



Overview

New York State's shift toward a Value Based Payment (VBP) delivery system is anticipated to enhance the value of services provided to the Medicaid population. However, this move also raises additional data privacy challenges, especially in the context of NYS law. In this changing environment, providers may need additional data in order to be more proactive and successful in VBP while continuing to protect members' individual privacy needs. Policy clarification or regulatory updates may be needed to support these efforts.

The VBP Patient Confidentiality Workgroup will focus on developing policy recommendations related to HIPAA and NYS privacy and security. These issues will require coordination between both the New York State Department of Health (DOH) and the New York State Education Department (NYSED) as well as other NYS stakeholders.

The Patient Confidentiality Workgroup's Mission: *Identify what updates can be made to the current data flow or regulatory framework that governs NYS privacy and security to ensure that New York State achieves its objectives associated with VBP, while upholding appropriate protections for Medicaid beneficiaries.*

Patient Confidentiality Workgroup Meeting 1

Policy Question: *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?*

The first VBP Patient Confidentiality workgroup session will be devoted to the development of a robust understanding of how patient health data is currently accessed and shared by various providers and payors. This foundation will be critical for informed discussion during the workgroup meetings, and the development of informed recommendations during the second meeting. There will be a particular focus on the agreements and consents that govern the sharing of patient data, and how these consents are currently being applied.

VBP Data Flow Process and Existing Consent Arrangements

Within the VBP framework, there are various information sharing agreements that govern how this data flows, and the extent to which that data is complete. This workgroup will be focused on those agreements in the context of this data flow. Below are a few examples of data sharing consent agreements:

- Medicaid Consent Form
- RHIO and Statewide Health Information Network (SHIN-NY) Opt-In

Identification of Data Sharing Gaps



As previously stated, an important goal of this workgroup is to understand information sharing regulation as it relates to VBP arrangements. Such arrangements can be complex and subject to multiple regulatory requirements. Guidance on how to interpret and comply with these requirements must consistently be updated as systems and processes evolve.

NYS previously underwent a review of its privacy laws in an effort to facilitate DSRIP-related protected health information (PHI) sharing. As a result of this exercise, the State provided selected guidance regarding sharing of PHI from State Medicaid sources, PHI generated by Managed Care Organizations (MCOs), and PHI managed by Qualified Entities (QE) with the focus now shifted toward VBP.

Now, certain data sharing gaps remain regarding VBP, and raise key discussion points for this workgroup. The following are some examples of previously identified data sharing gaps, which need to be evaluated for their appropriateness and remediated accordingly:

- a. *Medicaid Consent Form*: There is a lack of guidance regarding when opt-in/outs are necessary in light of the exception for health care operations contained in the Medicaid consent form. Some PPSs and other relevant upstream entities fear they need unique opt-in/out or alternative consent processes to receive data from downstream providers.
- b. *RHIO and SHIN-NY*: The RHIO and SHIN-NY data may be incomplete due to NYS patient confidentiality laws (e.g., Public Health Law §2782) which limit provider-to-provider data access. If data access is for non-treatment purposes, it is not clear what would constitute a “minimally necessary” standard for health care operations.
- c. *RHIO and SHIN-NY*: The RHIO and SHIN-NY opt-in do not necessarily include the consent of minor patients. Providers are therefore reluctant to provide access to minor patients’ data through the RHIOs and SHIN- NY.
- d. *Care Management*: Care management organizations may be neither covered entities nor providers, but may require access to PHI in a VBP environment. Confusion exists regarding the appropriate sharing of information with and by care management agencies (including health homes) which leads to burdensome and unnecessarily complex consent processes that are not clearly communicated to consumers.
- e. *Other*: Other entities and organizations may need access to confidential patient health data for the purposes of VBP. Who are these entities and organizations? What other agreements are in place that implicate the receipt of patient confidential health data by these entities and organizations?



Patient Confidentiality Workgroup Meeting 2

Policy Question: What legal agreements (e.g. consent agreement), laws or regulations need to be created or modified to allow for effective data sharing for the purposes of VBP (e.g. Care Management, CBOs, Vital Statistics)?

During its second meeting, the Patient Confidentiality Workgroup is tasked with providing recommendations regarding the regulatory and procedural framework surrounding HIPAA and NYS privacy and security that will ensure the move to VBP is successful and patient privacy is appropriately protected.

Current NYS privacy laws and regulations are more restrictive and provide less flexibility than federal HIPAA laws and regulations. These additional restrictions may prevent providers from sharing information for the purpose of coordinating care and evaluating the outcome of care, both of which are critical to successful VBP arrangements. As a result, additional guidance or modification may be needed.

In evaluating whether there are other means available to permit effective data sharing for VBP purposes while protecting a patient's confidential information, the below considerations should be taken into account:

- a. *Current Consent Agreement(s)*: Can consent agreements currently in place be clarified or modified to allow for appropriate data exchange within the VBP environment?
- b. *Additional Consent Agreement(2)*: Should additional, or a "global" consent agreement, be created specifically for VBP purposes that permits appropriate data exchange between interested entities and organizations.
- c. *Waiver(s)*: Are other forms of waiver available to permit effective data sharing for VBP purposes?
- d. *Safeguards*: What safeguards need to be created within these consent agreements or waivers to protect a patient's confidential information while adequately allowing data exchange for the purposes of VBP? For instance, areas of heightened concern, and restriction, should be considered such as behavioral health, substance abuse, HIV/AIDS, reproductive care and for minors.
- e. *Exceptions to State Law*: Are exceptions to state law a viable means to permit effective data sharing for VBP purposes? For areas of heightened concern, are exceptions to state law preferred over broader or clarified consent agreements.
- f. *Other Policy Questions not addressed by the workgroup*: As an example, a question was previously raised on the Vital Statistics file and accessing the data for VBP purposes. New York state regulation 10 NYCRR 400.22 says that only state employees may access VS. There are no exceptions or consent processes available to providers, PPSs, and NYS contractors. What modification could be made to permit VS be leveraged in the VBP environment?

The second workgroup meeting will conclude with a recap of the previous discussion, so that the group may find consensus on the recommendations it would like to put forth.