HIT Policy Committee
Information Exchange Workgroup
Transcript
March 19, 2013

Presentation

Operator
All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator
Thank you. Good afternoon 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 and transcribed, so please make sure you identify yourself when speaking. I'll now take roll call. Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Micky. Peter DeVault?

Peter DeVault, MS – Epic – Director of Interoperability
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Peter. Jeff Donnell? Jonah Frohlich?

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Jonah. Larry Garber?

Lawrence Garber, MD – Reliant Medical Group
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Larry. Dave Goetz?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Dave. James Golden? Charles Kennedy? Ted Kramer? Arien Malec?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
I'm here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Arien. Deven McGraw? Stephanie Reel? Cris Ross? Steven Stack?

Steven J. Stack, MD – American Medical Association
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Steven. Chris Tashjian? John Teichrow? Amy Zimmerman? Tim Cromwell? And Jessica Kahn? And the ONC staff members, if you could please identify yourself.

Kory Mertz – Office of the National Coordinator
This is Kory Mertz.

MacKenzie Robertson – Office of the national Coordinator
Thanks Kory.

Hunt Blair – Department of Vermont Health Access
Hunt Blair.

MacKenzie Robertson – Office of the National Coordinator
Thanks Hunt. And I believe we have Kelly Cronin on as well.

Kelly Cronin, MPH – Office of the National Coordinator
Yes, I'm here.

MacKenzie Robertson – Office of the National Coordinator
Okay, thanks. Then with that, Micky, I'll turn the agenda back to.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Okay. Great. Good afternoon members of the workgroup, really appreciate your joining today, and any members of the public who are listening in. This is Micky Tripathi, I'm the Chair of the Information Exchange Workgroup of the HIT Policy Committee. We – as I think you saw in the note that we sent out accompanying the presentation, we've had a little bit of a change in the work plan, in the immediate work plan for the IE Workgroup, really owing to a couple of developments on the HIT Policy Committee and CMS side that affect our overall timelines. First is the delay in Meaningful Use Stage 3 rulemaking, which CMS announced I think last week or the week before, would be delayed until the next calendar year, which from an HIT Policy Committee perspective means that it shifts to the right by about 3 months, the schedule for developing recommendations as input to the NPRM and then the Final Rule.

So, as you may recall, we were working hard toward looking at the recommendations that came from the Request for Comment that was put out last year, with an eye toward developing preliminary recommendations on Stage 3 for the Policy Committee. Now the timeline has sort of been extended on that, so we have a little bit more time and as the Policy Committee sort of develops its new calendar, and new timelines, then we'll have a much better sense of when we should be developing our own specific recommendations. But as I said, it's roughly three months that it's being pushed out. But as nature and ONC abhor the vacuum, sorry ONC couldn't resist, the – we do have a more immediate request to respond to the recently issued RFI that ONC and CMS put out for comment, related to interoperability and health information exchange.

And the – I guess we'll talk about the timelines in a second. But in terms of our immediate timeline, we have two calls scheduled before the April 3rd Policy Committee meeting, and so at the last Policy Committee meeting last week, the National Coordinator, Dr. Mostashari had asked specifically that we develop some recommendations and thoughts on the RFI for the consideration of the Policy Committee to ultimately convey to ONC and CMS regarding this RFI. So, since we have these two calls scheduled already, and the timelines for the Meaningful Use Stage 3 recommendations are pushed out, we thought it would make a lot of sense to use these two calls to consider the RFI specifically. So we're delighted to have Kelly Cronin from the ONC staff, who is the health care reform coordinator and has a lot of experience in health information exchange over a number of years. And she has been generous enough to offer to walk us through the RFI, some of the key questions coming out of it, give us some context to guide our deliberations as we think about this.

We'll come to the process going forward at the end, but just to give you a sense, so you can keep that in mind as Kelly goes through the presentation. What we thought would be a good process, given that we just have two meetings and a very focused timeline, is that we would have Kelly do a good walkthrough of the RFI and the various questions, and then whatever time we have left for specific conversation on this call would be great, but what we'll try to do is accomplish as much offline as possible. And in particular, send out the questions and any other sort of framing thoughts that we might have from the IE Workgroup to all the workgroup members, have an offline turn-around of responses, people's input to those questions with a few days in advance of the meeting on the 28th. And then we will offline sort of synthesize what we can from those inputs, identify any issues that still need discussion and then use the call on the 28th to look over the synthesis and try to iron out any remaining issues. And that will put us in a good position to have a final set of recommendations or thoughts for the Policy Committee on April 3rd. So, I think I got that all right, is that right Kory?

Kory Mertz – Office of the National Coordinator
Yup.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Okay. Great. So, why don't I now then, unless anyone has any questions – any of the workgroup members have questions on the work plan and on sort of the immediate objectives here, I will turn it over to Kelly.

Kelly Cronin, MPH – Office of the National Coordinator
Thanks Micky. I know this is a really quick turnaround, so sorry we're not giving you more time, but I guess you're sort of used to that. Luckily I think most people on the workgroup have been really steeped in these issues for quite some time, and probably have been thinking about answers to these questions in their sleep. But I do want to give you sort of a good sort of grounding and sort of how we got to where we were, or where we are, with what's described in the RFI, just so you have the context, as Micky said. And you can think through how to inform and guide actions that'll be taken in several months and years.

Next slide please. So just to start off, this is seeking input on a variety of policies, not just sort of ONC's policies or just certain CMS policies, it's sort of a comprehensive set of policies, under existing authorities that'll strengthen the business case for information exchange across providers. And really this is to get to true data liquidity where we have information following the patient wherever they access care across the healthcare system. Next slide. And really, this is recognition that I think a lot of us have had for quite some time, where the HITECH and the EHR incentives program is an enormous help to accelerate EHR adoption, certification, and interoperability more broadly, but to get to true widespread interoperability and exchange.

We recognize it's payment reform that's really going to drive it, and we need to be comprehensive in our efforts as we implement delivery and payment reforms that have really a set of policies that are unified across common goals and a policy direction to drive interoperability and exchange. And while we've had terrific uptake with the ACO programs and some of the other ACA changes in payment and some of the new care and delivery models are really encouraging, still the predominant way of getting paid, and the country is still fee for service. And there are other business motivations that are still really influencing provider behavior. So we need to get to the point where we're really driving information exchange, because it not only makes sense for patient care and for population health management, but that it also is in the best interest of providers as a part of the reimbursement system. And we're at a point now where while we've done a lot of internal thinking and we've tried to be as transparent as possible about that in the RFI, we really want to have stakeholder input before we go and make a lot of regulatory changes or a lot of tweaks to existing programs or as new ACA programs get implemented.

Next slide. So the overarching goal really is to have a whole set of policies, as I just mentioned, that will reach this goal of sharing information across the whole system. And it'll be a combination of likely incentives, payment adjustments, requirements over time when the market's ready, that will collectively result in a much more coordinated, value driven system. But we do want this to happen quickly, so we were looking for near-term levers that we can act on because we are in the middle of delivery and payment reform, and there's a lot riding on this coming to fruition. So, we recognize now and are clearly stating through this RFI, that we intend to rely on all our applicable statutory authorities, all regulations, policies, programs to really reach this goal. So it's not just a piecemeal approach, it's comprehensive across HHS, but really with a focus on CMS and ONC.

Next slide. So some of the questions that we've posed, hopefully you've had a chance to look at this, but they're a little more thorough than what's on this slide. But, we're really wondering out of all the changes in payment policy, what would have the most impact on Health Information Exchange? And across programs like the Medicare Shared Savings Program, reducing…or making payment adjustments based on readmission rates, and having those penalties increase over time, and a lot of these new ACA programs, what are having the greatest impact on HIE? And this is maybe more of a qualitative assessment and expert judgment at this point, because we don't have a huge amount of data to go on, but sort of in your own expert opinion, what do you think. And what aspects of the program design or implementation are either limiting their potential to have impact on HIE and support care coordination and what could…what more could be done to sort of maximize their input. And then to what extent do current CMS payment policies encourage or impede information exchange, sort of another flavor of the same question, but we really want to know around market competitors, are people sharing with others…like other hospitals in a competitive market, and what's keeping them from doing that, if it's the case.

And then also looking at some of the ineligibles, as we call them for meaningful use, what CMS and ONC policies would most impact post-acute long-term care providers, and that's both institutional and community and home-based care, and behavioral health providers. What could we be doing to reach them and making the business case stronger. And how could CMS and states use existing authorities to better support HIE, among Medicare and Medicaid providers. And again, looking especially towards post-acute long-term care and behavioral health. We do, I think, a pretty good job of laying out the existing authorities through all the waivers, 1915, 1115, state plan amendments, the matching fund policies and clearly some states are leveraging all of those right now to support their broader transformation efforts, and in doing so, providing some funding for HIE. But we really want to crystalize the thinking and really get a sense for is that enough and what else might need to be done.

Next slide. How can CMS leverage regulatory requirements for qualifying hospitals or other kinds of providers like skilled nursing facilities or nursing homes or other kinds of long-term post-acute care providers? As a part of survey and certification are really just conditions of participation for reimbursement. So for hospitals it would ultimately be a condition of participation. For post-acute long-term providers, they call … the legal term is requirements, so that they are set in regulation and then survey and cert – then sort of expresses the policy intent and then it sort of carries out with the state surveyors through – at the state level, as you know. But we're looking primarily sort of at the regulatory level, how do we change this. And we also have some specific questions about how could we best do that and what would…how could we potentially phase it in, given that that is a pretty serious requirement that would impact a lot of providers. And then the next is, how could the EHR Incentive Program advance provider directories that would support exchange between eligible professionals participating in the program. There might be some technical or policy changes in administering the program that, where we could build on this.

The next question is around CMMI authorities to test, evaluate and scale innovative payment and service delivery models in a way that would really accelerate HIE. This really could pertain to some existing programs, but I think we're also really forward looking in terms of new models that would be developed and implemented and tested. And then the next one addresses, really the next few address patient access to information, so what CMS and ONC policies and programs could most impact. Patient access and use of their electronic health information and management of their care and health and then what specific policy changes could we rely on to significantly increase standards-based electronic exchange of lab results, which I know this group has looked at pretty extensively. And we do have proposed rules out there that we've never finalized. So, it would be terrific to hear your thinking on that, particularly since you've already spent some time on it. And I think even the last hearing, you really, you recognized that that is one of the real lagging areas while there's terrific progress that Micky reported out on in the beginning of the hearing, labs is really sort of a problem area that we'd like to address through policies, if possible.

Next slide. So just to quickly recap on some things that we did highlight to reflect sort of our current thinking. We recognize that the Medicaid authorities all really allow for terrific opportunities for states to not only think through Medicaid transformation, but in some instances, like through the State Innovation Models, they can think about a multi-payer approach supported through perhaps a Medicaid waiver or a state plan and then through a 90-10 matching funds. But to really drive transformation more broadly and have health information exchange is critical piece of that. So, we detail that and would like input on, is that enough? Is it clear? Do the states need better communication around that? And for conditions of participation or requirements again for SNFs or nursing facilities, we're seeking input on how could we do this, how could we phase it in? What would be doable, not overly burdensome, recognizing that obviously the long-term care community has not had the advantage of participating in the EHR Incentive Program, but are increasingly being involved in these new care coordination programs and really need to be involved in the hand-off and transitions in and out of long-term care. Also, just a note there, the original regulations for nursing home quality were written in 1992, so, in a world that was not really electronic as we know it today. So there are some real opportunities, I think, for us to all to think about how to bring them along in a way that's doable and desirable from a patient perspective.

The eMeasures that are specific to care transitions, that would actually track the transmission of like a summary record say from hospital to treating follow up provider, those are under way, but those could be obviously incorporated into the inpatient quality reporting and the different post-acute long-term care reporting requirements. So we're sort of laying out that possibility, even though that's sort of a…on a trajectory where it's likely going to happen. And also through MU Stage 3 require or encourage health information exchange across providers that are in an ACO network. In the Medicare Shared Savings Program we were really silent on this in the final rule, as this program was being stood up, but now that we have a little more experience, there's 250 Medicare ACOs out there, it would be great to get people's current thoughts. Is the current approach really working in the market? Is it driving exchange just by nature of having to coordinate and be accountable for a population over time? Or do we need to be more explicit?

And we're also laying out some thinking around what we could do in terms of new CMMI care and payment models, either require an HIE strategy for applicants and rate them on that, or do we actually require some real progress, measureable progress for participants that are in these new models. And then the requirements and expectations in new models again that would apply to dual eligible, so whether it's in their capitation models or their fee for service, sort of where … some are starting off with a fee for service model. Should there be some, for example, guidance on the three-way contract that would clearly articulate the role and expectations of HIE?

So next slide. A few more ideas that we've been exploring, and really already acting on in some cases, to try to really get the patient access to their information and more engaged. Blue Button, as you know, has been sort of taking off in a variety of mechanisms, but we've most recently tried to get the Medicare Advantage world more tuned into this and asking them what they could do through their plans. And trying to think through, are there other new ways of incorporating shared decision-making, consumer engagement, access to information and perhaps new CMMI models. Should we be more explicit about that kind of patient engagement and the design of a new model perhaps? And then, changes in CLIA, which I think you're all well aware of, that were proposed, there's a HIPAA connection here. Again, this is just in the NPRM stages, but what should happen next, sort of what's the logical outcome, either in set of final rules or other actions. So that sort of summarizes the high level of the current thinking.

Next slide. And then our comments are due April 22nd. Obviously your immediate deadline I guess is April 3rd, to have a Policy Committee discussion around this. But we're really looking forward to your input in particular, since so many of you have been steeped in this for years and you really understand how payment policy is critical to making this happen. So, particularly since many of you are really so well informed around state policy levers, we'd really value your input around those levers in particular. So, if you feel like, since you're not necessarily representing the provider community at large, you may not – I mean clearly your response to all the questions would be highly valuable, you may not be directly impacted by the say requirements or conditions of participation that could eventually happen. So, we would expect, for example, the hospital community and the long-term care community to really weigh in on those, and we'll be seeking their input more explicitly. But, we really, anything you have time to think about and get back to the Policy Committee on will be really valuable to us. So thanks for taking this on in such a short timeframe.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Great. Well thanks Kelly. Certainly to the extent that we've at times felt either encumbered or constrained by having to live within what meaningful use has the authority, provides authority for, this seems to be at the opposite end of the spectrum, which is to say, consider anything that could be health motivating, but there's like the health information exchange that …

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, I think that's right, but I mean, we are trying to be focused with giving some very specific ideas on what anything could be, and what regulatory authorities would really, we think, potentially have high impact. So, we're trying to give you some grounding.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right, right. I was being somewhat …

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, but the overriding message is absolutely that we are pulling out all stops and we're very serious about driving this aggressively.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Kelly, this is Arien. In the pulling out all stops category, does the RFI contemplate use of other federal purchasing policies to influence non-CMS payment policies, just for example FEP, DOD and VA contracting, IHS contracting, other kinds of mechanisms for creating more alignment around quality measures or information exchange requirements or the like?

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, that's a great comment. We did not really make that a priority because we thought that there was already a lot to respond to, just focusing on sort of CMS's authorities and ONC authorities. But if you feel that's an important area to weigh-in on, there's nothing stopping you so please include that. You probably know there is a lot of federal alignment effort around quality measures with the intent of having those adopted more uniformly across programs because measure alignment is a real priority right now.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Yup.

Kelly Cronin, MPH – Office of the National Coordinator
But yeah, if you have ideas on how to go beyond CMS and ONC, please include them.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Excellent. Thank you.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Kelly, this Dave Goetz; I'm sorry. There's a lot of focus on transition, transitions particularly around the long-term care and other kind of external, as you say, the non-eligibles as it were. Involved in a lot of that is Medicare. Medicare has been not involved in the incentive program, I guess that's the kindest way I can put it and do you anticipate being able to, if there were payment suggestions that were attached, do you anticipate being able to…that Medicare would participate in some sort of additional payment methodology?

Kelly Cronin, MPH – Office of the National Coordinator
So, did you mean to say Medicaid initially?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
No, I meant to say Medicare.

Kelly Cronin, MPH – Office of the National Coordinator
I'm sorry, so …

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Well, it implicates Medicaid and Medicare, but Medicare has been the one – Medicaid, I know how to get my hands on that one, what I don't know how to get my hands on is Medicare.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah. Well, I think in some instances, I mean, we are seeking multi-payer approaches to things, so the bundle payments, for example, bundled payments for care improvement, that program is involving both inpatient and post-acute care in its four models. And that's intended to be Medicare, but many of the CMMI programs have sort of a multi-payer flavor whether it's comprehensive primary care initiative or the pioneer ACO program and a lot of the state innovation models with the design and the implementation, or testing states, are going to have that multi-payer construct, too. So I think that – and the duals, the dual eligible programs are clearly trying to align Medicare and Medicaid. So I think that there are opportunities to work in the incentives for exchange in an aligned way, whether it be starting maybe with waivers, or starting with Medicaid, but then looking beyond that.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
I guess the issue has seemingly been in the past that their discussion has been that they didn't feel they had the authority to support anything other than a plain old vanilla fee for service kind of approach, right.

Kelly Cronin, MPH – Office of the National Coordinator
Specifically for exchange, you mean.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Yeah, to be able to do an add-on or a bump or anything that would …

Kelly Cronin, MPH – Office of the National Coordinator
Right.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
… that would potentially then support that you could … is kind of Arien's comment, that if it was done for Medicare, for the other purchasers, DOD, VA, OPM, if it was done, then in concert with private purchasers, would that not…you could then spread the methodology, if you will, that would support some of this maybe.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah. I mean I think one of the other things just to keep in mind, is that given the reality of our budget constraints right now, and the pressure, not only under sequestration, but just more broadly with the entitlement programs, something that would require a lot of additional costs to the trust fund is probably not going to be well received, just talking very pragmatically.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Sure.

Kelly Cronin, MPH – Office of the National Coordinator
So, I think in the context of a shared savings model or partial capitation, global capitation or something that's moving towards a much more efficient payment mechanism, that's probably going to be something that would resonate more.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Okay. Yup.

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP
Kelly, this is Jonah. In the context of the shared savings program, I'm wondering if in the proposed rule there were some provisions about requiring a certain number of primary care physicians to be meaningful users of EHR, those went out and instead there was a final rule that double counted one measure around meaningful use, just in terms of the number of providers who were meaningful users that basically you get twice as many points if you have more meaningful users.

Kelly Cronin, MPH – Office of the National Coordinator
Right.

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP
Do you think there is an appetite for CMS to consider how you could give ACOs additional, I don't know what you want to call it exactly, but reward or bonus for having engaged in more kinds of exchange activity?

Kelly Cronin, MPH – Office of the National Coordinator
That's a great example and I think it would terrific for them to learn more about it. I don't think it, given the size of the program now, and just the complexity in administering a program like that, it's not something that they spend a lot of time thinking about. So I think, your input's going to be really valuable and really, if you could think through specific ways in which it really would help bolster care coordination and may even potentially help the success of the participants in their shared savings program, many of which are smaller organizations, physician-led, that may not have a lot of sophistication in this area. Anyway, all this is to say, you should absolutely articulate your thinking there and try to, yeah, try to crystalize it, because I think it would be really valuable.

Jonah Frohlich, MPH – Manatt, Phelps & Phillips, LLP
Okay. Well, I'd like to hear what others may think if they have any thoughts on this particular issue. I mean, we do a fair amount of work with a number of the MSSP ACOs that formed in the last year and they're certainly driving a lot of new exchange, and whether it might benefit the program, and HIE in general, if there were additional kinds of rewards offered to those participants for demonstrating more robust HIE capabilities like exchanging summary records, and that they could be recognized for that. I don't know if others feel differently or have any opinion on that, but I think that could be something that could help drive exchange and probably care coordination and quality in the MSSP program.

Christopher H. Tashjian, MD – River Falls Medical Clinics
As one of the practicing physicians on this workgroup, the exchange with the nursing homes is absolutely critical from a care standpoint and that if you look at it from a cost of readmission and communication, is that really even we've been trying to do it without incentives. There need to be standards, there need to be some kind of coordination of this because it's really kind of a hole in the HIT strategy. Does that make sense?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah. So that's – this is Micky – that's looking at the ineligibles question, which seems like an important one. So Jonah, back to your point for a second, I think it's an interesting question of, give that, I mean, it seems like the MSSP and the value-based purchasing programs in general are trying to get us towards saying that we're just going to reward people for delivering higher quality, more affordable, more effective care. And it just strikes me as being almost a step backward to say that, "Oh, an we're going to provide incentives for you to – certain types of infrastructure or do certain types of transactions," rather than just saying no, we're trying to move more toward the outcome measure, which is just, take a share of risk and do whatever you need to do to make things better.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
This is Arien. I don't see the RFI as specifically asking for what particular, and I think it's perfectly within our purview to say, we would prefer more outcomes oriented measures, correct?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, I think so.

M
Yeah, I would agree. Are you asking Kelly?

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, I think it's really up to your sort of general thinking as a workgroup whether or not you'd want somebody to be accountable for an HIE process measure versus just being accountable, for example, for a reduced readmission rate.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right. What's the, and I know this isn't an easy question to answer, but you definitely know more than I do about it, what are the limitations of the enabling statute, meaning for Medicare and Medicaid? Because my understanding, for example, would it require a change in statute for Medicare to essentially move completely away from a fee for service model and toward a value-based purchasing model.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah. I mean even the Medicare Shared Savings program is really built on fee for service. Yeah, yeah, I mean you could – the closest thing they have right now is the ability to scale new payment models. So, let's say for example if the duals program that relies on global capitation proves it could be certified by the actuaries as being cost savings plus it improves quality, then that could be scaled to a permanent payment policy. So, there's a route to get there, but right now they're largely stuck with their fee for service regulations.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
But Kelly, I think – this is Arien – I think given the recent change in, was it diabetes education, there was a recent change to add a procedure code for – that was more care coordinated activity, CMS does have flexibility in paying for care coordination activities, correct? And they also would have flexibility in defining the documentation requirements for example, for a given procedure code. Is that correct or …?

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, under evaluation and management codes, there are sort of ways in justifying higher levels of decision-making or care management that could involve care coordination, is that what you're …?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Yeah, so I was throwing out if, for example, on transition care providers, primary care providers would get a higher level of billing code for, for example performing med reconciliation and other kinds of care coordination activities. If that could qualify them for, for example, a level 5 billing code, regardless of the current E&M definition. Those are the kinds of things that I was thinking about.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah. I mean, that's terrific. That would be terrific input. That would be really helpful to clarify.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative So, maybe this more a question for Kory. Kory, are other workgroups also providing input on this RFI or are we sort of providing the primary input on it?

Kory Mertz – Office of the National Coordinator
You guys are the primary. I don't think – I've not heard that any other workgroups are looking at it.

MacKenzie Robertson – Office of the National Coordinator
Yeah, this is MacKenzie; it's just the IE Workgroup.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Okay.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Woo hoo.

MacKenzie Robertson – Office of the National Coordinator
Lucky you.

M
The sky is the limit.

M
I didn't think they liked us that much.

Lawrence Garber, MD – Reliant Medical Group
In this case, this is Larry. So if the sky is the limit, and everything is on the table, if HIPAA Privacy & Security was the ceiling instead of the floor, we'd all be exchanging like Indiana. So, is that on the table?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
I don't believe adjusting state law is part of CMS's mandate.

Lawrence Garber, MD – Reliant Medical Group
Okay. And…

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
That was Arien with the hopefully informed point of view, but probably Kelly would be the appropriate one to answer that question.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, I mean, I or Hunt could try to address it, he just has led a lot of privacy and security and health reform efforts in Vermont. Yeah, I mean, my take is similar to yours, Arien, since we've for the last seven or eight years have been trying to work a lot with states on these issues, and it's just a very complicated set of policies and state level privacy acts that we sort of have to negotiate around, is existing law.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
One idea I did that I did throw out to Joy a while back is the uniform statute process, and I haven't seen anything happen there, but the notion of there are efforts at a federal level to try to create more uniformity across states. That might be something we could think about.

Kelly Cronin, MPH – Office of the National Coordinator
Um hmm.

Lawrence Garber, MD – Reliant Medical Group
Also sort of in that pie in the sky mood that I'm in, because we've got a snow day, sort of, what about pushing more on the voluntary patient identifiers, obviously not necessarily universal patient identifier, but even encouraging the broad use of a voluntary one nationwide. That may also facilitate the exchange of information.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, you've probably heard the federals view on that before, we can't spend any resources on that, we're sort of forbidden by law to spend any federal resources on even a voluntary identifier. So, there has been a lot of discussion over the years about a state-based effort that could be multi-state, but it's not something that we can take action on.

Lawrence Garber, MD – Reliant Medical Group
They have to do it at the governor's councils.

M
Or ONC staff could work on it on the weekends … over Christmas.

Kelly Cronin, MPH – Office of the National Coordinator
I don't think Joy would like that.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
I was going to say, they get weekends, since we usually get weekends.

Joe Walker – Greater Tulsa Health Access Network – Technical Operations Director
This is Joe Walker. Would it be an appropriate input here to require that organizations be actually releasing their data to some kind of organization on an automated basis? That's been one of our biggest challenges is some vendors not setting up their systems in a way that information can be actually shared automatically, it requires their users to actually do something to export the information which is problematic to health information exchange.

Kelly Cronin, MPH – Office of the National Coordinator
Right. I mean if you could think through what the certification lever would be, or the certification requirement and how to express that or tie it to payment – I mean, if you can flesh out that thinking a bit more and if the workgroup wanted to iterate around that idea, that would be definitely in scope.

Joe Walker – Greater Tulsa Health Access Network – Technical Operations Director
Well in my mind its triggered to export a CCD essentially, that would just make a world of difference to the ability of a health information exchange to be able to interface with vendors. And that CCD of course would need to be one that would comply with the emerging standards the S&I Workgroup is working upon so that there's some uniformity in the way the information comes out. I know that a lot of vendors have had a real challenge in certifying…well, they haven't had any trouble at all certifying, because they all say they export CCDs. But in health information exchanges, we've had a bear of a time actually using those CCDs to be able to make real information exchange effective because they don't follow the standards that exist or they all pick different standards to follow. So, in my mind perfect criteria would be to have a defined standard for a CCD format and a requirement that their system have a trigger that can export a CCD. In addition, that trigger of course would need to be compliant with whatever their policy is so if they are an opt-in or opt-out, and then that trigger would have to be queued off the patient's consent status if they are an opt-in network. However, if they are an opt-out network, then it could just be an automatic thing.

In addition, every vendor's going to implement it differently, but in my mind there just needs to be an automatic trigger to export a CCD in a standardized format that everyone agrees upon what that standard is. And the S&I Work, the EHR Affinity Group is working on that CCD standard, so, I think that standard would be the right thing to put into the certification. Those are my thoughts and I know from Tulsa, that's been a point of continued emphasis with national policy around health information exchange and meaningful use, is that we need the EHR vendors to actually make it possible to do health information exchange and to let go of the data.

Kelly Cronin, MPH – Office of the National Coordinator
So maybe others can correct me, but I think in part the Stage 2 certification requirements are going to require the consolidated CDA to be able to do that kind of export.

M
That's right.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Oh yeah, this is Arien, it's absolutely correct. There are issues in terms of that's required in Stage 2 for transitions of care via Direct. There's additional goodness that we could go to in terms of trigger-based, publication for example, as well as clearly we've been thinking about query-based exchange.

Kelly Cronin, MPH – Office of the National Coordinator
So that – so either trigger-based or query-based exchange, yeah, but …

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
We should be making good progress on the data normalization issue, knock on wood, with consolidated CDA and the good work that was done there by HL7 and IHE. But, there's still more work that we could do there and then more work that we could do in terms of additional mechanisms for getting the data out of EHRs.

Kelly Cronin, MPH – Office of the National Coordinator
So I guess if the workgroups thinking could crystalize that along with how it would relate to, how would it be expressed in certification, and how would it be required through CMS policy – either through meaningful use or beyond it.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Right.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, so it seems – this is Micky – it seems like one of the big challenges for us as a workgroup is to identify sort of the key HIE enablers and then think about the levers.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
I'm sorry, just one more, what are the constraints around what we can do? There is a lot of – so one of the nice things about ACO or bundled payment kinds of organizations is they blur the line between providers. But in a traditional fee for service environment, are there fee for service payment mechanisms that would increase the incentive for, for example a provider, an ambulatory provider, to work with peers in the community for things like population management, analytics, quality reporting and those kinds of things? Because again, those kinds of things would increase the incentives to share data for population health purposes, and I'm just wondering what the, trying to think through where the hook points would be for getting a plus-up on fee for service for doing those kinds of things.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, that's a really, a really great question. I do wonder in the context of some of the new, like say there's a care management fee billed on top of fee for service, being tested. So looking at the comprehensive primary care initiative, if as a part of a care management fee for an advanced primary care practice you could contemplate exchange of summary records as a part of qualifying for that care management fee, that – I mean, that's one way I could think that might work – because there's actually something in the field around that now …

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
That's – and the reason I'm asking in these areas is that I'm starting to see population health driving information exchange and the population health ends up being the killer app for information exchange in many ways. And if we can increase the incentives for population health, we're going to increase all the other downstream incentives.

Kelly Cronin, MPH – Office of the National Coordinator
Right. Yeah. I mean, I think if there's sort of a general push – I mean, one thing, this is a little bit getting into the weeds, but in the last rulemaking process for physician fee for service payment, they did actually contemplate paying patient-centered medical homes or advanced primary care functions. And so, if that is on the table in the future, what might be some considerations for either qualifying that advanced primary care practice or making sure that as they do their care coordination and their care management functions, that it's enabled by health information exchange.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Other thoughts? Kelly, on – let me just look at this – on question 7, for some reason it specifically focuses on, it looks at provider directories, but specifically through the EHR Incentive Program lens. Was that just because there's just a grab bag of questions and they got thrown in there, or is there any specific thinking of why that's focused specifically on the EHR Incentive Program?

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, I think there were a few people that were really excited about the potential of having perhaps something like a direct email address or an identification being added to sort of the registry used for administering the meaningful use incentives. That might help enable identification of providers more routinely in the practice of exchange, if that data source was widely accessible and I haven't been that involved in that thinking. I don't know if Kory, if you have anything else to add or anybody else on the phone, maybe Hunt, I don't …

Kory Mertz – Office of the National Coordinator
I mean, that sounded about right from what I've heard as well, Kelly.

Hunt Blair – Department of Vermont Health Access
Yeah, I don't have anything to add about that, I think that sounds right.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Well, we have our work cut out for us.

M
So what's our timeline again?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
We – the presentation – delivery of recommendations on April 3rd, so I think actually maybe we can move ahead to that slide, isn't there a slide, yeah, it's …

Kory Mertz – Office of the National Coordinator
Yes.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
One – next slide please. And these are Kory's words because we were talking about short timeline – no, so we need to finalize the recommendations. We have a call scheduled for March 28th, so we'd like to be able to use that to consolidate, synthesize, iron out any remaining issues that we get in the line process as they described. So the idea was to use the remainder of today to discuss anything else that we may want to discuss, but I know everyone is just looking at this probably for the first time really, so there may be a limit to how much we can accomplish today. But the – we will then start some polite, but firm hounding of people to – we'll send out a list of the questions and try to get whatever input we can from any of you on any of the questions and then try to synthesize that by, I guess we'll take those back by March 26th so that we can then have something together for the 28th for us to dig into.

MacKenzie Robertson – Office of the National Coordinator
This is MacKenzie. Do we want to try and schedule another meeting, or do we think the one on March 28th will be sufficient?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
The likelihood we're going to get all these questions done in one meeting is low.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, so I guess – I mean there are two possible paths. One is that we don't even attempt to do all the questions and the other is that we try to schedule another meeting. What do people think about that? And another meeting would realistically, in order for it to be – let's see, April 3rd is the following Wednesday. So we have the 28th is a Thursday, is next Thursday, and then the following Wednesday is the Policy Committee meeting. It feels …

Kelly Cronin, MPH – Office of the National Coordinator
Micky, if it would be helpful, I know Jodi and Paul are sort of interested in what are sort of the…what do we most need to hear input on, and obviously the generic response is everything. I was initially thinking maybe you guys don't want to go so deep into the policy…the state policy levers or things like conditions of participation. But, given that Jonah and Dave and Amy and Hunt know so much about the state policy levers...I mean one approach could be just before your next meeting have folks share by email or a draft document their thoughts to specific answers and then you could try to aggregate and walk through them. Or just eliminate the ones that you don't think you can sort of weigh in on given the timeframe.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Yeah the other – Kelly, to that point, the other – this is Arien – the other approach would be to say, what are the high level policy principles first, that we're the most interested in and then sort of do a top down and then bottoms up. So if we – there were a lot of questions today about payment policy and paying for outcomes as being the major driver for health information exchange. If that's clearly one – if that is one of our top level concerns, maybe we establish that and then go do the bottoms-up approach.

Kelly Cronin, MPH – Office of the National Coordinator
Yeah, I think principles are great, I think that clearly can help guide our thinking. I think the details are also really valuable though, because we are at a point where we need to be implementing and acting, and the details matter.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
That's what I was suggesting, that we use the principles to help guide us in terms of which detailed responses we want to be doing.

Kelly Cronin, MPH – Office of the National Coordinator
Gotcha.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Maybe there's a state group that we know we can circulate around what we think are the kind of usual levers that we would have, again kind of focused on what we really do have, or a state would have its arms around and kind of think of it from an overarching point of view. I think, I know most of the people on here well enough to know, I think, what they would think about that. Maybe we could start with that kind of framework and then say, okay, these are the ways that as a state person, were I still one, this is what I would be doing, thinking through the different pieces that you have kind of at your command and those that you don't.

Hunt Blair – Department of Vermont Health Access
Yeah Dave, this is Hunt. I think that's a good idea and Kelly, since you included me in that list of state or former state people, I mean I'd be happy to help participate in that. Like an email conversation about that with folks and we can reach out to Amy and other state people who are in the group who aren't on the call today.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Yeah, this is Amy and I joined late, so, but I was having, I'm under deadlines so I've been trying to listen and do something under deadline, which is why I haven't been actively participating. But I would be happy to do that and I'll try to pick up. I wanted to try to listen and unfortunately, I had a critical deadline that didn't expect come up today. So …

Hunt Blair – Department of Vermont Health Access
See, that never happens in state …

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
So, I'm quietly listening, trying to absorb what I can with one half of the brain while the other half of the brain is doing what it needs to do on deadline.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
I'm wondering, this is Micky, is there – and just looking at the questions, some of them are a little bit overlapping, I think, which always happens, this isn't a criticism. I mean as you start to put this stuff together, it's not like they're all going to be completely orthogonal. But, I'm almost wondering is there…a matrix, whether it's a literal matrix or just … conceptual one that sort of has thoughts around different types of levers. We've talked about payment policies and maybe there are payment policies that are genuinely new payment policies versus tweaks to existing programs around innovative payment policies, like the Shared Savings Program, the Pioneer ACO, what have you. There are federal regulations and regulatory authorities and those are – there are a variety of different ones that Kelly even touched upon, there are state level regulations, there's certification of EHR systems through ONC, and I'm sure there are a couple of other levers. And then, on the other dimension, different types of HIE transactions, transitions of care, lab results, provider directory, and provider directory is not a transaction, but different components or functions, and then being able to – not that we necessarily have to show the matrix, but maybe that'll give some sense of which levers do we think are most appropriate for which types of transactions. Too complicated?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
No, I mean I think we've got to bucket it a little bit, I think that's right. I'm trying to – I don't have my little whiteboard out drawing up a matrix as we speak, but maybe that's something that you can take on and kind of circulate around. And say these are the buckets, now as you think about it, put the – throw stuff – who's going to throw stuff in what bucket, right?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right. Yeah, I mean I was – right, yeah, so I wasn't – it was more about thinking about how do we bucket this, what kind of framework do we put on it, rather than trying to go through an answer each question. Because again, some of them are slightly overlapping, some of them may have more or less priority from our perspective as a workgroup, or we may just feel like we don't really have the right people or the right skill sets to be answering any particular question. Or there may be other things that we think are important that just aren't in any of these questions.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
I recommend the whole RFI to everyone if you've not had a chance to read it, it will – I've read it a couple of times and you'll – it will help frame kind of the bucket discussion I think pretty well.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right. So let me just ask the group, what's the appetite for another call, because that will shape a little bit about how we want to try to chunk out this work, given an …

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Let me ask a process question Micky, about how that works. So for example, if us staties and former staties just circulated around and wanted to do a call around that – how does that implicate being a part of a FACA and all that stuff. I've never been really totally clear on that. Do we have open meeting rules; I guess is what I'm asking?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
That question's well above my pay-grade.

MacKenzie Robertson – Office of the National Coordinator
Sorry, so this is MacKenzie. I just want to make sure I heard the question. It's ONC policy to have all of our workgroup calls in the public, and to provide public comment. So, we can't do any offline. It's not a matter of FACA rules; it's more ONC policy.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Okay. No, that's fine I just wanted to understand. So if a subgroup of – just again, kind of to my example of state types or provider types or whomever, wanted to get together, I mean there are public records created by the email obviously that goes around, but if we wanted to have a call, it would have to be noticed in some fashion?

MacKenzie Robertson – Office of the National Coordinator
So, we don't need to notice it, like fifteen calendar days in advance, we would just need to schedule another call. But if we do want to break up into subgroups, the calls would need to be public.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Okay, got it. Just trying to understand.

MacKenzie Robertson – Office of the National Coordinator
Yup, no problem. I appreciate the questions.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
So this is Amy and I'm – I think if the next call is the 28th and then we need to have our recommendations done by the 3rd, is that what I was hearing?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yes.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Yeah, so, I mean we can try to do what we can by email. I think sometimes calls do help clarify issues more than an email. I'm trying to think whether we'd be better off trying to do another call like on the 1st, the 28th and the 1st, or…I don't know that we can put one in before the 28th.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
I think the last time we did this, it was really effective to have sub-workgroups and then have a couple of come together points. And maybe that's a good process.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Um hmm.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Yeah, I'm just concerned about the amount of time to – I mean, I don't have a problem breaking down into subgroups, but then to come together as a whole group, I think that's where we're gonna kind of lose time. Because we literally have two weeks.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Yeah.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yup. Well how would – given what you just said MacKenzie, what's an appropriate subgroup process if we were going to try to do that?

MacKenzie Robertson – Office of the National Coordinator
So, if you wanted to today break up, because we still have, well 20 minutes, it's not that much time. But if you wanted to break up into subgroups and then perhaps we had – if there were two or three subgroups, I'm not sure how many you guys were thinking. If we had subgroup calls next week, we can try and schedule those now for a time next week, and then we'd have the full workgroup meeting on the 28th to wrap it up. But again, the subgroup's going to have to report back up to the workgroup. So, either we're marching off the March 28th full workgroup call and trying to get subgroup calls in between now and then or we're going to have to schedule another workgroup call on perhaps the 1st, I believe that was Amy that said that, to report back. Deep sigh.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, if feels really tight to have …

MacKenzie Robertson – Office of the National Coordinator
I mean, either way.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Subgroups … what's that?

MacKenzie Robertson – Office of the National Coordinator
It is … either way; it's a really tight timeline. So I think you might do best by prioritizing questions and doing, maybe adding another workgroup call. The thing with subgroups too though is when they report back to the workgroup, if there's further deliberations, you don't really have time built in to discuss as a workgroup and then possibly change …

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
So maybe the way to do this instead of subgroups is to set up another meeting and then say, okay, we're going to focus on like the state-type related questions and considerations on this day and we're going to do the provider or this half of the meeting and the other provider and just make like a mega meeting, like a two-and-a-half hour call and do the first half on one – whatever those subgroups would be – you know what I'm saying?

MacKenzie Robertson – Office of the National Coordinator
Right.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
But that anyone can join any one of those, but it's a full workgroup. And then if we have to, if we're crunched on time, we can hopefully pick and choose what we can participate in and hopefully that aligns with our calendar. But so it's like subgroups without subgroups, if that makes any sense.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Um umm.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
And just dedicate, make it really clear which part of the call we're going to dedicate to which topics. Hopefully we can all be on the whole call, but like I said … or do two short one-hour calls instead of one two-hour call, if that …

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Well the call that's booked on the 28th is only an hour on my calendar. So, I think that's probably inadequate kind of regardless, right.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Maybe we can extend that.

MacKenzie Robertson – Office of the National Coordinator
Yeah, see I can – right now it's scheduled on the 29th from 10 to 11, so if everyone's in agreement now, I'll just go ahead and extend that 10 to 12.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
I can't do that.

MacKenzie Robertson – Office of the National Coordinator
Can you do 9 to 11?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
I can. Yeah, this is Micky; I can do 9 to 11.

MacKenzie Robertson – Office of the National Coordinator
Okay. We'll need you Micky you're the Chair.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
9 to 11 East Coast time, thank you.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Oh, Arien, we're doing everything we can to get this group …

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
…g getting all the snow, you've been getting all the snow; you guys are getting all the good weather.

MacKenzie Robertson – Office of the National Coordinator
9:30 to 11:30, is that better?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
I can't do anything after 11:30 – after 11, but I could certainly, if I dropped off for the last half hour, people could continue.

MacKenzie Robertson – Office of the National Coordinator
Right.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
If that's more acceptable.

MacKenzie Robertson – Office of the National Coordinator
I'll leave it up to the group. I'll be here either way. So, do you want to do 9 to 11 or 9:30 to 11:30?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Um, well …

MacKenzie Robertson – Office of the National Coordinator
Arien?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Arien, do you mind getting up a half hour early for us?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Just do what makes sense and I can either show up late or get up and …

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
All right.

MacKenzie Robertson – Office of the National Coordinator
So 9 to 11 then. I'll have March 28th changed to 9 to 11.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Arien, we owe you a pound of Pete's coffee.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Absolutely.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
It's in the mail.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Absolutely.

MacKenzie Robertson – Office of the National Coordinator
So, how does everyone – what about if we try and schedule – do we want to do a workgroup meeting perhaps on the 26th, to that would be we'd have a Tuesday, Thursday, or do you want to do April 1st, which would be the Thursday, Monday.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
It seems to me that if we're going to have another one, it ought to be the 25th or the 26th.

MacKenzie Robertson – Office of the National Coordinator
I would agree.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Because I mean the 1st is really … gets really tight at that point.

MacKenzie Robertson – Office of the National Coordinator
And then you still have time to revise slides over email if you need to before the committee meeting. So between the 25th and 26th, it looks like the 26th, the morning of the 26th works best, based on the other workgroup calls already scheduled. So I don't know if...we have 9 to 11:30 open on the 26th, Eastern Time.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
MacKenzie, you're going to do that to Arien again.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Loving it.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Let's go for 10 at least.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Morning is definitely better for me because those two nights are Passover Seder nights.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Oh.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
I mean, I'm hosting on the 25th, I'm taking a half day, but so morning would be probably better either way for me.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Is 10 to 12?

MacKenzie Robertson – Office of the National Coordinator
We can do 10 to 11:30, there's already another workgroup call scheduled at 12, and there has to be a half hour buffer in between. But I could also say …

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
I think that works.

MacKenzie Robertson – Office of the National Coordinator
If you want to do back to back, we have the afternoon of Wednesday the 27th wide open.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
No, I think it probably could require a little digesting time between the two. I kind of like the idea of the day between.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Yeah, I agree.

MacKenzie Robertson – Office of the National Coordinator
Then how about the 26th from 9:30 to 11:30? You get a half hour Arien.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator
MacKenzie, this is Michelle.

MacKenzie Robertson – Office of the National Coordinator
Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator
You can't do that.

MacKenzie Robertson – Office of the National Coordinator
Why?

Michelle Consolazio Nelson – Office of the National Coordinator
It has to be at 11, because there's the …

MacKenzie Robertson – Office of the National Coordinator
Quality Measure's at 12. If we do 9:30 to 11:30, there's a half hour break in between.

Michelle Consolazio Nelson – Office of the National Coordinator
On the 25th or 26th?

MacKenzie Robertson – Office of the National Coordinator
26th.

Michelle Consolazio Nelson – Office of the National Coordinator
Sorry.

MacKenzie Robertson – Office of the National Coordinator
So, March 26th 9:30 to 11:30, is that good for everyone, except Arien?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah.

MacKenzie Robertson – Office of the National Coordinator
Okay, so I'll have that sent out as well.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Jonah had to drop off, so he's protesting without knowing it.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
That's true, yeah; Jonah and I are in the same boat…

MacKenzie Robertson – Office of the National Coordinator
Okay, so March 26, 9:30 to 11:30 Eastern Time and then March 28 will be 9 to 11.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right. So, in terms of, and we can try to work offline to try to structure our thinking around this, so just get a little bit of, figure out what the focus should be for each call. But I'm just wondering – I mean, I've heard payment policy is one big topic area, I've heard state level regulations and statutes as another big area. Um, are those the kind of categories that make sense to everyone?

Amy Zimmerman, MPH – Rhode Island Executive Office of Health and Human Services – State HIT Coordinator
Yes.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Um hmm.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Are there others?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Umm.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Labs, do we want to consider CLIA and labs separately?

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, I mean, that seems like it's definitely a regulatory authority under HHS and a real need. So CLIA lab.

Lawrence Garber, MD – Reliant Medical Group
Do we believe that standards are sufficiently being pushed in other forms?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Can you explain more what you mean?

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
The ineligibles kind of, in that sense, maybe that's a category?

Lawrence Garber, MD – Reliant Medical Group
Essentially the – right, I mean that's – we want to be able to replace paper and so the paper forms that we're currently sending around from hospitals to the post-acute care community … seem to be replaced with CCDs, but they would be replaced with the standards that we are proposing for MU3, so I don't, in other words, I'm not sure if that's sufficient or whether we need to bring that up as well.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
And do you mean – are you including the MDS in that as well?

Lawrence Garber, MD – Reliant Medical Group
Exactly.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Yup. Yeah, I think MDS alignment with existing standards is a pretty meaty topic and an important one.

Lawrence Garber, MD – Reliant Medical Group
And OASIS as well.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Umm, yup.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
So are those – those are kind of in the category of the ineligibles, right?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Well, but it is CMS – these are CMS requirements.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Yeah, okay. Yup, fair enough. Right, so ineligible is only from a HITECH perspective.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Right.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Um hmm.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
But they're under the umbrella of CMS generally, yup. So I've got payment policies, state level regs, labs and CLIA authorities. We talked specifically about MDS and OASIS alignment, but Larry, it sounded like you were thinking more broadly about standards in general. Are there other authorities that CMS may have to weigh in on standards as well, in order to help forward standards?

Lawrence Garber, MD – Reliant Medical Group
I can't speak to what their authority is, but I – in terms of standards, it's also – not just the MSD/OASIS, but also the transfer of care and care plan data sets. The other is also standards for provider directory, as you know, whether it's pushing HPD Plus or whatever. Those are also other kinds of standards that will facilitate this … standards for consent, uh, convey and consent.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Well certainly the provider directory one's an interesting one because way back, a long time ago in the … we … consideration of provider directories, we talked about you know NPES and other CMS systems as perhaps being the foundation or the seed for some type of nationwide provider directory.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Couldn't we get … on that

Kelly Cronin, MPH – Office of the National Coordinator
Micky, to answer – I'm sorry.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
That's all right go ahead.

Kelly Cronin, MPH – Office of the National Coordinator
I was just going to speak briefly to the authority question you had around CMS. I mean I think a lot of the regulatory authorities for the different payment regulations, for example, could potentially be addressing to the extent that they involve information exchange related to reporting quality measures or other aspects of exchange between providers or between providers and the agency.

Lawrence Garber, MD – Reliant Medical Group
Okay.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
But largely contained within those specific kind of initiatives and new programs, right?

Kelly Cronin, MPH – Office of the National Coordinator
Well, I think as Larry was mentioning around OASIS and MDS, I mean those, sort of, for example the notice for proposed rulemaking for skilled nursing facilities is coming out and the extent that that addresses requirements for MDS, you could be evolving standards for those measurement and reporting systems.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Okay.

Kelly Cronin, MPH – Office of the National Coordinator
So, some of them are existing.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Okay.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
And then the – I think was it Dave, you were the one who was asking about data availability, correct, is that another general area or is that too small? I was thinking is there a general category of infrastructure, which would be to say are there pieces of infrastructure that CMS or HHS more broadly has for whatever business processes they already have, that could be more effectively leveraged to enable HIE, like the provider directory stuff we were just talking about or like better availability to claims data.

Dave Goetz – OPTUMInsight – Vice President, State Government Solutions
Right. I mean, I think it's – got to think on it.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Right. So right now I noted kind of five broad categories, payment policies, state level regs/statutes, CLIA authorities and any other authorities for labs, what I called sort of standards outside of HITECH, which is really what we just had about MDS and OASIS alignment, care plan data sets. Some of that may really be a focus on ineligibles, which HITECH wasn't able to touch, but it could be that there are other kinds of things that – other authorities that could help forward standards in particular areas. And then the last is this infrastructure category, are there categories of infrastructure that could be leveraged in ways that haven't been to date. Do those roughly make sense; are there any other ideas that people have about those? We can sort of flesh them out a little bit, send them around to the workgroup, make sure that everyone has had a chance to take a whack at them and then maybe divide up out next two calls between these, and so have each call focus on a couple of them.

Steven J. Stack, MD – American Medical Association
Micky, this is Steve Stack, I've been listening for this call trying to think about where to offer these observations, but, as you look to frame this work, I would personally suggest that we try to frame it within the lens of what this workgroup really traditionally has existed to do, which was to advise on information exchange and the things that enable information exchange and perhaps what facets of information being exchanged are uniquely or particularly useful to improving clinical care or the value proposition for the care provided. I get somewhat – somewhat isn't a gross understatement – I get concerned with a group like this, notwithstanding the fact that I've worked with many of you for many years and all of us have a wealth of knowledge about different facets of healthcare. But when we now would begin to discuss how bundled payment impacts things and the ACOs and what the initiatives of CMMI is doing, I mean, there are – we are now in the midst of a discussion that is very, very far afield and much broader than a narrowly constructed Information Exchange Workgroup that's a FACA, that's intended to advise a larger FACA, that's the HIT Policy Committee, that then in turn advises the National Coordinator for Health IT. It seems – it's not that the questions are unreasonable; it is perhaps the audience being asked the questions is not the right audience for a number of these questions. And so I have concerns that if the exercise is framed in a way that from the beginning has perhaps major conceptual challenges, that no matter what result we produce, it will take a lot of our hours of time to produce it, but the end result utility or helpfulness of it is not entirely clear to me. Does that make sense a little bit?

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
Steve, this is Arien. And the only reason that I'm push – I agree that we're not the experts in payment policy. I guess the other lens that I have is that I've seen the economic – the business case for information exchange significantly change, primarily driven by changes in policy. And so, there clearly are many more facets to a payment policy decision ...

Steven J. Stack, MD – American Medical Association
Right.

Arien Malec – RelayHealth Clinical Solutions – Vice President, Data Platform
… than information exchange, but I do think it's appropriate for us to think about which kinds of payment policies impact the business case for information exchange.

Steven J. Stack, MD – American Medical Association
Okay. And I think that's reasonable. I think framed that way, that's a more narrow focus or appropriate for this kind of group, if we can offer insights that are helpful. But otherwise I haven't, I mean you've all had a very rational discussion about this and I've enjoyed today listening and not speaking up quite as much.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
No, thanks Steven. I think, Arien, I think that's a great framing. And I'm thinking certainly in general we would want to sort of caveat our comments with some of the limitations of – that as you pointed out Steven, we – the group was formed specifically to respond to the HITECH statute as it relates to providing advice for the HITEC Program. This is broader, which is fair enough, we have a direct request for the Policy Committee to address these issues. So, we do our best, but with that caveat, and also with the short timeframe that we have. I don't know if that makes you feel any better, but …

Steven J. Stack, MD – American Medical Association
No, that's okay. No, I appreciate it. I mean, we all know each other pretty well after all these years, I mean, everyone is volunteering a lot of time to do a lot of value, hopefully for a good cause. And so I appreciate that.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Okay. Great. Well, are there any other thoughts before we – we have five minutes left and need to turn it over for the public comment. Are there any other thoughts, I mean I think we've had a great discussion, and actually got a lot more done than I expected to, in the way of sort of a framing perspective that we can now use to kind of block and tackle some responses to these questions. If not, we will be in touch offline and let me turn it over to MacKenzie.

Public Comment

MacKenzie Robertson – Office of the National Coordinator
Thanks. Operator, can you please open the lines for public comment?

Rebecca Armendariz – Project Coordinator, Altarum Institute
If you'd like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

MacKenzie Robertson – Office of the National Coordinator
Okay. Thanks everybody and just as a reminder, you will be seeing calendar appointments for March 26 9:30 a.m. to 11:30 a.m. Eastern time and our current March 28 IE Workgroup call will be extended from 9 a.m. to 11 a.m.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative
Okay. Very good. Thank you.

MacKenzie Robertson – Office of the National Coordinator
Thanks everybody.