



## Meeting #1

**Date: October 26, 2016 9:00 AM**

**Location: School of Public Health, 1 University Place, Rensselaer NY 12144**

### Attendees:



PC Workgroup  
Attendance.xlsx

## Overview

This was the first meeting of the Value Based Payment (VBP) Patient Confidentiality workgroup. The purpose of meeting #1 was to set the framework for the subsequent meetings concerning patient confidentiality.

The Agenda for this meeting included:

1. Welcome and Introductions
2. Workgroup Role and Charge
3. Introduction to Value Based Payments
4. Introduction to Technical & Data Sharing Issues Related to Patient Confidentiality

**Key Discussion Points** (reference the slide deck “102016 Patient Confidentiality Workgroup #1”)

### 1. Welcome and Introductions

The Patient Confidentiality workgroup co-chairs and DOH Sponsor opened the meeting with roundtable introductions of participants.

### 2. Workgroup Role and Charge

The co-chairs explained that several VBP subcommittee meetings occurred previously. While many recommendations were issued by through these groups, concrete recommendations regarding Patient Confidentiality were not issued. As a result, the Patient Confidentiality workgroup was formed to address outstanding policy questions. Specifically, there are two questions presented:

(1) What does the technical data flow look like for the purposes of VBP? What are the gaps in patient data consent agreements within this technical data flow?

(2) What legal agreements, laws or regulations must be created or modified to support effective data sharing within VBP?

### 3. Introduction to Value Based Payments

Workgroup members were provided with an overview of value based payments. The Medicaid VBP video was shared with the group. This video explained that there is a shift from volume based reimbursement to reimbursement based on quality. Under this new model, providers are rewarded based on quality care outcomes representing a fundamental shift from volume to value. Post DSRIP, value based payments will be the predominant methodology for care reimbursement in the state of New York.



The VBP Roadmap is the guiding document providing the steps necessary to reach New York State's (NYS) goal of tying 80-90% of provider payments to VBP by 2020. The workgroup learned that currently, 65% of Medicaid services are Level 0 VBP.

#### **4. Introduction to Technical & Data Sharing Issues Related to Patient Confidentiality**

The workgroup noted that currently that exchange of information is permitted for administrative services is permitted under HIPAA for treatment, payment and healthcare operations. It noted however that some New York State laws may be narrower than HIPAA. As example the workgroup considered current state examples of data exchange. These included a discussion of third party billing service were discussed. Similarly, the workgroup noted that shared electronic records system, for example the regional health information organizations (RHIO), are currently in place. The structure of the RHIO was outlined and discussed.

The workgroup considered future state examples of data sharing under VBP. These included data sharing for supportive housing services or to support an HIV coordinator. Participants noted that sometimes Community Based Organizations (CBO) play a critical role in the provision of care and that CBOs may need to be involved in the sharing of patient information under VBP. As a challenge, it was noted that direct providers of the services are often not in communication with CBOs. These parties may have no direct ability to facilitate information exchange. The group generally agreed that VBP would require a more broad exchange of certain protected health information.

The workgroup turned to the technical aspects of data sharing in the current state. In the case of using electronic health records (EHR) to exchange patient data, the group noted that there is the potential to use the Medicaid Data Warehouse. In this case, one can only access claims-level data if affirmative written consent is provided. Similarly, the group discussed the RHIOs. It was noted that RHIOs have "walls" to prevent unnecessary access to health data. However, it was noted that in the future state under VBP, for example, if a patient lives in New York City, but is injured in Buffalo, NY while on vacation, an emergency room in Buffalo should be able access the patient's protected health information (PHI). The group agreed that such functionality is beneficial to Medicaid beneficiaries.

The workgroup discussed the current state of various consent forms. It was noted that the general Medicaid consent is provided to beneficiaries upon enrollment. However, it was also noted that the general Medicaid consent form does not apply to the RHIOS but does apply to the State Health Information Network of New York (SHIN-NY). The general Medicaid consent is not limited to claims data, however, the group discussed that in the future state (under VBP) additional language may be needed pertaining to the RHIO or SHIN-NY especially as it relates to the applicability and permission to share data.

Under the current state, there is a limitation on the amount of information that can be shared with a Medicaid provider until an additional affirmative written consent is obtained beyond the general Medicaid consent form. Although it was noted that all consents must comply with federal law, the workgroup specifically discussed the more stringent New York State and Federal laws concerning the sharing sensitive information (for example, information related to mental health, HIV, reproduction, and substance use disorders).



The workgroup then discussed the ideal flow of data under the future state of VBP. Using an example where a provider within an ACO shares information with a RHIO, the group discussed how a consent form impacts this interaction. While the ACO or other entities may access the data, it is currently unclear whether the Medicaid program implicitly permits providers to share data in this way. The group reached the conclusion that if, under the current consent process, the entity intended for the disclosure could be identified, data exchange would be permissible. However, it was noted that in the future state, identification of particular providers may be an impossible administrative burden.

The workgroup then considered sensitive populations. In the case of minors both the minor and legal guardian (i.e. parent) could consent to the sharing of the minor's information. However, the workgroup determined that further discussion was required to understand the intricacies of this area. The participants also discussed whether the potential disclosure of minor health information on an Explanation of Benefits (EOB) was in or outside the scope of this workgroup. Lastly, it was noted that there may be special classes within the minor population that are exempted from current regulations. It was noted that a similar issue may arise with the sharing of mental health information.

The workgroup then considered the overarching issue regarding whether a more streamlined consent process was necessary to facilitate VBP in the future state. Workgroup members generally agreed it would be beneficial in the future state (VBP) to streamline the consent process. However, the workgroup raised the competing concern of patient confidentiality. The workgroup agreed that providers must be able to efficiently share information in order to have succeed and provide appropriate care through VBP. However, the workgroup determined that there may need to be appropriate safeguards placed upon the sharing of information in order to appropriately accommodate privacy concerns. The balancing of these concerns was generally agreed to constitute the nexus of the workgroup's focus.

The workgroup discussed the need to align NYS law patient confidentiality laws with HIPAA. The workgroup discussed the possibility of a patient signing an inclusive consent form that would allow for global information sharing. However, it was noted that patients were signing such a general consent form currently upon enrollment. The workgroup raised concern regarding what extent New York State considered such a consent to be viable under its laws. The workgroup agreed to explore this issue through subsequent meetings. The workgroup again expressed concern regarding patient privacy protections in this case. The workgroup noted the need for affirmative consent for substance use disorders (SUD) under federal law.

The workgroup thereafter discussed the technical ability required to limit dissemination of health information to a certain duration for a limited set of parties. It was noted that while a patient may provide general consent to access and disseminate data, patients may not be aware what data is out there, how much is shared, or what their physician already has access to. The workgroup agreed that greater patient education regarding what information is currently being shared would likely be necessary.

The workgroup discussed the need for consent to be informed. For informed consent providers may have to be identified by name. However, such a process may be overly burdensome to meet the needs of VBP. The requirements under this process have yet to be defined. However, the group noted that an educational protocol surrounding the consent process may substantiate informed consent.

**Materials distributed during the meeting:**

Document	Description
<p>VBP Patient Confidentiality Issue Brief</p>  <p>102416 Patient Confidentiality Workgr</p>	<p>This document details the high level policy questions related to patient confidentiality.</p>
<p>Patient Confidentiality Workgroup – Meeting #1</p>  <p>102016 Patient Confidentiality Workgr</p>	<p>A presentation deck of policy questions and options for consideration as it relates to VBP patient confidentiality. Includes a background on VBP concepts and patient confidentiality-specific VBP considerations.</p>

**Key Decisions**

The WG made decisions on the following key points during meeting #1:

- ✓ This series of workgroup meetings should identify an ideal state regarding sharing information

**Action Items:**

- Identify the current laws around sharing patient information
- Look for a graphic on the interpretation of sharing patient information
- Obtain a copy of the guide and rules around the framework on sharing minor information
- Obtain a copy of the white paper on the mapping of RHIOs
- Create a flow of data for the legal requirements of sharing data
- Obtain the State and federal regulations around patient confidentiality
- Obtain and distribute the ONC (Office of the National Coordinator) Office for Civil Rights (OCR) information sharing document
- Provide a copy of the NYeC consent analysis
- Outline the purpose of the data flow and clinical and claims data for both clinical and VBP purposes
- Look at ACO regulations and responsibilities surrounding patient confidentiality
- Obtain examples of how the data would be shared between providers

**Conclusion**

The next workgroup meeting will be held in Albany on November 8, 2016 and will include:

- 1) A discussion of potential recommendations from workgroup #1
- 2) An introduction and discussion of the regulatory and procedural framework surrounding patient confidentiality
- 3) Draft recommendations related to data flow for VBP sensitive to patient confidentiality considerations