1. Is an electronic file size an appropriate proxy for "pages" in setting fees for electronic access, or is it simply a substitute for a per-page proxy? If file size is appropriate, how should cost be calculated, particularly considering the questions below? If not, what is a better proxy for calculating labor costs for electronic access?

   File size is really not an appropriate proxy for paper documents. While one can argue that each individual sheet of paper carries with it a discrete cost, the cost of an electronic file does not equate with paper on a page-by-page basis. To illustrate, 100 sheets of paper might cost 5 cents per page. If that same data resides in an electronic format, there is little difference in cost between a single page worth of data and 100 pages. While some allowance might be made for data types (DICOM studies can consume a fair amount of electronic real estate), the cost of electronic storage is minimal and grows cheaper by the day. If the data is being placed on portable media for the patient, there is a one-time cost for that media (and again, that cost is negligible) – but no additional cost based on the volume of content.

2. One of the objectives of Stage 2 of the Meaningful Use EHR Incentive Program is to provide individuals the ability to view, download and transmit their health information.[1] Therefore, should the producible form and format of the electronic copy the individual requests affect how the individual is charged? (For example, an individual downloads an electronic copy onto a portable thumb drive or CD vs. using the download or transmit capabilities of certified EHR technology or email.) This issue may also arise when an individual uses personal health records or mobile health devices.

   My understanding of V/D/T is that it serves as a mechanism for patients to secure easy access to their health information in a standardized, electronic format. That format (a C-CDA) has been established, and while far from perfect, any health IT solution worth its salt should be able generate that C-CDA without requiring users to engage in technical acrobatics. One must surmise that health IT vendors who cannot or will not support V/D/T must be techically incompetent, obstructionist or both. If a patient wants to V/D/T a C-CDA from a certified EHR, it makes little or no sense to assign a cost to that activity – the certified EHR should support V/D/T with a few simple provider clicks. If V/D/T requires arcane knowledge and a complex process, the provider likely purchased the wrong EHR solution. In short, V/D/T of a C-CDA should be free.

   If the patient wants that C-CDA on portable media, then the nominal cost of that media could be passed along.

   If the patient wants a complete record in electronic format (the C-CDA along with anything and everything in the record), then some reasonable cost to generate that aggregate record makes sense.

3. If, due to interoperability issues between an EHR where the requested information is maintained, and the software used to create the copy for the individual (for example,

[1] 45 C.F.R. § 170.314.

proprietary software of a business associate which provides the electronic copy to the individual), the business associate must download the file from the EHR, and subsequently upload it to the business associate's software before generating an electronic copy for an individual, should labor costs associated with this process be charged to the individual? Why or why not? If so, how should they be calculated? Additionally, if the information is located in several different EHRs, downloaded, and uploaded to a separate software or system, should labor costs associated with this process be charged, as well – and if so, how should they be calculated?

Now we encounter real-world complexity, and the fair and reasonable question of who should pay for that complexity. This is a conundrum of sorts, as the patient can and should have access to their records and the provider (and perhaps the BA) should be compensated for the effort required to assemble an aggregate record from disparate sources. For the provider or BA who decides to turn this into a profit center and charge a usurious rate, the negative consequences of bad PR probably outweigh the revenues collected (think Regina Holliday or a similar consumer advocate using your operation as an example of a cold, uncaring, money-hungry data source). Rather than complicate this with a calculation based on number of data sources, bits/bytes/file sizes, and minutes/hours expended for assembly – a flat and reasonable fee applied uniformly (make it $20) would simplify life for everyone. Sure, it sounds overly simple, but it should be. It is 2015, and assembling an electronic record should be free or incredibly affordable.

Note also that this is where technology can save the day. For example, HIEs already aggregate data from multiple sources and make that data available to providers on behalf of patients. Why not make that aggregated data available to the patient? Several HIEs are already doing this, providing patient portals that give individuals one spot to access and manage all of their information. And certain patient engagement vendors (that includes our organization and others) exist in large part to enable patients to import data electronically from multiple sources so they can manage it themselves.

4. Similarly, if information from an EHR has to be printed on paper (therefore paginated) and then scanned and uploaded to a different software program used to create and/or send the copy for/to the individual, should the individual be charged, and if so, how should the cost be calculated?

Last time I checked, it was 2015. If data from an EHR has to be printed out, scanned, and uploaded to yet another application that has to send that now again electronic data to the individual, I can only assume I have traveled back in time. The original EHR vendor and the individual who selected that vendor should both visit the woodshed, and then be subjected to remedial education on modern technology. And the provider who uses this antiquated technology should not be compensated for their antiquated approach. Apply the aforementioned reasonable fee ($20) for this activity, and perhaps the provider will decide to abandon the horse and buggy. Pardon the sarcasm, but the patient should not have to bear the cost for ridiculous workflow. Those organizations who elect to

financially penalize the patient for this kind of activity should not be surprised that the patient wants to take all their records elsewhere.

5. Would you answer anything differently if the copy of the data from the designated record set were being transmitted to a non-HIPAA covered business, such as a PHR vendor compared to another HIPAA covered entity or that organization's business associate?

   For disclosure purposes, I am with a vendor who does offer a PHR (although we embrace HIPAA and in most cases offer that PHR as a business associate of a covered entity). With that said, why in the world does it matter? The cost to create and transmit an electronic record to another covered entity or BA is no more or less than the cost to create and transmit that same electronic record to the endpoint of the patient's choosing. In fact, if the patient wants their data transmitted to a PHR, there is no need for portable media cost, copying paper documents, etc.