



Meeting #3

Date: Tuesday, November 22, 2016 1:00 PM

Location: University at Albany – East Campus, 5 University Place, Rensselaer NY 12144

Attendees:



PC Workgroup
Attendance_11.22.16.:

Overview

This was the third meeting of the Value Based Payment (VBP) Patient Confidentiality workgroup. The purpose of Meeting #3 was to develop consensus recommendations related to patient confidentiality in a VBP context.

The Agenda for this meeting included:

1. Welcome and Introductions
2. Policy Framework
3. Review & Finalization of Draft Recommendations
4. Conclusions

Key Discussion Points (reference the slide deck “Patient Confidentiality Workgroup #3.pdf”)

1. Welcome and Introductions

The Patient Confidentiality workgroup co-chairs commenced the meeting with a roundtable introduction of participants. Participants were given an overview of the scope of the meeting, which included the finalization of draft recommendations developed by stakeholders in prior meetings.

2. Policy Framework

Participants were briefed on the transition to VBP and the anticipated changes in the way services will be delivered to the Medicaid population. Those changes raised key policy questions linked to one fundamental theme—with increased integration through VBP, more effective data exchange between entities within the system is a precondition to the delivery of integrated care while patient confidentiality considerations must nevertheless be protected.

Participants were asked to pay specific attention to implementation mechanisms (e.g., state legislation, model contract, DOH policy, regulatory changes, other modes, or a potential for no changes) for each of the recommendations under consideration.

3. Review & Finalization of Draft Recommendations

Throughout the remainder of the meeting, the discussion revolved around each potential policy recommendation. Participants discussed the feasibility and limitations of each recommendation. The central theme, balancing increased data dissemination against patient confidentiality protections, drove impassioned debate throughout the whole of the discussion.

Recommendation #1: DOH, working with OMH and other relevant agencies, should issue a new interpretation of State law to allow for the sharing health information for analytics, alerts, and other designated operational



purposes by clinical and non-clinical persons and entities, pursuant to contracts similar to a Business Associate Agreement (BAA) without affirmative consent from the patient.

This recommendation pertains specifically to information for alerts and the ability to perform analytics. This recommendation asserts that a BAA can be created to allow for analytics without affirmative consent from the patient. It was noted that the support of this recommendation would be HIPAA's exception for healthcare treatment and operations.

This recommendation would allow for 1) alert dissemination to relevant parties without affirmative consent (minimal clinical information, emergency room, inpatient admissions, other), and would permit 2) entities to use the clinical information for the purposes of doing all functions permitted through HIPAA's exceptions. Under this recommendation, "analytics" were noted to be permitted to the extent of HIPAA's exception for healthcare treatment, payment and operations.

The workgroup noted that the Medicare ACO model may provide a replicable consent model. Specific insight into the application of the Medicare ACO consent process was shared by stakeholders. The workgroup noted that traditionally, in Medicare, the entity seeking to use data for the purposes of analytics (the Medicare ACO) would rely upon Medicare mailings to inform patients that they were part of an initiative (or were "attributed"). Within this document, a disclosure about data sharing is generally included together with a provision that the patient has an opportunity to opt-out. Through this process, the Medicare ACO forms a one-to-one agreement with a RHIO (or RHIO like entity) and sends their attributed population's data through the RHIO. The Medicare ACO triages alerts and disseminates them to relevant care managers depending upon whom the patient is assigned to. The workgroup noted that through conjecture, this same process could be duplicated for the Medicaid population.

The workgroup noted that under current state, for a provider to receive an alert from a RHIO, such provider must have secured an affirmative written consent from the patient. Similarly, in current state, it was noted that a BAA allows for the exchange of data to/from the RHIO (a non-covered entity) to/from the provider who secured such consent without specific agreement from the patient. It was also noted that such BAA provides that health information will only be used for limited purposes specific to that contract.

However, the workgroup noted that a BAA only covers the first disclosure of information from the provider whom secured consent to/from the RHIO; it does not cover disclosure to a third party (e.g., from the RHIO to a provider who did not secure the consent). It was noted however that a potential option is to create a secondary or downstream BAA between the RHIO and the third party which relates back to the originally secured consent.

Similarly, it was noted this schematic may not be applicable to certain special populations. Notably, it could not be used to share information collected in/by a mental hygiene facility with entities that the NYS' mental hygiene laws prohibit information release.

Regarding mental hygiene the workgroup noted that there is an exception in 33.13(d) that provides that mental health facilities can share information without consent to managed care plans, health homes, and other entities that provide a care coordination function. The workgroup noted that currently an interpretation that allows for the disclosure of information to PPS lead entities under the "other entities" definition is being explored. The workgroup noted the possibility that VBP providers could be considered as serving a care coordination function under 33.13. However, it was noted that VBP contractors may contract-out aspects of their services to other entities. It was noted that such scenario would present additional complexities, such as in terms of re-disclosure. To the extent 33.13(d) could be extended to VBP contractors, it was noted that if such contractors were reviewed and approved by the state in a manner similar to the PPSs, the reasoning permitting data



dissemination to PPSs would be similar to such dissemination to VBP contractors and could warrant a review which could result in an opinion 33.13(d) be extended to VBP contractors.

Consensus recommendation: DOH, working with OMH and other relevant agencies, should issue a new interpretation of State law to allow for the sharing of PHI for healthcare operations purposes pursuant to contracts similar to a BAA without the consent of the patient, provided that the patients have the right to opt out. Under this interpretation, a BAA arrangement would need to be sufficient for the sharing of clinical information for the purposes of analytics (to the extent permitted by HIPAA's exception for treatment and healthcare operations). Further, alerts can be sent out without consent for the patient, provided that they do not include disclosure of information protected through NYS and Federal law to the extent that no exception or exclusion exists.

Recommendation #2: *Create and implement an opt-in consent form for data sharing with all providers for PHI outside of minimally necessary health data, excluding alerts and analytics. Opt-in consent will include consent to access data for the purpose of care management by non-clinical providers supporting the provision of health care.*

The group determined that this recommendation reflects current state activities with alerts and analytics carved out. Given the discussion, it was decided that this recommendation was no longer valid for consideration.

Recommendation #3: *DOH, working with OMH and other relevant agencies, should issue a new interpretation of State law to allow for sharing health information for treatment purposes, including care coordination, without affirmative consent from the patient. An opt-in consent form should be created and implemented for data sharing with all providers for PHI outside of minimally necessary health data, excluding alerts and analytics. Opt-in consent will include consent to access data for the purpose of care management by non-clinical providers supporting the provision of health care.*

This recommendation raised the discussion regarding the inclusion of SUD or mental health information. The workgroup noted that through 33.13, in NYS there would need to be a statutory change if the intent of the recommendation was to include mental health information. The workgroup noted that there was otherwise no clear avenue to reinterpret 33.13 for this purpose. The workgroup determined that this recommendation was limited to non-sensitive personal health information.

Consensus Recommendation: DOH, working with OMH and other relevant agencies should issue a broad interpretation of state law with regard to the sharing of health information for treatment, operation, and payment purposes, including care coordination, without affirmative consent from the patient. This includes access to data for the purposes of care management by non-clinical providers supporting the provision of health care. If necessary, statutory changes should be made that allow a consent process for the sharing of certain sensitive health information.

Recommendation #4: *Create and implement a single consent form for the purposes of data sharing in the Regional Health Information Organization (RHIO)/State Health Information Network of New York (SHIN-NY), Health and Recovery Plan (HARP), and Health Homes etc. Consent will be entered into the EHR.*

The workgroup determined that the reference to HARP should be removed from this recommendation. This recommendation should be inclusive of bi-directional information sharing to share and access information by both plans and providers. Under this recommendation, a broad, uniform consent would provide the ability to access and share information bi-directionally between all relevant providers.

Consensus Recommendation: To the extent that affirmative consent continues to be necessary for different categories of information, the state should make efforts towards the creation of a uniform consent form that is inclusive of plans and allows for bi-directional information sharing. Further, the group agreed that the consents should be inclusive of health care plans.

4. Conclusions

The workgroup agreed that further follow up will be conducted to solicit input on recommendations 5-8 which were not covered during this meeting.

Materials distributed during the meeting:

Document	Description
Patient Confidentiality Workgroup – Meeting #3  Patient Confidentiality Workg	A presentation deck of draft recommendations for consideration as they relate to VBP patient confidentiality.

Key Decisions

The Workgroup made decisions on the following key points during meeting #3:

- ✓ Recommendation 1: revised to reflect the scope of a BAA and the extent to which alerts can include PHI
- ✓ Recommendation 2: determined that it was no longer relevant
- ✓ Recommendation 3: determined that it pertained to non-sensitive information only and was revised to reflect the request for the broad reinterpretation of state law
- ✓ Recommendation 4: revised to reflect the inclusion of plans and bi-directional information sharing

Action Items:

- Further input will be solicited from workgroup members on remaining recommendations

Conclusion

This meeting will be continued in a fourth session scheduled for December 21, 2016. Thereafter, a formalized recommendation report will be submitted to the VBP Subcommittee for further review.