Information Blocking (IB) Task Force

Transcript
April 12, 2019
Virtual Meeting

SPEAKERS

Name	Organization	Title
Michael Adcock	Individual	Co-Chair
Andrew Truscott	Accenture	Co-Chair
Cynthia A. Fisher	WaterRev LLC	Member
Valerie Grey	New York eHealth Collaborative	Member
Anil K. Jain	IBM Watson Health	Member
John Kansky	Indiana Health Information Exchange	Member
Steven Lane	Sutter Health	Member
Arien Malec	Change Healthcare	Member
Denni McColm	Citizens Memorial Healthcare	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Sasha TerMaat	Epic	Member
Lauren Thompson	DoD/VA Interagency Program Office	Member
Sheryl Turney	Anthem Blue Cross Blue Shield	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Cassandra Hadley	Office of the National Coordinator	HITAC Back-up/Support
Mike Lipinski	Office of the National Coordinator	Staff Lead
Mark Knee	Office of the National Coordinator	Staff Lead
Penelope Hughes	Office of the National Coordinator	Back-up/Support
Morris Landau	Office of the National Coordinator	Back-up/Support
Lauren Wu	Office of the National Coordinator	SME

Operator
All lines are now bridged.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Good morning, everyone. Welcome to the Information Blocking Task Force. Quick roll call and then we'll jump right into it. Andy Truscott?

Andrew Truscott – Accenture – Co-Chair
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Michael Adcock? Steven Lane?

Steven Lane – Sutter Health – Member
Hello?

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

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Denise Webb? Sasha TerMaat?

Sasha TerMaat – Epic – Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Aaron Miri? Arien Malec? Valerie Grey?

Valerie Grey – New York eHealth Collaborative – Member
Here.

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

Anil Jain – IBM Watson Health – Member
Here.

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

John Kansky – Indiana Health Information Exchange – Member
Here.

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

Cynthia A. Fisher – WaterRev LLC – Member
Present.

Lauren Richie – Office of the National Coordinator for Health Information Technology - Designated Federal Officer
Lauren Thompson? And Denni McColm? Okay. I'll hand it over to you, Andy.

Denise Webb – Individual – Member
Denise Webb is here.

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

Andrew Truscott – Accenture – Co-Chair
Good morning, everybody. It's been so long since we last met. I was waiting for some humor and laughter at that point.

Anil Jain – IBM Watson Health – Member
I think we're just exhausted.

Andrew Truscott – Accenture – Co-Chair
Well, those of you that flew across the country and then still joined the first call yesterday, you have my eternal gratitude. Actually, I think we're going to have a slight twist in the agenda we see in front of us today. I'd like to focus on the definitions of EHI, HIE, HIN and touch upon health IT provider as well. I've had considerable discussion and feedback from all of you on the call over the last 24-48 hours.

I think we should go through those as a group and try and come to some degree of consensus

of where we land. I'd like to start with electronic health information. Mark, if you can just enhance the screen so we can go through this together. I would like to suggest that we consider as a Task Force adding a fourth type of information to a definition we currently have.

I appreciate that before we want to touch on the third part as well. That's another type of information, which is not individually identifiable but it's still relevant to an individual's care. Specifically, this would be to enable some of the potential directions the public policy around price transparency might take and would possibly line us up with the broader definition of health information as per HIPAA, but with the obvious electronic media portion of it.

I'd like to open up for a bit of discussion of the group as to whether we feel that is actually a useful approach or not. Specifically, I'd like to keep it in a separate definition so it's pretty straightforward for people to understand where it sits and what's what. Who would like to go first?

Steven Lane – Sutter Health – Member

Andy, do you have that written down somewhere so we can see it?

Andrew Truscott – Accenture – Co-Chair

I don't. I was going to add it on the fly. I was going to start with the sentiment and discuss it with you and get the wording in. I can quite cheerfully put some potential drafting down there for us to throw rocks at. That's fine by me.

Steven Lane – Sutter Health – Member

I think that would be helpful for me. I'm just opening the new document.

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

Andy, while you're opening – this is Mark, hey, everyone – I have the text pulled up on the screen right now. Just a note for the people that weren't in work group one, we just emphasized – so, our definition is essentially one and two here with the exception of adding as defined in HIPAA is a proposal by this group and also adding the parenthetical (s) after future payment.

So, that's the ONC definition, I believe, unless Andy snuck anything else in there. Three is the real proposed edition from this group so far and that Andy is proposing in addition of four. I just want to make that clear.

Andrew Truscott – Accenture – Co-Chair

It's not Andy's proposal. It's a group proposal, but yes.

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

Yeah, the group. Exactly.

John Kansky – Indiana Health Information Exchange – Member

Andy, this is John. I remember us talking about this before. Can you hit me over the head with the object of the game in adding this fourth? What problem are we solving?

Andrew Truscott – Accenture – Co-Chair

I think we all agree that there are some policy machinations going on right now about how price transparency could be enabled across the US healthcare ecosystem. This is to basically put the tracks in place so that information sharing is not a blocker to enabling that to happen. So, we're not saying it should be shared. We're just saying the definition of EHI includes this information. We should be able to share it if there was a mandate to share it. Right now, there isn't and that's not our call.

John Kansky – Indiana Health Information Exchange – Member

Sorry if this comment is too soon or out of sequence, but my concern is that I understand what you just said, but I'm trying to think through the ramifications of including a new class of information in EHI when EHI is used to implement – that definition is important in stating and implementing the regulations throughout.

Andrew Truscott – Accenture – Co-Chair

I agree. If I had it my way, we would have a separate information chart entirely. It's not EHI. It's probably EAHI or something like that. But we don't have that luxury to do that. Mark, correct me if I'm wrong.

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

You don't. I can't say what you can and can't recommend, but generally speaking, Cures says that information blocking would be defined as an interference with the access, exchange, or use of electronic health information. Within that scope, we look at EHI under this regulation for information blocking purposes.

Cynthia A. Fisher – WaterRev LLC – Member

Hi, this is Cynthia. I sent in the longer document to the entire group today to look at. I know I've tried to be clear and articulate this, but if you look at Cures Act on electronic health information and you go to the original line of health information and the law, it points back to HIPAA in 1996 and HIPAA has several class under health information, including this broader definition, which the preamble is very clear that all of this is in relation to the care and the health and the decision making of the health of that patient.

If we have the broader definition of HIPAA, which basically says payments and future payments are part of it, it should be held accountable under information blocking. So, to be overtly clear, patients have the right to see their entire picture as it pertains to their health and their health decisions. This has been in law since '96. The whole goal here is if we just provide this broader bit, then we can open the pipe for also pricing to be clearly part of it as

part of accountability and information blocking. It will allow for a broader way for patients to get access what they are due and deserve.

Andrew Truscott – Accenture – Co-Chair

Cynthia, that's a good background. Mark, you need to refresh your document view because I've updated it since we've been talking.

Valerie Grey – New York eHealth Collaborative – Member

Andy, it's Val. I'm sorry to interrupt. I don't know if I received the document from Cynthia that she just referenced. That may be helpful because I'm still confused here.

Andrew Truscott – Accenture – Co-Chair

Okay. Cynthia, can you make sure that's left your outbox, please?

Cynthia A. Fisher – WaterRev LLC – Member

Yes, I'll resend it.

Andrew Truscott – Accenture – Co-Chair

If I just try and paraphrase, I think Cynthia was articulating that there is a class of information which is not uniquely identifiable to an individual yet is directly relevant when it comes to transparency of pricing around the individual and that that information should not be blocked.

Valerie Grey – New York eHealth Collaborative – Member

Andy, this is Val again – I'm sorry I'm being dumb – but I guess I don't understand what this fourth category would be introducing that's not already in the prior categories if it's already in HIPAA because we already referenced HIPAA and then we say even broader than HIPAA.

Andrew Truscott – Accenture – Co-Chair

Okay. So, hang on a second. Class one is electronically protected health information as defined in HIPAA. That's a particular subset of the data that's provided in HIPAA, protected health information. Then we broaden out to electronic – I've put some wording in here and we can change this – around electronic individual health information. So, any other information identifies the individual, etc.

And then this other class that Cynthia is referring to is information which is relevant to a patient's care or pricing and payment, but it's not individually identifiable. So, it's things like Charge masters, etc., where they are relevant because they lay down schema in which the remuneration of that patient's care will proceed. However, they're not covered by electronically protected health information or any other information that identifies the individual, etc. Cynthia, did I capture that correctly?

Cynthia A. Fisher – WaterRev LLC – Member

Yes. I think the broader definition is the first definition and then you get to the individual,

which is a subset and then you get to protected. We sort of have it backward. Think of it in layers. This is about treating the patients as it relates to the individuals, but it is really the broader definition, then the individual, then protected. It's three tiers. It's all defined within HIPAA consistently that way as health information and electronic health information definition as well.

So, it's really enabling the future of care to work both as a physician and patient interchange of what are the right choices, what will be the best quality at the appropriate, most affordable price to that patient. This is the future. We wouldn't buy a care without seeing the price.

Andrew Truscott – Accenture – Co-Chair
Cynthia, to help the group, beyond Chargemasters, have you got some specific examples of other information types that we can insert into the preamble, potentially, to illustrate this out?

Steven Lane – Sutter Health – Member
Can I jump in?

Andrew Truscott – Accenture – Co-Chair
Oh, sorry, Anil. You've got your hand up.

Steven Lane – Sutter Health – Member
No, it's Steven.

Andrew Truscott – Accenture – Co-Chair
Anil has got his hand up.

Steven Lane – Sutter Health – Member
Oh, I'm sorry. My bad.

Andrew Truscott – Accenture – Co-Chair
Anil?

Anil Jain – IBM Watson Health – Member
Yeah, sure. Thank you. I just want to say that I think that it's really important to understand what we mean by identifiable. Chargemaster data that's not relevant to that patient should not be shared. Chargemaster data that's relevant to the patient would therefore then be identifiable with that patient and could be shared or should be shared.

I'm still not understanding what the distinction is here. We're trying to broaden the types of information, but it has to tie back to the care of that patient. Otherwise I don't understand how we would not say then other Chargemaster data that's not relevant to that patient shouldn't also be shared. It doesn't make sense to me.

Andrew Truscott – Accenture – Co-Chair

Hang on. Hang on. Cynthia, think through that response and let's let Steven get in because I'm sure it was on the same topic.

Steven Lane – Sutter Health – Member

Yeah. I think Chargemaster is a little bit of a red herring. I think what Cynthia is getting at – correct me if I'm wrong – is we're really trying to get to the cost data for the individual patient. As we've heard repeatedly, showing a Chargemaster doesn't help. It's really showing that calculated contracted cost based on the patient's payer, plan, condition, etc., which, again, doesn't necessarily have to include the patient identifiable data because it could have to do with their employer group or the plan they selected.

It's not necessarily the full Chargemaster. It's derived based on patient characteristics, but it's not patient-identifiable, per se. It might apply to the patient's spouse or someone else in a similar plan. I think it's getting down at a more granular level than the full Chargemaster.

Andrew Truscott – Accenture – Co-Chair

Okay. Chargemaster is a misnomer. Cynthia, do you want to give us some examples?

Cynthia A. Fisher – WaterRev LLC – Member

Imagine in Uber like where we go and we have choices and we can ride share or we can look at what's available. We can look at a taxi price or we could look at a ride share or an Uber X, right? You get to see the different prices and you get to choose. Unless patients can actually get access for a blood test to be able to say okay, if I stay here, I will be charged $4,300.00 for an infectious disease blood test to see a healthcare worker. That's outrageous.

But if I could see another price, if I could actually see those prices posted with my doctor, I could see that I'm ambulatory, I could walk six blocks in this neighborhood and get it for $200.00 with a $20.00 out-of-pocket copay at a negotiated rate. But until we can see the actual prices, we can't make decisions that are affordable. We're being information blocked by staying within the healthcare system that we are in the chair that we're in to get a facilities fee of $275.00 to draw that blood versus being able to walk six blocks and get it for $20.00 out-of-pocket and $200.00. This is a real case.

So, the issue with pricing transparency is you have to have access to being able to see relevant data to that physician and patient decision. So, a college kid coming out of school trying to get a job, if they can't see the prices, they're so much in the hole before they even have a chance at the world. We have this opportunity to use health information broader definition and information blocking – under the information blocking domain because it is information blocking – let's be real – not to have transparency in price.

Andrew Truscott – Accenture – Co-Chair

Cynthia, we don't have the charter to use the information blocking regulation to create a public policy around that information mandate.

Cynthia A. Fisher – WaterRev LLC – Member

But this isn't public policy. This is a health information definition to open the pipes so that open APIs can be developed and innovators – if you guys don't do it as the EHR vendors or the providers or the payers – let the open applications be able to get access to the pipes that are HL7 already pathway approved as a standard and allow the market to work. That's the game-changing moment in time to open the pipes.

Andrew Truscott – Accenture – Co-Chair

So, Cynthia, we've got to be very clear. We are able to specify the information scope, but if there is no mandate for that information to be shared, we have created the tracks, but we are not able to say that information must be shared. Anil, you had your hand up.

Anil Jain – IBM Watson Health – Member

I did, but I think it may have been already covered. If we're talking about price transparency, there might be other parts of our comments that Cynthia, you can fold your argument into. I think no one is arguing against price transparency. The question is within the information blocking and the definitions of EHI, is this the best place to impact that or is there a broader conversation that needs to happen. I thought there was an RFI around that, but I could be wrong.

Andrew Truscott – Accenture – Co-Chair

There is an RFI around the broader price transparency discussion. All we're talking about right now –

Cynthia A. Fisher – WaterRev LLC – Member

You allow patients access to a comparative analytic of their own test results – say we're allowing things to be in machine readable format of our health and trends in health if we can compare that to general data that might be able to be shared in that moment in time in comparative graphing through an open API with the physician. So, if you allow for that piping to be open, you do it there and you could also do it in the future of pricing.

I go back to saying the broader definition of HIPAA is all health information that relates to that patient, the individual. So, it's all health information that relates to their health and their care plan. If you can't get access on the pipe for visibility and transparency, how can you make the appropriate quality and price decision or allow for that? Otherwise, patients are continued to be kept as sheep with no voice, with no choice with their wallet and to the management of their health.

We have to honor – that broader definition is already in law. It just hasn't been enforced. Now, we have the enforceable tools to go get it done. The technology exists and I just think it's irresponsible of us if we don't follow the law of the broader information definition to go get it done.

Andrew Truscott – Accenture – Co-Chair

Cynthia, are you comfortable with the drafting that is in front of you right now?

Cynthia A. Fisher – WaterRev LLC – Member
I couldn't hear you clearly.

Andrew Truscott – Accenture – Co-Chair
Are you comfortable with the drafting as it's on the screen right now?

Cynthia A. Fisher – WaterRev LLC – Member
I had to step out of the conference that I'm in to take the call. So, I left my iPad there. So, I can't see it.

Andrew Truscott – Accenture – Co-Chair
That's all right. Anil's got his hand raised.

Anil Jain – IBM Watson Health – Member
Maybe I'm just being really dense here. I don't understand. If the information relates to an individual, then any transmission of that information, by definition, it would have to be identifiable to that individual. Why do we need this additional thing?

Andrew Truscott – Accenture – Co-Chair
I don't think that's quite true.

Anil Jain – IBM Watson Health – Member
Well, so, for example, if someone says, "Give me the price of my upcoming knee surgery," I would have to have some information in there about who I am. Therefore, by definition, it would have to be identifiable.

Andrew Truscott – Accenture – Co-Chair
I think what Cynthia's argument is is that there is a shift going on in the market around how patients wish to make choices about their future.

Anil Jain – IBM Watson Health – Member
I get that. You can't have that transparency without knowing some information about me. I don't think we're going to be doing any consumer a service. I'm sorry. We're not going to be doing any –

Andrew Truscott – Accenture – Co-Chair
Let Anil finish.

Anil Jain – IBM Watson Health – Member
We're not going to be doing consumers any justice if we simply make information that's health-related available without some context. That context has to be about that person. By

then, if you make that connection, it would have to have some information that's identifiable to that person. I'm not disagreeing with the need for transparency. What I'm saying is the way it's currently written should account for those use cases.

What I think the unintended consequence by broadening the lens is that every bit of information that a hospital or a health plan or anyone else might have might be related to a health decision, are you then basically saying that all that information needs to be made available? That would be really problematic, in my opinion.

Cynthia A. Fisher – WaterRev LLC – Member

Well, it's really problematic when a patient gets a $101,000.00 out-of-network surgical fee that they thought the surgeon was in-network. They have to check the anesthesia. They have to look at everything and do it themselves, block and tackle. That's really problematic and that is today. Then the bills come seven months later.

Anil Jain – IBM Watson Health – Member

How is that not accounted for? I'm sorry. How is that not accounted for?

Cynthia A. Fisher – WaterRev LLC – Member

Let me get back to your point on the data on this point on the issue. You can have the individual be identifiable to what the payer and the contract negotiated rate and the out-of-pocket and the deductible status, all of that is absolutely appropriate.

And what we're saying for the broader definition, that patient should be able to shop. If a health plan negotiated a really terrible rate for that patient and they could walk across the street and get it another place that that same health plan could see it through that broader pipe, as it refers to that patient or they could get it for cash at half the price of that, which we're seeing happen in the marketplace, why shouldn't' the patient say, "Well, heck, I could save money in my HSA.

My employer could reward me for not paying $4,300.00, but for paying $200.00. I'll pay that out of my deductible. I have a $6,000.00 deductible. I'll get rewarded by my employer for saving money." Wouldn't that be a better model and allow the consumer to not only set access to the clinical information but get access to their decision and be able to choose to keep it in their HAS and their savings and not be empowered? Unless we have the patients make that decision and have that display, that's opening a pipe.

Anil Jain – IBM Watson Health – Member

I don't know how that relates to this.

Cynthia A. Fisher – WaterRev LLC – Member

Because our job is to open the pipes for the future, to open APIs and technology and all of us compete, just like the financial services industry did. We have to open the pipes. That's our job on this committee. If we look at the three levels within the HIPAA definition and within the health information and the accountability under information blocking, then we can have those pipes be open. Believe me, it will take time. I understand that. But our job is to open

the pipes.

Andrew Truscott – Accenture – Co-Chair
Sheryl Turney?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Of course, I've shared my feelings on this before, but I do want to clarify. I think, Andy, it merits clarifying – the charge of this committee isn't to broaden the pipes. It's to provide input on the things we've been charged to do. I do think it's fair to say, Cynthia, that you have your perspective, which is completely appropriate, but there is room for other points of view as well. I think that there's a caution that we're trying to communicate that perhaps is not resonating.

That is that when you broaden the language in the way that you – we believe that what you're looking for is already in the language that we have and by broadening it the way that you are, you're actually going to make this rule unimplementable because where is the boundary, then? Then all data that everyone uses to process health decisions isn't available electronically in the manner in which you've communicated, nor is it available even internally in most organizations in the way in which you're anticipating.

So, having the rule to make that available in a timeframe that's very compressed already for what we're trying to do essentially could make the rule not implementable and I don't think any of us want to see that happen. Sometimes we have to move through phases or levels of maturity and I think we need to consider this especially for, as I've indicated before, present and future, which is a different animal than claims data availability.

It needs to have some level of maturity applied to it. There aren't APIs today support it. There are no implementation guides in terms of standards on how it should be done. Those are things that all need to be developed which are going to take time. Most of the payers provide price transparency or cost transparency tools that actually tell you who are all the network providers for labs, where you can go, and how much it's going to be, and what it would cost out of pocket. You've presented some examples.

As we've said, all stakeholders are not the same. So, perhaps we should approach this from a stakeholder perspective – those people who have coverage versus those people that don't, those people that have high-deductible plans versus those people that don't, but at the end of the day, there is some responsibility that a member or patient will have to take in order to even look up in their tool or look up in the data what lab is the one that they can go through for $20.00. That requires some responsibility on behalf of the patient.

So, yes, we don't want to make it difficult, but at the end of the day, what is the tool and what is the answer may not be the same for all stakeholder groups. That's my two cents on this topic.

Andrew Truscott – Accenture – Co-Chair

Thank you, Sheryl. I'll take that as being a whole dollar's worth of two cents because that was excellent. Thank you so much for the input. Denise, Sasha, Steven – you've been uncharacteristically quiet.

Sasha TerMaat – Epic – Member

I guess I'm still trying to digest exactly what proposal we're considering here.

Andrew Truscott – Accenture – Co-Chair

The addition of the language you see that might be defined in point three. The box is highlighted. Just so you know, above this, this is some slight tweaking, nothing material. It doesn't change any of it. It's just the ability to carve out individual electronic health information versus more generic.

Sasha TerMaat – Epic – Member

My take is that I think it would be more effective to create outside of this a separate definition of the pricing information of interest and the policies that would govern the availability of that pricing information.

I know from some of the other Task Forces where we talked about the conditions of certification, for example, electronic health information is used in so many different places where it wouldn't make sense to include, for example, in a patient's particular download all of this external information that is more of interest for a different use case. So, I would favor working on the pricing transparency information separate from the definition of electronic health information.

Andrew Truscott – Accenture – Co-Chair

Okay. I think where EHI is used – this is one of my enduring concerns, actually. This meeting has had other regulations around it with the tighter individual meaning. My understanding is that where it is used elsewhere, it is referred to, but it doesn't necessarily mean everything. So, it wouldn't – if it's not relevant to be included – let's just call it administrative and financial information that Cynthia was proposing – that that wouldn't be included in the export function. Mark, we can use you to help us with that.

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

Just to clarify, the definition you're looking at here for EHI is specific to 171, which is information blocking. You need to look at it in that context, really. I can't speak to every time we use EHI, but what I can say the definition is in 171 for information blocking.

Andrew Truscott – Accenture – Co-Chair

Okay. Thank you.

Sasha TerMaat – Epic – Member

So, if the other criterion says export all electronic health information, it's not referencing the same definition?

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

I think we spoke about this before.

Andrew Truscott – Accenture – Co-Chair

Refresh our memories.

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

I don't remember exactly how the conversation went. I know Lauren Wu is on the call as well. She might want to weigh in. The EHI export is a different context. That's in the conditions of certification. So, it applies only to developers of certified health IT or developers with certified products under the program. So, the EHI export is being considered in a different Task Force. It's a different context, I guess, is all I'm saying. I don't know that we want to get into the specifics of that right now because it might take a while. I believe it was discussed in both Task Forces.

Lauren Wu – Office of the National Coordinator for Health Information Technology – SME

This is Lauren. The only thing I'd add is that obviously, we specifically proposed electronic health information export to align with the electronic health information definition across information blocking as well as that specific criterion as well as the TEFCA as well for consistency. So, whatever definition you all are proposing or any additions or subtractions to it that you're proposing will align across all of those different use cases. It does apply when you think about that use case as well. Was there a specific question about that criterion proposal?

Sasha TerMaat – Epic – Member

I think that answers my question. Thank you. I just wanted to make sure I understood the ramifications of making changes to this definition. I do think some of them will flow through to other cases.

Lauren Wu – Office of the National Coordinator for Health Information Technology – SME

Yes, that's right, Sasha.

Andrew Truscott – Accenture – Co-Chair

Certainly, in information blocking, EHI is used. So, we would need to make sure that's set too. If Mark scrolls up slightly to try and help us potentially include this and preserve some of the downstream meanings, I've kind of just said okay, the individual stuff is electronic individual health information, which is part of electronic health information, so, we don't fall into that redefinition issue.

That might be helpful. We can go through and say, "Do we mean individual health information? Do we mean electronically protected health information?" So, I think I that could help not have unintended consequences. It comes back to this call – Mark, scroll down

again, please. Do we want to have this broader definition which is purely – we can strip out the word administrative and just have financial. That's what we need to consider. Denise?

Denise Webb – Individual – Member

Yes. Thank you.

Andrew Truscott – Accenture – Co-Chair

How on earth did you raise your hand? You're driving. Do not raise your hand. Just shout at us.

Denise Webb – Individual – Member

Actually, I have my daughter driving me. So, I can participate. So, anyway, I appreciate Cynthia's perspective and I understand where she wants to go, but I do concur with what Sheryl contributed. I just want to say that because I'm the Co-Chair of the other Task Force, where we're discussing EHI export, I'm very concerned about how we define this because we either have to do it within primers that are going to support the EHI export criteria or we have to constrain the EHI export criterion to specifically certified technology.

Presently, it tends to apply to all technology of a certified health IT developer that could change EHI that is being unified in the data provider or the health system. So, I really think if we're too broad here, I agree with Sheryl, we're not going to be able to implement it. It's going to be a mess.

Andrew Truscott – Accenture – Co-Chair

Okay. Thank you, Denise. For those of you who are online and looking, I've just included – Cynthia circulated a document to us all. She gave me [inaudible] as well. I've just put in an alternative drafting of three, which is actually a completely clear copy of what's currently in 2i, but just with all the contextualization around the individual identifiable, which is a very broad definition of information.

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

And I apologize. My document refreshed when Andy added that. I'm trying to get back down there.

Andrew Truscott – Accenture – Co-Chair

Mark, we need to get you a new laptop.

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

I know. Talk to the people above me.

Andrew Truscott – Accenture – Co-Chair

I shall make this a recommendation of the Task Force – Mark Knee gets a new laptop.

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

Now, it's doing it again. So, maybe you could read out what you put in there, Andy. It's doing weird stuff.

Andrew Truscott – Accenture – Co-Chair

Okay. So, an alternative definition could be any other information that is transmitted by or maintained on electronic media as defined in 45CFR16103 that relates to the past, present, or future health or condition of an individual, the provision of healthcare to an individual, or the past, present, and future payment of the provision of healthcare to an individual. Those of you that are looking online right now can see it and Mark, who is just refreshing.

Sasha TerMaat – Epic – Member

Andy, we're comparing old three and new three now?

Andrew Truscott – Accenture – Co-Chair

Yes. I've just included it because that's the drafting that Cynthia provided in her document that she circulated for those that haven't had the opportunity to read it yet. Mark's popping it on the screen.

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

Yeah. So, I finally got it up there. So, here's what we're looking at for all.

Cynthia A. Fisher – WaterRev LLC – Member

I apologize. I just have to step back in the conference because they're going to be referring to me for the next two to five minutes. Sorry.

Denise Webb – Individual – Member

Which one is new and which one is old?

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

They're both new, right, Andy?

Andrew Truscott – Accenture – Co-Chair

They're both new in square brackets. The first one is a drafting which I did based upon Cynthia's document to try and have a light touch in here. The second one is taken directly from Cynthia's document and it's fundamentally the same as the core individual definition that we had but without the identifiable component to it.

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

While people are thinking this over, I just wanted to reiterate from ONC's perspective, it seems like we might be – there might just be two different ways of thinking about this in the group. As far as moving on, it would be okay to have a majority and minority opinion or however you want to word it, I think, just to make sure that everyone's voice is heard.

Andrew Truscott – Accenture – Co-Chair

Yeah. That's where we're coming from. Go on. Steven Lane has his hand raised.

Steven Lane – Sutter Health – Member

Yeah. I think it would be best to try to collapse these into one for clarity's sake so that we can deal with it altogether. Also, Sheryl, could you restate what you said was your core objection to this? I really do have sympathy for what Cynthia's trying to accomplish. I'm trying to understand what the objection is.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

So, the objection is that when we open it up to data that's not linked to an individual, then where does the information stop? We're not just talking about price information here. She has stated before she's looking for all information that can be used, including risk scores and things of that nature, which again, I don't have a problem with any of those things in the right context and how they need to be applied to a particular individual.

I just think that the example that she used before was basically she wanted anybody to be able to, as a member, go in and see this is the rate that Hospital A has negotiated for Aetna, Cigna, United, whatever, but that's not meaningful to a person who's already within a plan that they've signed up for. So, making the data manageable to them is what I'm saying.

It does appear that by broadening it, she's looking for a different set of information to be released. Again, with appropriate guardrails, I wouldn't have a problem with that either, but right now, we're trying to resolve information blocking for the basis of the individual. I think we have to start somewhere and that's my objection. I do think it has unintended consequences by opening that up into other things we haven't even discussed in this group.

Andrew Truscott – Accenture – Co-Chair

Thank you, Sheryl. Valerie?

Valerie Grey – New York eHealth Collaborative – Member

Thanks, Andy. I guess I just wanted to go on the record to say that I also believe that we've got to get to a point where we've got better price transparency, but I share Sheryl, John, and Anil's concerns with this. I think that the reason CMS put out an RFI for pricing is because, to Sheryl's point, it isn't that simple. It really does depend on each individual's circumstance and whether they're insured or they're not insured. Even a negotiated price, if you have no insurance, there are different provisions for discounts and then there's the out-of-pocket.

Even if you got to start to move around Chargemasters, how do you actually convey price when a provider is getting paid on a value-based care arrangement or a capitation

arrangement? It's just not this simple. I think we've got to be very deliberate in order to really get to meaningful price transparency in the future. I just don't think there's enough clarity here to get there. I don't disagree. I thought our recommendation had been we would create a Task Force designed to just tackle these very serious issues, but throwing a definition in towards the tail end of something, I'm very uncomfortable.

Andrew Truscott – Accenture – Co-Chair

Thanks, Valerie. That is helpful input. I can actually see where we may have not divergent opinions, but agreement on points one and two. I just narrowed them to 2(i) and 2(ii) to try and make things easier, but a minority opinion on point three, and then we'll ask ONC to consider the two options there. Anybody else? John Kansky, you've been silent. John doesn't seem to want to come forth. Okay.

John Kansky – Indiana Health Information Exchange – Member

Andy?

Andrew Truscott – Accenture – Co-Chair

Yes.

John Kansky – Indiana Health Information Exchange – Member

You prompted me on mute about 80 feet from my phone.

Andrew Truscott – Accenture – Co-Chair

You have a remarkably large study then, sir.

John Kansky – Indiana Health Information Exchange – Member

My team is wondering why I'm running across my office. So, really, I'm just echoing Anil, Sheryl, and Valerie and I put my comment in the chat box.

Andrew Truscott – Accenture – Co-Chair

Oh, yes. Okay. Could we open to public comment, then, please?

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

Operator, can we please open the public line?

Operator

If you would like to make a public comment, please press star-one on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press star-two if you'd like to remove your comment from the queue. For participants using speaker equipment, it may be necessary to pick up your handset before pressing the star keys.

Andrew Truscott – Accenture – Co-Chair

This in particular will be an area where public comment will be highly welcomed by the entire

Task Force to help us with our deliberations here.

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

And Operator, any comments in the queue?

Operator

Not at this time.

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

Okay. Andy, if it's okay with you, we'll leave the comment line open for the last ten minutes and see if we get any takers.

Andrew Truscott – Accenture – Co-Chair

That's cool. Thank you. Okay, guys, if you can just go back to the document on screen, what I've suggested is that we actually – we have a divergent opinion. I think we have some very deeply held and articulately expressed opinions discussing two on this particular clause to be recommended. I propose to the group that we include it as a stated divergent opinion for consideration by ONC and that it is a minority recommendation coming out of the group. Would the group as a whole be comfortable for us taking that opinion and expressing it like that? Sheryl, raise your hand, please.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

And further, I would say that we should definitely make a recommendation as many of us have recommended that we establish a Task Force and focus on this as one of our top priorities. We definitely need to move this forward, but I think it's more complex than Uber and it's not the same as ordering from a restaurant menu. I'm more than happy to do whatever needs to be done to help this move forward as I've volunteered in the past.

Andrew Truscott – Accenture – Co-Chair

So, I believe Lauren would be delighted that you are proposing yourself to join that Task Force. In the RFI around price transparency, we have already got the recommendation drafted. Therefore, a Task Force to be instantiated to running parallel so that we don't inadvertently slow down this regulation draft by trying to couple it tightly together. I think that addresses that view. Does it not, Sheryl?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Yes, absolutely.

Andrew Truscott – Accenture – Co-Chair

Okay. Great. I'm going to go back to what we've got on the table right now. Mark, can you share the screen?

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

I'm doing it right now.

Cynthia A. Fisher – WaterRev LLC – Member

Andy, may I just make the comment that we have on this Task Force at the table primarily today's software providers, insurance plan providers, and representation of systems integrators as well. We do not have at the table for looking at the future technology innovators.

I would just like to bring that to the attention of the Committee to say look, I think there's a missing voice at the table. If we look at information blocking as a whole, the goal is to get the information out so that the patient can have the best access to the best quality of care at the lowest possible price. If they're blocked and into a narrow rabbit hole of just what is individually identifiable to them, then they can't see everything around them.

I just want to go on record to say unless we open the big pipes and we allow technological innovation and small businesses and creative minds to come in and do things differently, not status quo, then we are continuing to have protectionism built in. So, I do believe that we're also not consistent with the HIPAA law with the three levels of definition. I will stop and agree that the majority can decide and I'll move on. I just want to go on record.

Andrew Truscott – Accenture – Co-Chair

Thank you very much. You are on record. This is a public call and this is a matter of record. John Kansky, you had your hand raised first.

John Kansky – Indiana Health Information Exchange – Member

I was just reacting to Cynthia's comment. I think there's plenty of organizations represented that view themselves as technology innovators, including my own. So, I think we bring that perspective.

Andrew Truscott – Accenture – Co-Chair

Thank you, John. Sheryl?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

I'm sorry. That was from before. Sorry.

Andrew Truscott – Accenture – Co-Chair

No worries. Anil?

Anil Jain – IBM Watson Health – Member

Yeah. I just want to add I think we see ourselves as technology innovators and we have lots of innovative groups within the broader IBM that innovate and we help a lot of small companies innovate in this space. I think my position and I think we should be thinking about what is

being prevented with the current way it's written versus how are we interpreting, I think, remains to be seen.

I think no one is arguing against price transparency. No one is arguing against innovation. The question before us is is the current language sufficient to do this in a way that makes sense or are we going to have unintended consequences if we were to broaden the language. I think that's where we're coming from. That could actually be a harm to innovators if it's not clear. They end up going down a path that becomes a challenging process down the road.

So, respectful to Cynthia's position and having been the small innovator and now being part of a larger group that's helping others innovate, I want to make sure that we don't lose sight of the fact that sometimes, broad language can actually make it harder for innovation if we're not clear.

Andrew Truscott – Accenture – Co-Chair

Thank you, Anil. I'm going to maintain the role of Chair and not comment. What I am going to say is on the screen right now, you have the drafting as Cynthia has provided. I've noted in front of it that it is the additional text for consideration as a divergent opinion. Is the Task Force happy for this to be our drafted recommendation as it stands? I'm just going to say – all in the Task Force in agreement, please say aye.

Valerie Grey – New York eHealth Collaborative – Member

Andy, it's Val. I'm still a little confused. So, you're asking us to…

Andrew Truscott – Accenture – Co-Chair

To vote on the current drafting you have in front of you. We've got the original definition we had prior to today. And then we're stating that there is some additional text for consideration, but it is a divergent opinion. So, it's not got the full endorsement of the entire group.

Valerie Grey – New York eHealth Collaborative – Member

Okay. I thought you had said before you were going to indicate it was a minority opinion.

Andrew Truscott – Accenture – Co-Chair

I did. You're right. Hang on a second. I was clicking in the wrong place – divergent minority opinion. Done. Anil Jain has got his hand raised.

Anil Jain – IBM Watson Health – Member

Real quick – we're one committee, one Task Force. I think we should have one consensus-driven point of view. There are plenty of other ways to get a minority opinion voiced. Now, I will go with whatever the group decides, but having a divergent minority opinion be folded in in this way, is that something that we've been doing as part of our committee work? If so, then let's do that.

Andrew Truscott – Accenture – Co-Chair

We have not had any other divergent opinion where we haven't been able to come to an absolute majority agreement on what we're recommending. So, this would be the first.

Anil Jain – IBM Watson Health – Member

What I would recommend is that we have the consensus of language, but then put Cynthia's concerns as part of our discussion and say we want to ensure that this particular viewpoint is reflected in the way the current regs are written. I think the point of view is right. I think the way that we're constructing it may be off.

Andrew Truscott – Accenture – Co-Chair

I'm going to call a close to the conversation at this point. I do want to go to the vote. I am, as the Chair, happy to go with the group decision here. If we do not want to draft it this way, I want to approach it in a different direction. Then you'll need to vote nay. Okay? I'm going to go back to the vote. All in favor of leaving it as it currently is drafted on screen, noting this is additional text for consideration that's divergent, minority opinion, please say aye. Sigh doesn't count, whoever that was.

Steven Lane – Sutter Health – Member

That was Steven sighing. I thought sighing was a good vote.

Andrew Truscott – Accenture – Co-Chair

Not yet. No agreement. Okay. Abstentions?

Steven Lane – Sutter Health – Member

I'll abstain – Steven Lane.

Andrew Truscott – Accenture – Co-Chair

All against. Please say nay.

Multiple Speakers

Nay.

Andrew Truscott – Accenture – Co-Chair

Marvelous. So, we don't want any of this. Guys, someone has a proposal. Do you want to propose what Anil had, that we part this into the discussion?

Sheryl Turney – Anthem Blue Cross Blue Shield – Member

Yeah. I agree with that, Andy.

Andrew Truscott – Accenture – Co-Chair

Second vote – we take this word as additional text for consideration and put that into our discussion section. Those in favor, say aye.

Multiple Speakers
Aye.

Andrew Truscott – Accenture – Co-Chair
Okay. Those against, please say nay. Those abstaining, please say abstain. Okay. It sounds like we've got an absolute majority that we're going to put it into the discussion text and I have already done so. Look at that, a majority opinion. Okay. Guys, thank you ever so much. We've got to the bottom of the hour. Have we got any public comments? Operator?

Operator
Not at this time.

Andrew Truscott – Accenture – Co-Chair
Okay. Team, thank you very much for your time today. Have a great weekend. I look forward to speaking to you all next week.

Sheryl Turney – Anthem Blue Cross Blue Shield – Member
Thank you, Andy.

Anil Jain – IBM Watson Health – Member
Thank you.

Andrew Truscott – Accenture – Co-Chair
Thank you. Take care.