

**Governance Workgroup – Subgroup #3
Transcript
May 22, 2012**

Roll Call

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Good afternoon, this is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Policy Committee's Governance Workgroup. It is a public meeting, a public call and there will be an opportunity for the public to make comments at the end. I'll begin by taking roll. Jan Root?

Jan Root, PhD – Utah Health Information Network

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Michael Matthews?

Michael Matthews – CEO - MedVA

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

John Blair? Okay, John Mattison? Are there any other members of the Governance Workgroup who are on the call right now? Okay, would staff identify themselves?

Adam Aten – Office of the National Coordinator

Adam Aten, ONC.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, good, well I think you two can go ahead; this is a subgroup so there is no need for a quorum and so by all means just go ahead.

Jan Root, PhD – Utah Health Information Network

Okay, basically what we're going to do today is keep following through the questions and then open up the call for public comment. What we hope to do is start with S-6 and Mary Jo is spurring me on to get all the way through 55 today. So, if we can look at the slide, I don't know if that is available to you Mary Jo for S-6?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Caitlin would you put up the slide deck?

Caitlin Collins – Altarum Institute

Yes, it is up and we are moving through it now.

Jan Root, PhD – Utah Health Information Network

There we go. Great.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, a little...

Caitlin Collins – Altarum Institute

I'm sorry, what slide was it?

Jan Root, PhD – Utah Health Information Network

It's on my slide deck Mary Jo it is slide #6.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

There you go, that's it.

Jan Root, PhD – Utah Health Information Network

Great. Okay. An NVE must not use or disclose de-identified health information to which it has access for any commercial purpose and I put a little...my first thought about this question was what's the breathe of this? This is a pretty broad thing. Are we just talking about exchange to the NHIN or all of the data and of course both of those can create problems. So, Michael, thoughts?

Michael Matthews – CEO – MedVA

I'm sorry...the slide deck that way. That's not something that Med Virginia does or intends to do, but I was struck by the same question though in terms of the boundaries of this work. I don't think that we should make that imposition on a local node for their local activities, but certainly data acquired through the Nationwide Health Information Network. You know, in parallel if you unpack this one there are probably a lot of different dimensions or different levels that you could get to with it.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

For example, if somebody made a query that retrieved that data it's integrated into their medical record and then is part of, well I call it node, but a participant let's say, you know, at that point do the NHIN rules apply?

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

Or is it the local rules that apply? One of the things with exchange in the coordinating committee that we worked so hard on during the DURSA days was the principle of local autonomy.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

That there are the rules of the road for the exchange from one entity to another, but then within the local environment we need to respect the local entities on policy framework and I'm not exactly clear how this one sorts itself out.

Jan Root, PhD – Utah Health Information Network

Yes, I have. I mean, I would agree with you, you know, like our HIE doesn't sell data but to say that to an entity like Kaiser or Mayo, I mean it gets...the line between selling data and research can get very blurry and the idea of trying to tag all the NHIN data that you've brought in for clinical treatment purposes and say, oh, this stuff can't be included in a study that might have commercial...oh, it just gets really...So, I

think I would agree that this needs to be...you know, I would say something like an NVE must have a privacy policy posted that clearly identifies if it uses, you know, sells data for any commercial purposes and then everybody can kind of make a decision whether they want to exchange with that entity or not.

Michael Matthews – CEO – MedVA

I think that's a good suggestion. Yeah, it lets all the parties then know how that data potentially can be used by one of the participants.

Jan Root, PhD – Utah Health Information Network

Right. Yeah. Anyway.

Michael Matthews – CEO – MedVA

Mary Jo, do you have any more background on that particular one that might shed light?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I don't really and I might ask Adam while we're talking to quickly turn to the RFI. My assumption was that...well, no I think you were right to raise the need for clarification and I think having raised the need for clarification then you would be right, and you know, it would be very appropriate for you to make a comment like I think I heard you just make, but I'm not sure that the data that is being exchanged...what I have is that once the data has entered the entities system of record it's hard to flag that as being segregated and not available for commercial purposes.

Jan Root, PhD – Utah Health Information Network

Yeah, because when I read it, it was on my copy of this, the RFI is on page 45 and 46, you know, there were issues around trust and I guess all that, but I think this is actually, even if you were to say "yes" this is must be with continuous conditions as this are impossible. It's just impossible to monitor or enforce and so I don't believe in trying to pass policies that are impossible to enforce.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right.

Jan Root, PhD – Utah Health Information Network

So, I think we should make the suggestion that every entity must have a privacy policy, you know, a privacy notice which is published and then entities can go ahead and make a decision whether or not they want to include that, because, you know, in the HIPAA privacy notice it includes...you have to say about this selling this commercialization, you have to include that in your privacy notice.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Now, I can say that there is in fact a condition in there already that specifically does say that there must be a privacy policy that goes well beyond HIPAA that says exactly what an entity does do with the information that is exchanged. So, that is already in there as a separate condition. So, while we're not asked to comment on it, it sounds like you're supporting that other security.

Jan Root, PhD – Utah Health Information Network

Yeah.

Adam Aten – Office of the National Coordinator

This is Adam and yeah, you're right Mary Jo, the notice of privacy practices we have a separate CTE that covers that. The additional context to add for S-6 is a concern that we've heard in terms of providers entering into business associated agreements and, you know, not being able to have, you know, the resources and the ability to effectively negotiate sometimes with bigger players and so this provides some added protections for the providers in entering into some of those contracts.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right, I think that makes the extra dimension there...excuse me for my phone number ringing through for just a minute, the extra dimension there is that I did think that this meant to pertain not to the receiving entities per se, but assuming the NVE in its status as a facilitator of exchange. Now, granted, Kaiser might well seek to be an NVE but also there might be, you know, vendors who are NVEs and Health Information Service Providers that are NVEs that are not in the business of providing care but are only in the business of facilitating the exchange of information.

Jan Root, PhD – Utah Health Information Network

Yeah, that's a good point Mary Jo. For, example...

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

How would you like to address that scenario?

Jan Root, PhD – Utah Health Information Network

My first thought about anybody who is an NVE who is was not somehow directly either a payer or a provider but is rather a vendor of some sort and that would probably include HIEs, that they should not...I would support this, that they must not use or disclose de-identified health information for which it has access to any commercial purpose, that's NHIN's policy with every vendor that we do business with is they are not allowed to use unit data for any commercial purposes period.

Michael Matthews – CEO – MedVA

Yeah, I mean, as a general framework I agree with that, but what if both the sender and receiver of that data agreed that it could be de-identified and sold for commercial purposes? I mean...

Jan Root, PhD – Utah Health Information Network

Well, that's the sender and the receiver so that...again...and this I think maybe we need to say that this needs to be earmarked for a little more detailed discussion because we need to keep moving on here, but what I was talking about specifically let's say Ingenix became an NVE, well Ingenix is a data crunching company, they're neither a provider nor a payer, they provide software, they do services. And I would suggest that Ingenix not be able to commercialize this data. So, anyway that's just what I was suggesting, but could we tag this Mary Jo for perhaps a little more discussion later?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

If you have time.

Jan Root, PhD – Utah Health Information Network

Yes, if we have time.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right and you could bring it up with the full Workgroup if you want knowing that this was not an area that was flagged for our Workgroup.

Jan Root, PhD – Utah Health Information Network

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

But, I would say you could certainly bring that up at the next full Workgroup meeting perhaps?

Jan Root, PhD – Utah Health Information Network

Okay, cool. Is that okay, Michael?

Michael Matthews – CEO – MedVA

Mary Jo, help me out with what we need to do with the disposition of these. At this point in the overall NPRM is it sufficient for our Workgroup to just flag it and say this item needs further clarification and we also refer it to the other condition related to the HIPAA and...I mean could this Workgroup's work be done on that or how far do we have to carry this?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

No, that would be perfectly appropriate. Again, this was not actually assigned to our Workgroup. We didn't preclude any Workgroup that had an interest in a topic from taking it up; it was just in the matter from the point-of-view of timing that we wanted to hope that they would prioritize other questions. So, I think as you've stated it you'd like to flag it, it needs further clarification, you've identified some of your concerns and you certainly have endorsed the other, I believe it's condition S-5 which relates to the more complete privacy policy.

Michael Matthews – CEO – MedVA

Jan, I'm just thinking, you know, everything seems to be moving along pretty quickly, if there is a way to not slow things down and not make a career out of this.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

I think we all have day jobs the last time I looked.

Jan Root, PhD – Utah Health Information Network

The last time I looked. Yeah, okay. Are we okay with it then?

Michael Matthews – CEO – MedVA

I'm good with the way Mary Jo just stated it, yes.

Jan Root, PhD – Utah Health Information Network

Okay, good. Then let's move onto S-10. An NVE must have the means to verify that a provider requesting an individual's health information through a query and response model has or is in the process of establishing a treatment relationship with that individual. And I have to say that I agree with the sentiment behind this, but I have never figured out a way to actually operationalize this other than through an attestation model, which is what NHIN's HIE employs. But, I don't really verify, it's that verify that is extremely problematic.

Michael Matthews – CEO – MedVA

Is there anything in this RFI that gets into the concept of permitted purposes?

Jan Root, PhD – Utah Health Information Network

I didn't see anything. Mary Jo or Adam?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Adam is probably going to be more able to find that than I am.

Jan Root, PhD – Utah Health Information Network

Because, when you read on page 48 where the RFI talks about this, you know, it's all...it says that we believe that in order to ensure trust in the query response model that one as a business practice the NVE

should restrict access to patient data for treatment purposes to providers who have or are in the process of establishing a treatment relationship with that patient and that as a safeguard CTE the NVE be required to have the mechanism in place to verify that such a relationship exists. I have no idea how one would verify this, only from an HIE perspective.

Again, you know, what we use, is we use a risk model which is the model that is in place. I guess I worry about this is that this is one of those opportunities where you could go beyond what is absolutely required by the law but in doing so you create such an obstacle to implementation that you essentially make the whole project impossible. I just have a lot of problems with this one.

If they must have an NVE that attest that a provider requesting an individual health record is in the process, you know, either has or is in the process of establishing a treatment with relationship I'd be okay with that. We can log the attestation and then the violation, if the provider is not in a treatment relationship with that person, the violation is on the provider's head. But, this is asking me to peer into the provider's scheduling and all sorts of things and basically take on a liability that actually belongs to the provider, at least not to an HIE.

Now, if the NVE is Kaiser, yeah, as a provider they've got to know this anyway, but if NVEs include companies like Ingenix or Allscripts, or HIEs like NHIN I don't see how this is doable.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I think the scenario here was that a generalized query in response model would enable an authorized, you know, provider to go, I'm going to use a colloquial term, to go fishing so to speak.

Jan Root, PhD – Utah Health Information Network

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And to just go and try and troll for patients, for new patients.

Jan Root, PhD – Utah Health Information Network

Yes, and you know...

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And so I think that this was certainly the intent of this condition.

Jan Root, PhD – Utah Health Information Network

Yes and we've had several years of discussion, we being the NHIN community, and what we've settled on again as I said is an attestation model as well as monitoring. We monitor people's use and we're establishing baselines for, you know, clinic day, what's their normal query, level of query every week and if they exceed that we're going to give them a call, you know, or some people go so far as to turn them off and then give them a call. But, it's this verifying, means to verify I don't have any way of verifying that a provider...Ingenix would have absolutely no way to verify this. A provider requesting an individual's...you know, I mean, I just have a lot of trouble with this. So, I would not accept this as it is currently stated.

Michael Matthews – CEO – MedVA

All right, so I'll carry on with the prior thing then, to dispose of this one if we said that we respect the intent of this particular condition.

Jan Root, PhD – Utah Health Information Network

Correct.

Michael Matthews – CEO – MedVA

I have concerns about the verification process and would seek more clarification as to expectations or mechanisms anticipated to be able to do that and raise also the possibility of attestation on the part of the end-user to be able to meet that requirement.

Jan Root, PhD – Utah Health Information Network

Yeah, I mean it requires attestation and then it requires that the end-user, HIE, the provider, you know, be on the hook for their own violations.

Michael Matthews – CEO – MedVA

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Jan Root, PhD – Utah Health Information Network

Because that is where HIPAA puts it.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

So, just to clarify the last...I think I missed part of the last of what Michael was saying, I understood that we respect the intent of the condition, have concerns about verification of the process, seek more clarification on the verification process and then you mentioned something...the ability of the end-user to and that's where I'm...

Jan Root, PhD – Utah Health Information Network

Attest.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

To attest.

Jan Root, PhD – Utah Health Information Network

Yes, the attestation. Again, the goal here I think Mary Jo is to keep the liability where HIPAA places it, which is on the covered entity on the provider.

Michael Matthews – CEO – MedVA

So, does attestation by the end-user meet the requirement verification as stated in that condition?

Jan Root, PhD – Utah Health Information Network

Good way to phrase it.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, got that.

Jan Root, PhD – Utah Health Information Network

Okay. So, we okay to move to 52? So, should this, let's see you want to migrate us up one slide. Great, should the CTE be limited to only preventing one NVE. Okay, so let's place this in a little context because we've leaped through the document here, we're all the way up to the mid 50s.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yes, so it's on page 53 and the condition is an NVE must send and receive any planned electronic information, electronic exchange message from another NVE without imposing financial preconditions on any other NVE.

Jan Root, PhD – Utah Health Information Network

And let me ask you Mary Jo, does that translate to, you know, if it was just letting its hair down, to say that nobody can charge anybody for this exchange?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, I think that that is part of where the question is getting it, it's saying that, you know, the text says that an NVE could not impose a business requirement on another NVE such as fees that would otherwise prevent another NVE from exchanging health information on behalf of its customer. So, again what it's trying to prevent is instances where an NVE with a significant market share could try to leverage their market dominance to imposing economic rent or excessive fees resulting in market distortions.

Jan Root, PhD – Utah Health Information Network

Right.

Michael Matthews – CEO – MedVA

Well, here's a question for you, like on our work with SSA where the fees that are normally paid to the hospitals to obtain copies of the medical record, the \$15.00 per chart, that goes to Med Virginia since we're responding on behalf of the hospital. The hospital knows that we're doing that, SSA knows to send the check to us. So, it's not...I guess I'm struck by the word "impose" versus a mutually agreeable contractual relationship between the entities. I think we have to support commerce. I mean we have not even begun to understand what HIE business models are going to be successful. We have a pretty good understanding of a lot that are not going to be successful, but, you know, I think the business model is still evolving and I agree that the word "impose" is troublesome, but I also don't want this to stand in the way of business transactions that might be agreeable to both parties.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Michael, if I've understood you correctly though the example that you gave was between what would be an NVE and its user, in other words you're offering a fee for service to your user. I think what this is getting at is if you had...let's think of it as the equivalent of AT&T and Verizon and that AT&T wouldn't let telephone messages cross it's, you know, lines that came from Verizon customers without charging Verizon a fee. So, in other words this is NVE to NVE.

Jan Root, PhD – Utah Health Information Network

Yeah.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yeah, this is NVE to NVE. This is not getting at the business model of the NVE with its clients.

Jan Root, PhD – Utah Health Information Network

And I think they're thinking possibly about predatory pricing.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right.

Jan Root, PhD – Utah Health Information Network

For example some vendor company says you can connect to us through the NHIN for nothing and so it's very low cost, which is typically the way you drive business to you, but they also have another pricing so somebody comes to them and says "well I'd like to do it" and they say "oh for you, you've got pay \$10.00 a pop" because all of these are private, the business arrangements are private. The fees part, you might sign the DURSA but the DURSA doesn't cover fees.

Michael Matthews – CEO – MedVA

Well, let me use a different example. Would the VA be considered an NVE? Could be?

Jan Root, PhD – Utah Health Information Network

I think so.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yes, if it applies and this would not have anything to do with whether it asks the people who connected to it to pay a fee for the services they received, like as you said SSA does. But it's as if VA would tell I don't know Med Virginia or VA would tell Kaiser "I'm not exchanging with you except by imposing a predatory fee." But, again I don't think that certainly wasn't the scenario. The scenario was, you know, the equivalent of a service provider getting a lock on say a regional market.

Michael Matthews – CEO – MedVA

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And it could be that it's a vendor.

Jan Root, PhD – Utah Health Information Network

Sure.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I mean, we know that there are some regions where single vendors have dominance. And if that vendor said "okay, I've locked up this state and if anyone wants to come in and get information from any providers in this state they're going to have to pay a toll."

Michael Matthews – CEO – MedVA

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And set it at a level that does become...

Jan Root, PhD – Utah Health Information Network

Predatory.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Predatory, right.

Jan Root, PhD – Utah Health Information Network

Right. You know, I think this comes back to the question of how much right does the government have to control business practices and I don't know the answer to that and I think the answer is varied depending on whatever corner of the economy you're talking about. Because, I mean basically if they don't want to

have any predatory fees then they should just say if you're going to be an NHIN member you can't charge anybody for this. I don't know.

Michael Matthews – CEO – MedVA

Again, we're not...I think the context of this though is that we're not...this is not a liquor license; we're not establishing utilities or monopolies out there. To me that's where you'd have a concern about...

Jan Root, PhD – Utah Health Information Network

Well, but there are monopolies in some environments as Mary Jo said, those already exist.

Michael Matthews – CEO – MedVA

For de facto they're not de jure monopolies whereas somebody has said there can only be one NVE.

Jan Root, PhD – Utah Health Information Network

Oh, yeah, right this is true.

Michael Matthews – CEO – MedVA

...one HIE but that's where, again if we let market forces play out on this if somebody tried to impose a toll road at this point it's not that big a deal to establish another road between the participating entities and so whether we decree it as such in this thing and say there "shalt not be any tolls" or whether we just recognize that again we're in an ever evolving space and maybe somebody's toll road is that much better and people are willing to pay the freight on it versus building something that doesn't have that kind of toll established on it.

Jan Root, PhD – Utah Health Information Network

Yeah, but you have to remember that this is connected to some very complex software that you don't just swap out at the drop of hat, you know, this is connected to your EHR, that's not something you just change. So, if for example some EHR has a, you know, a lock on a market some place, Let's say Cerner has a lock on a market somewhere in the Michigan area, okay, so does that mean Cerner is going to be able to charge all their members a lot.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

But remember this is not about Cerner charging its members.

Jan Root, PhD – Utah Health Information Network

Right.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

It's about Cerner charging Epic...

Jan Root, PhD – Utah Health Information Network

A competing entity, yes, right exactly.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

...NVE.

Jan Root, PhD – Utah Health Information Network

Right, so Cerner would charge Epic.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

So, I think that I can capture where you're going here.

Jan Root, PhD – Utah Health Information Network

Yes, so Cerner would charge Epic because that's another market that the Cerner geographic area needs to exchange with the Epic geographic area, I mean when you look at clearinghouses for example, okay clearinghouse to clearinghouse connections all of those contractual relationships are one, very private and two, it's what you can negotiate and that just depends on if you have what the other person wants, if they want it enough they'll pay for it. There is a kind of a going market kind of a rate for it, but it's all very, very private. And there are definitely some big clearinghouses that do charge a lot for certain services if you're not an 800 pound gorilla but you need the service.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

So, what would you like to do about this question?

Jan Root, PhD – Utah Health Information Network

I just don't know how you would ever...in which an NVE would create an inequitable electronic exchange environment, one, how are you ever going to figure that out? And two, who is going to decide this? I mean, does this mean that all entities have to publish their fees? Maybe you could say that, that all the entities have to publish their fee schedules for exchanging with other entities, would that...because that would make it...that would take it out of the realm of secret and make it public.

Michael Matthews – CEO – MedVA

I wonder if we can just broaden this out to a concern or request that more information in the market dynamics, market forces for the HIE connectivity space be examined in order to ensure that consumer interest, however we want to frame it, are in fact protected and that these de facto monopolies aren't being abused in terms of their ability to impose fees where there is a...and to me the thing that ties to the greater social good for those transactions and that sort of thing I get what we're talking about here, I just...Jan, I mean you make a good point about you can't just plug and unplug these things, fair point. In the long-term market forces are in play but in the short-run the space is controlled by a single vendor who could impose some kind of controls. It could do public harm.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

So, anyway, Mary Jo I was just thinking, could there be some kind of suggestion about an unintended consequence of somebody coming in to this space in a powerful way could be, well we're all sort of stuck without any near-term ability to move to other market alternatives. Does that make any sense?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I tell you what, why don't I take it; I think...why don't I chew on this after the call. I've taken complete notes and I think I understand sort of the nuance that you're trying to make even if I can't articulate it precisely right now, but I do understand you want a sense of concern, you appreciate the underlying concern, but you believe that more study is needed, more understanding of the actual market forces to determine precisely how to protect consumer interest and that I did hear the possible suggestion of requiring NVEs to publish their fee structures as one part of any approach.

Jan Root, PhD – Utah Health Information Network

Yeah, okay. We okay with that?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I'll send this around to you, I mean this will just be a draft and you're free to then once you see it, you know, again to by all means edit away.

Jan Root, PhD – Utah Health Information Network

And it kind of relates to question 53. If we could scroll to 53, which actually in a way is what we've been sort of talking about which is should the CTE address the fees an NVE could charge its customers to facilitate electronic exchange or should it be left to the market to determine? You know, there is the concern about the large entities possibly muscling out small people, I mean I think this is in a way kind of what we've been talking about. Are you there?

Michael Matthews – CEO – MedVA

Yeah, I'm...

Jan Root, PhD – Utah Health Information Network

Okay, sorry, I thought my phone hung up on me for a second.

Michael Matthews – CEO – MedVA

As we say in Virginia, I'm noodling.

Jan Root, PhD – Utah Health Information Network

Ah, that's a good term.

Michael Matthews – CEO – MedVA

This is getting into a level of granularity that I just don't think we have any business in. I mean, what does that mean exactly? What if Med Virginia had some value added services that we wrap around it.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

You know, that we take that bundle and we integrate it into the electronic medical record and do what Kaiser does and have an NHIN launcher button inside the EMR...I mean...does that violate it, does it not violate it?

Jan Root, PhD – Utah Health Information Network

Yeah.

Michael Matthews – CEO – MedVA

I get the intent part of this again, if you're in a monopoly position on it, but it seems like we're sort of in this like no man's land, pardon the term, but, you know, we're not a utility. Utilities can be regulated but it's not really to the point where it's a true marketplace either, but yet we're something like a utility and so that is where I think we just have to be careful that we're not, we're both trying to represent, you know, what are the public goods and this kind of thing but not to impede the development of the innovative approaches and models and that sort of thing.

Jan Root, PhD – Utah Health Information Network

One idea about publishing fees for example to go back to that suggestion that we had would be, you know, markets work best when there is the ability to shop for the right couch, right? You've got 6 couches, one is leather, one is a cheap cotton, you know what the price is, you know what your budget is, you figure out what you can buy and you go there. Part of the challenge with the NHIN fee structure is that it often, I will predict, will be buried in a sort of a more global kind of a package, which is how NwHIN will probably do it. We're not going to charge our members a specific NHIN fee you're just going to get rolled into the overall HIE membership.

Michael Matthews – CEO – MedVA

I tell you I would object to publishing a fee to use your methodology with the SOAP, yeah, I mean you can read the Sunday circular to see who is having a sale and base it on that, but when you get there the retailer is not bound by anything and they will have to report out what the price is.

Jan Root, PhD – Utah Health Information Network

True.

Michael Matthews – CEO – MedVA

If I want to buy three and get a 20% additional discount that's between me and the store. I mean, I think this is one part we could toss out, you know, publishing fees is a possible avenue to address this. I just wouldn't want to...

Jan Root, PhD – Utah Health Information Network

It would be hard.

Michael Matthews – CEO – MedVA

...purpose...

Jan Root, PhD – Utah Health Information Network

It would be hard like I said for NWHIN we're not going to piece out a fee for this; it would be really hard to publish a fee because we wouldn't have a fee per see.

Michael Matthews – CEO – MedVA

Right.

Jan Root, PhD – Utah Health Information Network

For this service, so I'm turning around and arguing back against myself here. However, I think that it's important somehow, and I don't know how to do it, to bring some kind of transparency, I mean, because this is the problem with the healthcare industry in general it's not a market, you can't price things, you don't know what kind of service you're going to get. With health information exchange on the other hand, there is a market in a sense that...there is a general sense amongst providers for example about what's a good price to hire a clearinghouse to ship a claim for you, it's not as specific as the sofa issue but it harkens back to your point Michael about wrapping other services in and that whole complexity. So, I'm talking in circles, sorry.

Michael Matthews – CEO – MedVA

Well, you know, maybe again kind of going back a little bit to a comment I made about maybe there is an overarching statement around, you know, we're not talking about a utility but yet the market has not evolved to a point where a true market force is and checks and balances are in place.

Jan Root, PhD – Utah Health Information Network

Correct.

Michael Matthews – CEO – MedVA

And so maybe Mary Jo that's an overall message back to the big Workgroup that what we're trying to figure out is where do you kind of set that middle ground line, if you will, to not over regulate it, because it's not a utility.

Jan Root, PhD – Utah Health Information Network

Right.

Michael Matthews – CEO – MedVA

But there are checks and balances, and protections that a more mature market would have, so this is an example of that, the toll road thing that we were talking about is another example of that.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Jan Root, PhD – Utah Health Information Network

Yeah, I think that's probably the most important statement is that the market is not mature. We just don't know. And so it's not a utility. So, I would definitely agree with Michael that this should not be government regulated in terms of fees charged.

Michael Matthews – CEO – MedVA

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Michael Matthews – CEO – MedVA

I can't wait to see your notes on this Mary Jo.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I can't wait to see what I'm going to say about this.

Jan Root, PhD – Utah Health Information Network

Okay, are we okay with 53 then? We're charging along, great. Let's take a look at 54. If we can move that slide up one, well that's 55, can we go back one? There we go. Under what circumstances, if any, should an NVE be permitted to impose requirements on other NVEs? Mary Jo and Adam perhaps you can...this is following a chain of questions around fees and so I'm kind of assuming that this is also about fees?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yeah, it's really building on question 52, which was, you know, should there be limits on fees that would be financial preconditions and so this then says should any NVE be able to set any kind of other precondition on...

Jan Root, PhD – Utah Health Information Network

So, this is beyond fees?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

On, you know, nonfinancial, in other words, the financial aspect was supposedly covered in question 52.

Jan Root, PhD – Utah Health Information Network

So, this is also beyond what the DURSA already has set? Because the DURSA has a lot of liability and indemnity issues. Is that correct? I mean, are we assuming that the DURSA is going to continue to exist into the future? Do you know Adam or Mary Jo, anybody know about the longevity of the DURSA?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

...up to ONC to...ONC wouldn't have a voice in that evolution, I mean it would be how the members of the exchange respond to what they see in governance.

Jan Root, PhD – Utah Health Information Network

Yeah, okay, I mean, for example with NwHIN we require all our members with the exception of the NHIN to sign an electronic commerce agreement and, you know, it's got a lot of stuff in it, basically it says "yes, I promise to agree to abide by HIPAA and blah, blah, blah" right? And so, for those concerns, those "requirements" are covered in the DURSA. If the DURSA goes away somebody is going to have to negotiate that same stuff except more on a point to point kind of a basis.

Michael Matthews – CEO – MedVA

Mary Jo, correct me if you have a different point-of-view on this. I think we agree on this that this sentence specifically, governance for exchange as we know it today, and where exchange is and this broader Nationwide Health Information Network rulemaking begins, yet I think that's still somewhat needing further discussion or clarification, or at least there seems to be differences of opinion around that, but moving forward the going assumption of the coordinating committee is that the coordinating committee is a product of DURSA and it derives its power from that mutual trust covenant amongst the signatories to the DURSA and so the DURSA and the coordinating committee in its responsibilities to the production participants would continue on. And so, this isn't specifically to replace DURSA or exchange as we know it today or the coordinating committee and then Mary Jo you'll have to fill in the rest of the sentence.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, no, I think that you're exactly right. I think what we've always I think said publically we expected would happen is that once there is a final rule and it's clear what can be accomplished through the mechanism set up by governance, we would expect the exchange participants to take a look at that new environment and say "okay, what don't we need to worry about anymore" like now we have a document, we've accomplished all of our trust and interoperability needs through the document through called the DURSA. Now we can see that elements B, C, M, Q, T and Z are taken care of by governance.

Michael Matthews – CEO – MedVA

Right.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And so we don't need that in our DURSA anymore. So, will we'll rewrite our DURSA and when we move the elements that are now covered by nationwide governance, but if indeed we still feel that we have a need and an interest to have some additional requirements then we will voluntarily sign a modified DURSA and so I think what this question is getting at is what, if any, of these types of requirements do you think might be legitimate for one exchange entity to impose on another and you two are fairly familiar with the types of requirements that you currently impose and again, it's one thing to say you have them within the DURSA but take off your exchange hat right now and just speaking from the point-of-view of a knowledgeable individual looking at this field, what requirements, if any, would you want to see, if any, you know, that one NVE would have to fulfill toward another or might want to impose, or could be allowed to impose on another?

Adam Aten – Office of the National Coordinator

And this is Adam, to re-emphasize what Mary Jo said, nonfinancial requirements for question 54.

Jan Root, PhD – Utah Health Information Network

Yeah, well for example if NwHIN wanted to exchange data with somebody and then in their privacy notice they say that they sell data, we would say, well we'd love to exchange data with you but you can't sell the data that we give you and they may or may not like that. That might be...is that an example of an additional requirement?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Certainly data use agreements that have particular limitations would be one example of a business agreement.

Jan Root, PhD – Utah Health Information Network

Right.

Michael Matthews – CEO – MedVA

Yeah, that's a slippery slope.

Jan Root, PhD – Utah Health Information Network

It is.

Michael Matthews – CEO – MedVA

Yeah, because then again trying to get out of the situation, you have the duty to respond and not having somebody be selective and well, Jan I like you and people Utah are pretty cool so, you know, I'm going to allow our data to be exchanged with Utah, but, you know, the people in Illinois just tick me off and I'm going to shut down any flow to any entity in Illinois, you know, I'm being a little factious of course, but you know, it's that kind of thing where in your example if that's an important consideration that would go across all NVEs then we ought to bake it in to the overall framework and just say "you can't sell the data" and so it's a level playing field, and so that way if that's an issue then let's make sure that it's universally applied. Because also in trying to balance with, you know, things like that is that principle of local autonomy.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

Where if I send the data to you and you have a role's based access and I have only physicians looking at my data, which is not the case, but for example, I can't impose on you a restriction that says only physicians can look at my data. I get it to you and then it's your rules.

Jan Root, PhD – Utah Health Information Network

Yeah, and that's generally how we have handled even things like HIEs with NwHIN as an opt-in model but HIEs with an opt-out model basically we just say to them, you've got to do your own rules, whatever those are, and we've got to do our own rules, you know, you deal with this and all that stuff and then we can exchange data with the understanding that we're each going to follow our own rules as currently published.

There are cases and I don't know exactly how this would work, but for example we're trying to exchange immunization data with Idaho, the Idaho HIE, and we do want to do this through the NHIN structure, I don't have a law that says payers cannot view immunization data, at least kid's immunization data, and so in order for NHIN to get immunization data from Idaho we have to agree that we will not expose the Idaho Immunization Data to Utah payers, otherwise they won't give it to us. So, that might be another kind of example where the Idaho NVE would be permitted to impose a requirement on the Utah NVE in order to permit that data to flow. So, I think there are some circumstances, but I also think it will take a long time to understand this in any depth.

Michael Matthews – CEO – MedVA

My concern is when we're trying to set up these conditions so that data are free flowing within the constraints and parameters that we're setting up here, and, you know, it's one thing to envision the world that it is today with say, you know, 30-40 entities and, you know, if you in Utah and Idaho wanted to do something special all right, well that's probably manageable, but, you know, in our lifetime it's going to be 500 or 1000 out there.

Jan Root, PhD – Utah Health Information Network

Yes.

Michael Matthews – CEO – MedVA

And having systems smart enough to know, okay well Utah and Idaho agreed to this but Utah and Montana agreed to something else.

Jan Root, PhD – Utah Health Information Network

Yes and if it is, you know, if those different agreements are based on state statutes.

Michael Matthews – CEO – MedVA

Yes.

Jan Root, PhD – Utah Health Information Network

I mean you're kind of stuck until the statute changes if ever. So, yeah, but I think again we're assuming that the DURSA is kind of a floor to these kind of exchanges and so whatever the imposed requirements would be it doesn't conflict with anything in the DURSA.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, but again, I think for the purposes of answering the question what we need to know is I think is to specify the exact elements in the DURSA that you believe perhaps ought to be a floor for others, I mean, if that's what I'm hearing you say.

Jan Root, PhD – Utah Health Information Network

Well, that would take a very detailed analysis. So, for example, what Idaho and NwHIN are planning on doing is Idaho is test to get connected, NwHIN is already connected, Idaho will get through its test and then when we start to exchange immunization data we're going to have a supplemental agreement, because Idaho won't exchange any immunization data with us unless we say "yes, we will honor Idaho's Law."

Michael Matthews – CEO – MedVA

Again, how do we dispose of this? How does this sound, that we state what our concerns are that we recognized that...we're trying to preserve the local autonomy principle number one.

Jan Root, PhD – Utah Health Information Network

Right.

Michael Matthews – CEO – MedVA

But, we also recognize there maybe NVEs that have certain specific restrictions whether they are state imposed or others and that we just raise it as an issue to be further discussed and explored, but again I don't think we have to wrestle it to the ground what all the possibilities are at this point.

Jan Root, PhD – Utah Health Information Network

Yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Jan Root, PhD – Utah Health Information Network

Okay, do we want to get started on 55 anyway, we can take a look at 55?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

So, I can give you some extra background on 55 in that what we're...this is really getting at collecting data as much for, not so much the negative side of monitoring as the affirmative side of seeing trends and patterns, and levels of transactions. So, it's not trying to be seen as a heavy-handed approach to monitoring each HIEs activity although it could certainly have that effect, but the intention was to be able to gather data that would help to serve to understand developments in the field.

Jan Root, PhD – Utah Health Information Network

Yeah, okay.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

And that's what...data might be, you know, might be useful.

Jan Root, PhD – Utah Health Information Network

And this would be given to ONC correct?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right now it's unspecified, but I think you can assume that it probably would be ONC although it could...I don't think that mechanism has been determined.

Jan Root, PhD – Utah Health Information Network

Okay, so it could just be the governance committee whatever that ends up being? Is that another viable possibility here?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, at this point I wouldn't...I think we can't...

Jan Root, PhD – Utah Health Information Network

Can't say, okay.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

No not that we can say, we can't speculate because we simply haven't addressed it yet.

Jan Root, PhD – Utah Health Information Network

Well, I mean the suggestion about transaction volume is useful. I think you have to be a little careful about this because there are some competitive aspects to disclosing transaction volumes.

Michael Matthews – CEO – MedVA

Absolutely.

Jan Root, PhD – Utah Health Information Network

That you have to be careful. So, I guess what I'm saying is any data that was given to whomever, the report would need to be aggregated in a way that doesn't highlight particular NVEs, rather, I mean again I'm just talking off the top of my head here, that report would be about the NHIN rather than any particular NVE. NHIN publishes data like that all of the time, but we don't pick out our individual members and say, well select health did this many claim volumes, because that's a very proprietary piece of information.

Michael Matthews – CEO – MedVA

So, what do you think, Jan, I mean how comfortable would you be to report out the transactions just on NHIN, your transactions with to say VA, DoD and...

Jan Root, PhD – Utah Health Information Network

Yeah, we can do that. I will tell you because we actually are trying to do that with a pilot that we have going with the VA purchased care program and it is a...sorry to use that word, but getting our numbers to reconcile, oh, my gosh. So, I would put a little side technical note in here that there would be a need to be a lot of work about what is the standard reporting mechanism and testing that as perhaps part of your on-boarding process. It's not simple. Anyway, I'm perfectly okay with reporting...I don't even know if I want to say though with the VA or SSA, or any of those things, I would rather that it was aggregated all

the way up to the NHIN and say the NHIN sent this many labs, and the NHIN did this many whatever by message types.

Michael Matthews – CEO – MedVA

But, you're not going to know that unless the NVE report it, right?

Jan Root, PhD – Utah Health Information Network

Yes, so they would report it to whomever and that whomever would keep that individual NVE data confidential and would publish it as an aggregate kind of a report.

Michael Matthews – CEO – MedVA

I think that's got merit. So, an NVE...you have the second question in that question 55, how should it be made available to the public, you know, in aggregate would be your suggestion, and it should be transaction volume by end-user type. I guess I'm all right with end-user type.

Jan Root, PhD – Utah Health Information Network

Yeah, see that will be difficult as well, at least for the HIEs for example, again how we're doing it with the VA is the VA doesn't query a provider on the NwHIN HIE, they query NwHIN and we pull together, I forget the current name for it, but basically it's a CCD that can have many, many, many data sources. So, I guess maybe that would count as one transaction to a provider, the VA, right? And then if, I'm just trying to think this through, and then if a provider in Utah queried the VA that would count as another one, it is sort of not the same now, I mean it is and it isn't.

Let's take social security, you know, when social security, hopefully we're going to start working on that sometime soon, social security queries the HIE, the hoped for goal is that, in the long-term that the HIE could give social security, you know, kind of in one full swoop all the patient information and all that stuff all set up all the data about a patient through a single query...

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

So, I think what I'm hearing in the interest of time is that you're basically concerned about the actual metrics and how they would be stood up, because it would be very important to establish what those metrics were and how they could be collected because it varies through entity to entity, that you would be comfortable once those metrics were determined that the data was reported to the governance channel, but that the public report should only be aggregated data and not identify any individual NVE.

Jan Root, PhD – Utah Health Information Network

Yeah, and presumably whoever the governance is, is that they would treat that as proprietary information and they would treat that information with confidence.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Michael Matthews – CEO – MedVA

That works for me.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, I think we're at the end.

Jan Root, PhD – Utah Health Information Network

Yeah, Ta dum, hey we did it Mary Jo, Ta dum.

Public Comment

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yes, okay, operator would you open the lines for public comment?

Alan Merritt– Altarum Institute

If you would like to make a public comment and you're listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comments at this time.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, thank you everybody.

Michael Matthews – CEO – MedVA

Thank you.

Jan Root, PhD – Utah Health Information Network

Thank you.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Of course, you're all free to join the other governance group calls that are on Friday.

Jan Root, PhD – Utah Health Information Network

Yes, I'll be calling in.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay.

Jan Root, PhD – Utah Health Information Network

So, these are great discussions.

Michael Matthews – CEO – MedVA

Take care folks, bye-bye.

Jan Root, PhD – Utah Health Information Network

All right, thanks, bye-bye. Thanks again, Mary Jo.