy has to discuss at that time. And then take one final look – you know, take one look at it in draft form, at the presentation, and then if we end up ending early, I will certainly try to push hard to end early to give people back time. And then we can do whatever we need to off line.

**Arien Malec – RelayHealth Clinical Solutions**

I would ask a favor to start with the state work.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep.

**Arien Malec – RelayHealth Clinical Solutions**

Because I am much less – much less familiarity there, and then maybe go to infrastructure.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Happy to do that.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

So we're starting now at what time here? We're starting at 9:30?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Nine thirty. Yes.

**MacKenzie Robertson – Office of the National Coordinator**

I'll have the appointment updated. This is MacKenzie.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Thank you.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Great. And Kory and I will work to get a document out. It'll probably be toward the later part of tomorrow, unfortunately, just given the timeline here, but we'll get something out so that we can at least walk through that. And we will start with the state level stuff, and that allows Arien the leeway to join us late, and then we'll dive into infrastructure, and then reviewing whatever state the presentation is in at that point. And then everything else we'll do offline.

**Arien Malec – RelayHealth Clinical Solutions**

Thank you so much.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

And Micky –

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

– other than myself, do we have other state-based folks on the workgroup that we want to make sure can try to be on the call?

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yeah. That's a good thought, Amy. We can reach out to them specifically. I know Jim Golden, and certainly Dave has experience at the state level. But we can see if there are any others.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. I think it'd be helpful to – I mean, I –

[Crosstalk]

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

– I'm happy to give my perspective.

**Arien Malec – RelayHealth Clinical Solutions**

Yeah, Jonah also.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Jonah also.

**Amy Zimmerman – Rhode Island Office of Health & Human Services**

Yeah. So I just think if you – if we let people know that we're going to have that discussion and what – and around what time, then that will help maybe make sure they can be on the call for that part.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Yep. That makes sense. Okay? Great. Well, thank you, everyone. Let me turn it over to MacKenzie for public comment.

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

Operator, can you please open the lines for public comment?

**Caitlin Collins – Altarum Institute**

If you are on the phone and would like to make a public comment, please press star one at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press star 1 to be placed in the comment queue. We do not have any comment at this time.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Okay. Well, thanks, everyone.

**Arien Malec – RelayHealth Clinical Solutions**

Thank you.

**Micky Tripathi – Massachusetts eHealth Collaborative**

Bye.