

**Information Exchange Workgroup
Subgroup 2
Transcript
May 25, 2012**

Roll Call

MacKenzie Robertson - Office of the National Coordinator

Thank you. Good morning, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Information Exchange Workgroup Subgroup #2. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so please be sure to identify yourself before speaking. I'll quickly go through roll and then ask any staff members on the line to also identify themselves.

So, we have Cris Ross.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I'm here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Chris. Larry Garber.

Lawrence Garber – Reliant Medical Group

I'm here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Larry. Chris Tashjian.

Christopher Tashjian, MD – River Falls Medical Clinic

Yes.

MacKenzie Robertson - Office of the National Coordinator

Thanks. Did I pronounce that right, Chris?

Christopher Tashjian, MD – River Falls Medical Clinic

You did, very good.

MacKenzie Robertson - Office of the National Coordinator

Deven McGraw.

Deven McGraw – Center for Democracy & Technology – Director

Here.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Deven. Arien Malec.

Arien Malec – RelayHealth

Hello.

MacKenzie Robertson - Office of the National Coordinator

Hello. And do we have any staff on the line?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Mary Jo Deering.

Claudia Williams – Office of the National Coordinator

Claudia Williams.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Claudia. Okay, I'll turn the agenda over to you, Chris.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

All right. It sounds like we have an energized and unruly group this morning, so we're going to have a lot of fun.

Claudia Williams – Office of the National Coordinator

Cris, would you mind if I went through a couple of process things first?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Please do.

Claudia Williams – Office of the National Coordinator

Sorry to interject. I'll make it quick. We just put in place a kind of lightweight process to help the group with comment development and we wanted to propose it and if it sounds good, great, and if any revisions, that would be good, too. So, we'll be meeting twice for an hour each. Of course, Cris will be leading discussion starting with the priority questions and we would just ask if you could, Cris, to help the group kind of summarize the question at the end of each discussion because Tari ..., who is sitting here is going to be keeping track of the comments of the group and feeding back to the group as quickly as possible after the meeting just a draft reflecting the comments that you guys can revise and finalize.

We would ask, even where it's not possible for you to reach consensus or where you don't reach consensus that the comments can still reflect the range of kind of perspectives and considerations that the group discussed. And, in addition, if you look at the calendar invite it includes the full set of questions that the IU Workgroup is considering and also has the CTEs because some of the questions we'll be talking about today refer back to a CTE and you might just want to look at that for reference.

We will be discussing our comments in the full Workgroup on the 4th and so we've also asked if Cris can help us finalize a set of comments to bring forward to them that day. And that's all I wanted to cover, but does that sound like a good approach? Any suggestions to change it?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

That was exactly what I wanted to go over. The one question, Claudia, is I also think in a separate e-mail we got an e-mail that said IU WG Subgroup 2 Meeting May 25th Draft Comments, that's just the questions that we're supposed to address and I'm wondering if people have that document open as well?

Arien Malec – RelayHealth

Or are you going to display that also on the Web conference?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

That's where I was going next is whether we were going to do it in real time and be able to edit as we see it.

Claudia Williams – Office of the National Coordinator

I don't think we had set up those capabilities for this.

Deven McGraw – Center for Democracy & Technology – Director

I do have the comments open, Cris. It's Deven.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Okay. Does everybody else have that document?

MacKenzie Robertson - Office of the National Coordinator

It's one of the attachments in the Webinar, too. So, Alison or Allen, can we open that up.

Alison Gary – Altarum Institute – Communication Technologies Coordinator

Yes, we'll take care of that momentarily. We're pulling it up now.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Okay. And then the only other technical issue is I was going to make a suggestion that I think that just from clerical purposes question 43 also has a pair with it, question 44. And I'm going to suggest that we be bold and comment on question 44 as well, just as I reviewed them over the last couple of days, it feels like those two are paired together.

But, with that in place since we have two meetings I wanted to get feedback from the group, but my hope would be that we would get through at least the priority questions in this call and hopefully make a run at some of the secondary questions and then in our second call we would finish the secondary questions and review the answers and documents we had from this conversation to wrap up our consensus. Is that sufficient for everyone? All right, let's see what we can do.

So, I would suggest we just plunge in unless Claudia or anyone else from ONC has something? I would suggest that people have the RFI open to get the context of what the CTEs are that we're looking at while we answer these questions.

So, with that in mind, I suggest we go to question 34, which relates to Condition S5. And maybe, Claudia, can you summarize what the other Workgroups have done? Has someone done sort of a description of the problem before we answer it or are we just assuming that everyone is reading along?

Claudia Williams – Office of the National Coordinator

I think you might want to repeat the CTE, but otherwise I would suggest you assume everyone is reading along and I have it in front of me if you want me to read it.

Deven McGraw – Center for Democracy & Technology – Director

As do I.

Claudia Williams – Office of the National Coordinator

Or just assume everyone is looking at it.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, I assume that everybody is looking at it, so I think what's relevant here is we're looking at condition S5, correct? That's what we should be looking at as the CTE. So, "An NVE must make publicly available a notice of its data practices describing why IIHI is collected, how it is used and to whom and for what reasons it is disclosed," and our question is, "What is the anticipated cost and administrative burden for providing such notice?"

Christopher Tashjian, MD – River Falls Medical Clinic

I don't think you can answer that question without actually answering question 36.

Arien Malec – RelayHealth

Right. I completely agree. It really depends substantially on whether you are required to disclose the types of disclosure or every particular disclosure and there are cases where the disclosure is not under the control of the NVE, but is actually under control of the covered entities who are using the NVE and in such cases, what should be the requirement for disclosure there?

Deven McGraw – Center for Democracy & Technology – Director

If it's helpful, we started taking up this question of notice, some of these other questions related to notice, in our Tiger Team call a week ago and while we didn't finish the general sense of the group was that categories of information collected by the NVE, if any, and the essentially what the NVE does with data in categories was important to have as a sort of notice to the public and that generally posting it on the Website and providing participants in the NVE, say at the provider level with resources to help them educate their patients, particularly for meaningful choice purposes, was important, but that the level of detail down to, you know, we disclosed it on Saturday to X Entity for this particular activity or even down to really specifics was probably not necessary and would be overwhelming to people, a notice that you probably couldn't really read.

Arien Malec – RelayHealth

Deven, in cases where the disclosure is under the control of the participants, is that an NVE responsibility or is that a participant responsibility?

Deven McGraw – Center for Democracy & Technology – Director

You know, I think it really depends. To me, the vision of what I would look for as a privacy advocate from an NVE is a notice that says we facilitate disclosures of health information by our participants for treatment, for payment and for X purposes at a summary level. And that includes when the NVE doesn't control the disclosures, but helps facilitate it. But it just generally gives a notice to people about what they're doing, which I think is generally what's trying to be captured here.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

And there's some direction on the bottom of page 43 and top of 44 in the RFI that gives three examples of the kinds of notice that's contemplated by the CTE and I guess I have two questions about it. Number one is this says explicitly that the type of notice contemplated by the CTE would differ in certain aspects from a HIPAA privacy rule NPP and then it describes those.

So, my question number one is, I'm curious to ask of this group because it came up as I looked at these other questions of why do we think we need something that differs from HIPAA? Is it important that there be divergence or addition to HIPAA because I think in every instance it's an addition to HIPAA as opposed to an exception to HIPAA. And, Deven, we may lean on you heavily for this, but I'm trying to understand why we need another regulatory; a general broad question I think we're going to ask a bunch of times is is it HIPAA sufficient and why do we need another regulatory regime if HIPAA is sufficient?

Deven McGraw – Center for Democracy & Technology – Director

So, it's actually a pretty simple answer. HIPAA doesn't actually require you in your notice of privacy practices to say what you're doing with data, you just have to disclose what you can do with data. So, HIPAA actually permits a lot of uses and disclosures without consent and you could satisfy a HIPAA notice by just saying we are permitted to disclose your information for the following purposes and just essentially pare it back, a summary of the regulations versus actually telling people what it is that you're doing.

And in the case of the NVE, given that they're probably disclosing data for a limited set of purpose or facilitating the disclosure of data for a more limited set of purposes than HIPAA actually permits, but it's actually advantageous to have the notice just be reflective of what's actually going on versus what the law permits you to do.

Lawrence Garber – Reliant Medical Group

Now the other question is with this condition here, is this just disclosing what they will be doing without explicit patient consent? So, in other words, if an NVE gives patients the opportunity to also have their data released for research purposes, is that something that needs to be part of this notice?

Deven McGraw – Center for Democracy & Technology – Director

Yes, but I think it's taken care of. It's important that the notice be layered so that there's sort of a summary, you know, we facilitate exchange or we exchange data for treatment purposes at the direction

of the physicians who are treating you. We also provide individuals with an opportunity to participate in research, but we'll separately ask you to authorize this, if that's the case.

Lawrence Garber – Reliant Medical Group

And I think that makes sense, but I don't think that that was clear here.

Deven McGraw – Center for Democracy & Technology – Director

Okay. Yeah, I didn't read it as being limited. It's what are you doing with data in categories as a notice.

Claudia Williams – Office of the National Coordinator

Just a little bit of background. I think one of the concepts is that outside of the kinds of uses, you know, if we're seeing intermediaries develop and we want to see a thriving health information exchange set of services that are supporting patient care that we're moving into, in many ways, a different environment than was created by HIPAA where just simply having these entities be clear and transparent about what they are actually doing can help build that public trust and build and make more robust exchange.

So, it may not just be like from a legal standpoint what's the best thing, but really does this play a role in facilitating the robust kind of expansion and services and use and more rapid development than might be otherwise possible.

M

One of the things I worry about in areas like this, and I just looked at, by the way, I looked at our privacy notices and it's pretty explicit in terms of what it is that we do. What I worry about is that somebody finds out that we do X, we think we've given adequate notice that we do X, they think we haven't and there is this requirement that we're required to submit to. I would like some kind of safe harbor or at least some notion of what the categories of disclosure might be so that I can have some reasonable assurance that I'm given adequate notice. Otherwise I'm required to do something, but I don't know all of the categories of notice that I need to comply with.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, in the interest of accelerating things here a little bit or moving them along, I think what I'm hearing in the conversation so far is what the anticipated costs and administrative burden is of notice, it sounds to me as though actually providing the notice is not particularly difficult. It's the cost and administrative burden of managing all of the set of infrastructure associated with that. It's not the actual notice that's the issue. It's a magic environment, right?

M

So, Cris, it depends. We supply an audit trail that tells a patient exactly what happened, who viewed what and when. But, with regard to this kind of notice with the assumption, as Deven notes, that it's categorical and with the assumption that the kinds of categories are well defined, I think providing notice has low administrative burden. In cases where it's non-categorical, in cases where it requires prior notice for every kind of exchange and in cases where the categories of notice aren't well-defined then it creates a burden and the burden is primarily a legal and compliance burden of just figuring out what it is we're supposed to do.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

It's a decent summary. What are people's opinions about that?

Deven McGraw – Center for Democracy & Technology – Director

I think that's fair. It's not easy to do notice well, because you have to do it short or people to read it, but then it does run the risk of people saying, well, you didn't tell me about that specific thing.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Well, I'm also thinking we're going to maybe mark these answers as we go through other things. There's some questions later that talk about which parties should be responsible for which pieces of this. It's not clear to me, for example, how often an NVE's practices would actually be visible to a consumer as

opposed to the activities of the NVE being visible to the consumer via some other party, like a covered entity or perhaps even their vendor.

Lawrence Garber – Reliant Medical Group

There's another question that I think we're answering where that was going to be my concern.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Is that a decent summary for question 34? I'm hearing that where managing notice is a categorical item that it's a relatively low cost and burden, but where there's many exceptions and variations and requirements to provide data that will create legal and compliance risk and cost.

M

Cris, just as an amendment, categorical, particularly when the categories are well defined.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Thank you. Has staff got that, ONC? Beautiful. Should we move on to question 37, which relates to condition S6, "An NVE must not use or disclose de-identified health information to which it has access for any commercial purpose."

M

Can I just start off by saying hell no.

Deven McGraw – Center for Democracy & Technology – Director

Hell no to the CTE or?

M

Hell no to the CTE in some many cases. So, Deven, I loved your recent blog post, I have no idea where you were posting, noting the FTC rules for use of de-identified data. I can think of so many good and compelling reasons to use de-identified health information for operations, to improve clinical care and I would want to charge for the service and I think that would be a commercial purpose. I think this one is far too restrictive. People would just go straight to you're going to sell my data to IMS and there are many cases that noble and well intentioned that this would prohibit.

Deven McGraw – Center for Democracy & Technology – Director

I understand why this is in here because I think we're all aware of the controversy surrounding the mining of de-identified data, but I think it's way too hard to draw a line between something that's commercial and something that contributes to a public good, since health care is at its core an enterprise that needs to make money in order to function.

And so without a clear way of being able to make that distinction in a way that won't end up having unintended consequences I think it would be hard. We hope to be able to get to this question on the Tiger Team. It's a secondary question for us. What we are going to suggest in our own comments is that rather than focusing on a prohibition on commercial uses, that they instead take the STC route and say de-identify according to HIPAA standards and prohibit, commit to non-re-identification and commit your downstream recipients to the same.

M

Deven, I was just about to quote you in a HeathBeat article on exactly that and propose that. So, the exempt from this privacy, as long as business is using such data, publicly commit no to re-identify it and prohibit any downstream recipients of such data from re-identifying it.

Lawrence Garber – Reliant Medical Group

Now, there are two issues here. So, one is from a patient's perspective, which is we don't want this to be re-identifiable. The second perspective is from a healthcare organization, an IDN, for instance, that's feeding the data to other parts of the state or wherever it needs to go. Those organizations themselves have a financial interest in the data. They're doing research with pharmaceutical companies, or being

able to qualify for art grants or whatever because they themselves have access to this data within their organization.

Now, if suddenly this is available through a byproduct of what they had to do for business sending this to other organizations, the places that they used to rely on for their research funding is no longer available to them because they can go elsewhere to get the data that they had to give. They will be losing business. I think you're going to have some controversy. I mean, you don't want an IDN to say, okay, I'm not going to participate in a statewide health information exchange because if I do that, now the pharma will go to the state and get all my data and I'll be out of business.

M

I think that's a bit of a red herring in the sense that – and Deven will correct me if I've got this wrong – but under HIPAA a business associate has not right to use data except as permitted. And that is inclusive of, the only organization that has the right to use de-identified data is the covered entity and in my business associate agreement I need to explicitly grant rights for use of de-identified data to the business associate. Deven, do I have that right?

Deven McGraw – Center for Democracy & Technology – Director

Well, what needs to happen in a business associate agreement is for the covered entity to give the business associate the right to de-identify the data. Once that's done the business associate could then use the de-identified data in whatever ways.

M

Deven, can I limit the use for de-identification?

Deven McGraw – Center for Democracy & Technology – Director

Sure. Yeah, absolutely, but I think that the power dynamic here – I didn't recognize the previous speaker's voice.

Lawrence Garber – Reliant Medical Group

It was Larry.

Deven McGraw – Center for Democracy & Technology – Director

Oh, thanks, Larry; some of these HIE's may, in fact, have more power to set the terms of the business associate agreement than the individual participant, so if the HIE wants to be, as a business associate, wants to be in the business of mining the de-identified data they'll set that as a term of participation and then either the participant likes those terms or doesn't like those terms, but probably has limited capability to change the terms of the deal and the agreement itself.

M

I would note then, Larry, our experience as an HIE provider is that this comes up as a contract term in every negotiation.

Deven McGraw – Center for Democracy & Technology – Director

Wow, interesting. Well, that's the reason why it needs to be transparent.

M

That's right. And that IDNs have, they are the major funding source for health information exchanges, whether at a state level or at an enterprise level and so have considerable say in data use rights.

Lawrence Garber – Reliant Medical Group

And remember, it's not necessarily the person who I'm directly connecting to because an NVE can be connecting to another NVE as data is being sent wherever it has to end up for its final destination. So, it's not even the person that I have direct relationship with. Which is why, of course, these CTEs are being established so that wherever it goes I have an understanding that there's a baseline that I can expect. And I think that's why this condition is here is the fact that we don't have direct relationships and that this

could be someone in another part of the country who I wouldn't have thought to go look up on a Website to see what they're going to be doing with the data that I sent.

Arien Malec – RelayHealth

Once I grant data use rights for de-identified data the decision in many cases has been made. It doesn't matter whether there's a tertiary intermediary. The choice is under the control of the organization that I granted data use rights or de-identified data. So, once I've made that decision it's immaterial whether the person that I handed it down to is a tertiary intermediary or whoever else my secondary intermediary has decided to do business with. The issue is as a covered entity the data use rights that I've negotiated with my business associate.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

All right. I want to move us here. I'm not trying to cut off the conversation, but what I'm hearing is strong consensus that this is chilling on a variety of business models. I'm hearing a suggestion that we use the Deven McGraw formulation of apply the FTC rule and commitment to non-re-identification and if someone, Arien, if you were reading that and had that site and could send it to... so that we could get that included in the record that would be great.

Arien Malec – RelayHealth

I will forward the brilliant comments on to anybody who wants to hear it.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I love that. And what I'm interested in is just to be as helpful as we can here in informing the record. The question says, "What impact, if any, would the CTE have on various evolving business models?" I would like to just ask us to brainstorm quickly around let's list some of the half dozen business models that we just talked about that would be chilled here.

And what I'm hearing is I've heard statewide exchange, I've heard public health. I would like to offer ACO and risk sharing where people are doing population management and there's a desire to do benchmarking with peers and others. What other models do we think could be impinged by this?

Lawrence Garber – Reliant Medical Group

Research.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, research; research by companies that in addition to creating public benefit have commercial interests as well like pharma companies.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

How about payer operations in some fashion, under TPO, generally under HIPAA.

Deven McGraw – Center for Democracy & Technology – Director

Sure.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Okay. Anybody else want to weigh in on anything else that would be a challenge here?

Arien Malec – RelayHealth

There's an almost infinite set of evil and good uses for this data. I think it's just useful to give a representative set about what good and appropriate uses would be limited.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Makes total sense. So, the second question is, "Would the additional trust gained from the CT outweigh the potential impact on these models?" And I think our answer is simply, no.

Deven McGraw – Center for Democracy & Technology – Director

Right.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Is that working for everybody?

Claudia Williams – Office of the National Coordinator

Yes.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

All right. Then let's talk about question 8, "On what other entities would this have an effect?" Perhaps we just answered that, but I want to make sure we deal with that explicitly. I would like to offer up for consideration an NVE doesn't exist in a vacuum. An NVE is typically going to be connected to some other entity and I think of that entity primarily being things like EHR vendors, PHR vendors and others. Do we want to comment on what other forms of entities this would have an effect on?

Arien Malec – RelayHealth

Well, I also think the covered entities themselves would be limited in what they would reasonably want to do with their NVE.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Right. I would want to call out PHRs. I guess I'm sort of interested in the idea of if a PHR or other kind of provider portal allowed me to compare my health to other people with similar demographics, you know, I'd like to have access to that data. And I would want to present that to Cris Ross because he really needs to lose that next seven pounds.

Arien Malec – RelayHealth

I would note that this is the use of de-identified data and not aggregated data, although in many cases the use is of aggregated data as opposed to de-identified data.

Deven McGraw – Center for Democracy & Technology – Director

Well, most aggregated data fits the de-identification standards.

Arien Malec – RelayHealth

Okay, I was assuming that once – and, again, not a HIPAA lawyer – I was assuming that if I aggregated from sources that are de-identified it's now in the aggregated data category as opposed to the de-identified data category, which is a different category under HIPAA.

Deven McGraw – Center for Democracy & Technology – Director

No, not really. That's the same.

Arien Malec – RelayHealth

Then, yeah, there are so many highly appropriate uses that are chilled that...

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

We will have stern and firm comments on that question, how's that?

Lawrence Garber – Reliant Medical Group

But I want to reinforce the importance that they can't willy-nilly be using these for commercial purposes. The other example was that the Mass Medical Society was looking at offering a low cost or free EHR to its members, physicians. And one of the ones we were looking at you could tell that their business model was to sell de-identified data by the IMS and we chose not to do that and I'm concerned that if we don't have proper, clear-cut protections people will not use Health Information Exchange if they think that the data is going to be sold.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, totally fair point. All right, thank you. I hate to be cracking the whip when the conversation is so good and such smart people, but I think we need to move on. questions 52 and 53 are next on our list and they relate to condition BP1 on page 54 of the RFI and that condition is, “An NVE must send and receive any planned electronic exchange message from another NVE without imposing financial pre-conditions on any other NVE.” Comments.

Christopher Tashjian, MD – River Falls Medical Clinic

I think this is a great idea. I can’t imagine what would kill the exchange of information any more than the addition of fees.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, I agree.

Arien Malec – RelayHealth

So, I would like to bring this in the context of net neutrality rather than in the context of financial pre-conditions and I think the net neutrality frame is a more expansive; there’s quality of services, there’s all kinds of other things that I can do to limit open and fair exchange. Correspondingly, there’s all kinds of business arrangements that I might make with another party that involves financial pre-conditions.

So, for example, there might be and, Cris, you probably know this area better than I do, there may be contractual relationships that I have with an intermediary that I’m downstream using that involves what could be termed financial pre-conditions that don’t, in fact, create a non-neutral network.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, I would suggest that today there are a significant number of entities that look like NVEs that charge fees to each other and the ecosystem works successfully. Those examples would be the e-prescribing world for sure and in the world of lab exchange. So, today e-prescribing is free to doctors, mainly because a fee is paid by pharmacy and PBM partially to Surescripts to manage those transactions, but Surescripts pays many people, including other networks, substantial amount of money to other networks, to move messages. And it covers the cost of operations at that network.

So, we write handsome checks to RelayHealth on a monthly basis.

Arien Malec – RelayHealth

And we appreciate it.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yes, you do and you send cards and letters and flowers at Christmas. It’s lovely, Arien, it really is. There’s just all kinds of networks that exist in commercial space where there are all sorts of fees. So, the question that I’ve got is is there a market failure here that we are concerned about and is there any evidence to suggest the NVEs won’t compete on price as well as service?

Arien Malec – RelayHealth

Cris, the concern here is that I’m Google – I’m going to put this in a net neutrality frame – I’m Google and I will use my search power to limit the ability of my participants to access one of my competitors. Or, I’m Verizon and I will use my backbone power to shut down somebody else or I will privilege one of the participants in a network in ways that reduce quality of service for others. So, that’s the net neutrality argument.

And I think, where some of this came up with discussions that we were having around direct where HISPs were using or creating kind of fake Direct environments where they were managing effectively a proprietary exchange and then they were controlling whom their providers could access or talk to and that really violated the intent of Direct.

And so I think this condition was aimed at that kind of situation. I completely agree with you that as it's written it prohibits a lot of things that are highly useful in the real world.

Deven McGraw – Center for Democracy & Technology – Director

But how then, Arien, do we write it in order to prohibit the circumstance that you were talking about that arose in Direct, that is, I agree that it's sort of more similar to Internet neutrality but since this set of provisions is going to apply to private networks as well, how do we keep the financial barriers from enabling one provider to exchange one another when they're using different?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

And before you answer that, Arien, because I think your answer will be great, I would want to look specifically at the language of question 52, which says, "Should this be limited to only preventing one NVE from imposing a financial pre-condition on another's?" And then it says, "Or, should it be broader to cover other instances...?" I would make the argument that that question should be reworded to say, "Or should it be narrower to cover specific instances in which an NVE could create an inequitable electronic exchange environment?"

Because I think, Arien, what you're saying is the general idea of a free market charging fees with each other is perhaps acceptable, but the idea of someone using market power to extract unreasonable rents is not. And I would use the example that within the Surescripts world we have separate lines of business, but if you just divide our clinical inter-operability business from our e-prescribing business the two are entirely separate. You need not be an e-prescriber in order to participate in clinical inter-operability and there's no financial exchange between those two because we have such power in the e-prescribing space it's unreasonable for us to impose that pre-condition on clinical inter-operability.

Claudia Williams – Office of the National Coordinator

I think you guys are getting at this, but I just want to maybe put a finer point on it. I think, as Arien said, what we're seeing is business models and business interests being a barrier, not the technical requirements and I'm guessing in any world of the future there will continue to be businesses that see value in being a closed network and the question is how do you create an environment that's optimal for the provider and, especially for Stage 2 where you want a care summary to easily get sent with Direct, just as an e-mail will get sent across many, many providers and maybe not wanting a situation where you require actually to even negotiate a business agreement.

So, it could even be the step of having to have a business agreement in place that ends up being something that makes it harder for me to just send a message when I want to. I think part of the underlying thing for this I actually getting at what's going to create the right business environment and what's a step too far?

Arien Malec – RelayHealth

My answer to this would have been to turn to Deven yet again and turn to Deven's counterpart at the CDT on net neutrality and see if there's language that we can use from the net neutrality world or debate. Because I'm sure that people have gone through all of the quite reasonable uses of financial arrangements in the Internet world and all of the unreasonable uses of financial arrangements to limit or restrict exchange.

Deven McGraw – Center for Democracy & Technology – Director

It's a really good point, Arien. Unfortunately, I'm not in the office so I can't even run down the hall to ask my net neutrality expert, David Sohn, but I can certainly grab him when I'm back in the office next week and send him an e-mail to tee up the discussion. There may be some language that we typically ask regulators to use or legislators on net neutrality that may be really helpful.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, what I'm hearing across a really broad range here; well, let me just poll people. What do people think about sort of net neutrality as a framework for thinking about this? Does that seem to make sense? Should we continue to pursue that as a model? Deven, Larry, Chris, what do you think?

Christopher Tashjian, MD – River Falls Medical Clinic

Yeah, I think that's reasonable.

Lawrence Garber – Reliant Medical Group

It's a good concept.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, if the idea here is the kind of inappropriate use of market power, is that a fair brief summary of a complicated topic?

Arien Malec – RelayHealth

From my experience in participating in these discussions in a prior life the answer would be yes.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, I think so.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, the idea here is that we want to make it, to get to Claudia's question about closed networks, we want to make it work so that anyone who wants to gain access to another network should be able to do so on a level playing field with other people who want to get access to that network and who want to get access to similar other networks. I know that's sort of difficult, somewhat easy to say hard to administer, but is that sort of the principle?

Arien Malec – RelayHealth

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Lawrence Garber – Reliant Medical Group

Yes.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Okay. So, if that's the question I guess I want to restage the question I had before, which is we've got two questions, which is preventing financial pre-conditions sort of at all or the second, where it says should it be broader to cover other instances, I'd like to forward the idea that I actually think that question should say or should it be narrower to cover specific instances in which an NVE could create an inequitable electronic exchange environment.

Arien Malec – RelayHealth

That's right. I would note that BP2 is actually aimed at the same net neutrality goal. One of the ways that an NVE could restrict information exchange is by not publishing, for example, in Direct context the certificates associated with its addressees to another entity. What I'd note is BP1 and BP2 are getting at a broader notion, getting at it in a sort of blunt way, but it's actually the broad principle of neutrality that's important, not the specific conditions.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, that makes sense. So, then let's parse these questions 52, 53, 54 and I guess just through 54, we'll get to 55 in a minute. So, question 53 is, "Should," you can read it; can they charge its customers a fee to facilitate electronic exchange or should this be left to the markets to determine? So, I guess the question is regardless of where we end up on net neutrality, do we think that this BTE should actually address the issue of setting fees.

Arien Malec – RelayHealth

No.

Lawrence Garber – Reliant Medical Group

Really can't do it.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, we're saying that we don't want to have a regulatory environment of no set fees, but the tripwire here is excessive use of market power to somehow restrict exchange of data? Is that fair?

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Arien Malec – RelayHealth

Yes.

Lawrence Garber – Reliant Medical Group

Yes.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, then let's get microscopic around question 54 and we talk about what circumstances in which an NVE should be permitted to impose requirements on other NVEs. And I think we may need to answer what could those requirements be?

Arien Malec – RelayHealth

And this is where I would love to look at the framework for net neutrality.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, and my apologies, but hopefully it's something that I can get around to the group by e-mail so that we're not taking the time that we want to take for the secondary questions on our only other call.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Great. So, should we just table this one temporarily, ask everyone to read those materials and come back and really put a fine point on it in our next call?

Deven McGraw – Center for Democracy & Technology – Director

Sounds like a plan.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

This is like the best Workgroup ever. All right.

Claudia Williams – Office of the National Coordinator

Have a call before the holiday weekend.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, well, there might be something magical in that strategy.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I'm feeling the North Carolina pine in the background.

Lawrence Garber – Reliant Medical Group

So, our next meeting is July 3rd?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Okay. Let's go to question 55, which relates to Condition BP3, "An NVE must report on users and transaction volume for validated services." And the question is, "What data would be most useful to be collected, how should it be made available?"

Arien Malec – RelayHealth

To whom?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, right. That was my question in getting ready for this. Is it to consumers? Is it to regulators?

Deven McGraw – Center for Democracy & Technology – Director

Remind me of the CTE this is related to.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Well, the condition BP3 is, “An NVE must report on users and transaction volume for validated services.” It’s under the category of business practices CTE.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

I can perhaps add a little bit of information there. Again, we were on question 55 correct? This is not a question of reporting data as a point of sort of negative oversight of an entity, but more from a very positive monitoring the market, monitoring trends and how to capture information about the scope of exchange, which is taking place over time and to be able to discern patterns here and there. So, that was certainly one of the underlying reasons, which I think is spelled out in some of the text of the RFI.

And so the assumption was, well, it doesn’t say exactly what the channels of reporting would be and your group would be quite wise if you want to raise that as a problem and make a suggestion, but I think the assumption is that it flows upward so that ultimately ONC and, perhaps, others would be able to see these trends. But, again, if you want to point out where more detail is needed, that would be very helpful.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

That’s helpful, Mary Jo. So, with that in mind I’d make a proposal that the idea of reporting on users and transaction volumes to a policy-making and regulatory entity like ONC and, perhaps, to state entities makes sense. I know some states are asking for reports on this kind of data. However, this is also probably a way in which proprietary information of an NVE would be exposed. There’s a degree which some of these may be non-profits, some of these may be businesses and they may not be interested in showing exactly what their transaction volumes and other things look like in a kind of public compendia.

I’m not sure there’s a huge risk there, but I assume that that’s one of the issues that would come into play.

Arien Malec – RelayHealth

I can imagine many situations where I would love to get at my competitors transaction volume and use it against them and vice versa.

Lawrence Garber – Reliant Medical Group

Arien, isn’t there another issue here? If we’re using Direct and I go get a certificate then I’m using the Internet after that sending my SMPPS, my message, and it’s likely that HIE has no idea what I’m sending or how much I’m sending, so the data itself may not be accurate.

Arien Malec – RelayHealth

Well, the displeasure would only apply to entities that got accreditation.

Lawrence Garber – Reliant Medical Group

Because let’s say you’ve got an NVE that’s set up a provider directory and certificate authority and that’s a whole state probably and they’re handing out these certificates and so I want to send a message, I go grab the certificate from the state so they’re an NVE. But then the message I actually send goes over the Internet and never really touches them and so they don’t know for sure what I’ve said, yet they themselves were an NVE.

Arien Malec – RelayHealth

Right. Again, that also gets at what kind of data. So, in that case you might suggest that they would report volumes of people who access their directory, but since they're not actually providing services for transport they, obviously can't report on transaction volume for transport.

Lawrence Garber – Reliant Medical Group

Right. And so then you get back, okay, well, if some are going to be reporting what they know of transaction volume and you know that that's not a complete picture, then are we actually getting value out of only collecting partial information from data that we know is likely to be partial and over time become more and more partial as people are able to just use the Direct protocols.

So, I'm just wondering are we trying to do something that's going to be incomplete and actually become worse over time.

Arien Malec – RelayHealth

Right. And then the other question is, okay, am I on the hook for anything ONC wants? Am I on the hook for a specified set and format of things that ONC wants? It's really hard for me to judge the cost of complying with this condition in the absence of additional information.

Claudia Williams – Office of the National Coordinator

But to Mary Jo's point, part of what we're trying to assess is whether, in fact, this whole enterprise has had a positive impact on the growth of exchange, the use of exchange, the types of exchange. So, if that's our goal the question to you guys is what data might be most productive for that and how feasible is it to collect it?

So, you're right there's not a specification, but that's in part because we've tried to lay out what the goal is and get input on how to shape those requirements.

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

And I think if you wish, you can certainly also separate out the issue of reporting that data to some policy entity versus what might be made publicly available.

Arien Malec – RelayHealth

That question is specifically asked.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Right. So, I'm stuck, I mean I think we've had a good discussion here about the problems with this so if we get into the atoms of question 55, "What data would be most useful to be collected?" The question implies user and transaction volume data. I don't mean to be obtuse, but I'm having a hard time figuring out how you would measure a user if you were an NVE.

Arien Malec – RelayHealth

I think the intent is number of users.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I understand. I'm just thinking it may be hard to report what that number of users is in some respect.

Lawrence Garber – Reliant Medical Group

Is that organizations? Is that providers within those organizations?

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Right. And an NVE may not have full visibility if it's connected NVE-to-NVE. So, I may have to do a best estimate of what's a, for instance, unique user or originated user or authenticated user. There's probably some adjective on that that would be important.

Deven McGraw – Center for Democracy & Technology – Director

It sounds like it's a good idea to report this level of questions and concerns and maybe under the theory that certainly some reporting to ONC and potentially also to the public makes sense from a transparency standpoint, but teasing out with a plethora of different NVE models exactly what needs to be reported may take more time and should be based more on experience than we're able to answer in a comment period before a proposed rule.

Arien Malec – RelayHealth

I think that's a brilliant summary and then I think there's data that makes sense to report to the public, but data that's reported to the public should not disclose without permission data that's relevant to a specific NVE and their business practices. So, for example, e-prescribing data in aggregate is a highly useful data point for policy makers, but what Allscripts transaction volume is versus NextGen's transaction volume is also a useful thing for policy makers, but I think falls outside of the bounds of acceptability.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Well, actually Surescripts does provide some data to ONC under a contract. We're going to get some questions later and what we do under that contract would actually be a violation of some of the proposed CTEs further along. Just for what it's worth.

Arien Malec – RelayHealth

And so what I'm getting at is that if ONC disclosed totally prescribing volume to the public, that seems reasonable. If ONC disclosed Allscripts transaction volume to the public that seems unreasonable.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, it provides market share data and a variety of other things that are proprietary. So, Deven's conclusion I think sounded great. I think the principle here is that we're focusing on reporting to ONC and I would augment that with state regulatory entities with the goal of market development and business development and monitoring progress.

Arien Malec – RelayHealth

And policy gains.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Yeah, for policy gains as opposed to not providing that information on a consumer reports kind of basis where we would look to ONC or a state regulatory entity to collect data and report on the quality or size of an NVE for purposes of disclosing to the public that purpose, that the data to be disclosed to the public I think Arien summarized as being aggregate data about that state's activity or that geography's activity, as opposed to NVE by NVE. Fair?

Deven McGraw – Center for Democracy & Technology – Director

Yeah, that sounds good. The consumer advocate in me wonders if there's a way when there's a market for NVEs to be able to disclose to the potential participants, but that is not something that should be prescribed in an NHIN governance document.

Christopher Tashjian, MD – River Falls Medical Clinic

Someone who may use that, I'm not sure I want my name out there or my group's name out there. That would discourage use of it.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Exactly. All right, so we've made it through the primary questions. We have three minutes left. Mary Jo and Claudia, is this a public meeting and do we take comment or is this just a Workgroup meeting?

MacKenzie Robertson - Office of the National Coordinator

Hi, this is MacKenzie. It's still a public call. We have time built in the agenda for public comment, so if you want we can open the lines now.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

I think we've got just a few minutes left, three minutes left. So, before we open for public comment let me just summarize. We're going to come back to questions 52 through 54 in the context of net neutrality. We're going to ask the Workgroup members to read those materials as homework. And I suggest we start there and then plow into the secondary questions next time. And if there are materials that ONC has summarized about our conversation so far that we also take a look at those. Is that a fair agenda for our next meeting?

Lawrence Garber – Reliant Medical Group

Sounds good.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

So, MacKenzie, let's open to public comment.

Public Comment

MacKenzie Robertson - Office of the National Coordinator

Great, thanks. Operator, can you please open the line for public comment.

Operator

We have no comments at this time.

MacKenzie Robertson - Office of the National Coordinator

Thank you.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Fantastic. So, ONC staff any other comments or questions or directions for us?

Claudia Williams – Office of the National Coordinator

Yes, Tari had one more.

Tari

Hi, this is Tari. I was just going to say if anyone has time before our meeting next Friday to look at the next questions if you feel comfortable sending me a few bullet points and we can get the conversation started since there's a longer list of questions there and we already kind of know what we're responding to.

Deven McGraw – Center for Democracy & Technology – Director

That's a good idea. We'll try to do that.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

And if we could distribute it I'd suggest that we distribute it to everyone on the Workgroup so we're all seeing each other's comments, right?

Tari

Yes, you'll receive those from me before next meeting.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

That's fantastic. Well, I'm ready to declare adjournment and that this is, in fact, the best Workgroup ever.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Cris? Hi, this is Micky. I've been silently stalking in the background, doing other work and just want to say I'm totally impressed.

W

And I'll add... quietly stalking in the background as well, multi-tasking, listening in and would agree.

Cris Ross – Surescripts – EVP & General Manager, Clinical Interoperability

Thanks, ladies and gentlemen. Have a fantastic weekend.

Deven McGraw – Center for Democracy & Technology – Director

Thank you. Thanks, Cris. Bye.