

**New York eHealth Collaborative Policy Committee Meeting**  
**December 19, 2017**  
**2 p.m. – 4 p.m.**  
**Meeting Notes**

A meeting of the NYeC Policy Committee was held on December 19, 2017. Present either in person or via telephone were:

Art Levin, Center for Medical Consumers, Co-Chair Policy Committee  
Nance Shatzkin, Bronx RHIO  
Steve Allen, HealthLink  
Tom Check, Healthix RHIO  
Amy Warner, Rochester RHIO  
James Kirkwood, NYS DOH  
Deirdre Depew, NYS DOH  
Geraldine Johnson, NYS DOH  
Roslyn Windhol, NYS OMH  
Dan Tietz, AIDS Institute  
Dr. John-Paul Mead, Cayuga Medical Associates  
Dr. Tom Mahoney, Common Ground Health  
Maria Ayoob, NYSTEC  
Laura Alfredo, GNYHA  
Zeynep Sumer-King, GNYHA  
Evan Brooksby, HANYS  
Valerie Grey, NYeC  
Cindy Sutliff, NYeC  
Jeannette Rossoff, NYeC  
Nathan Donnelly, NYeC  
Bob Belfort, Manatt  
Alex Dworkowitz, Manatt

The meeting was called to order by Mr. Levin at 2 p.m.

**I. Welcome and Introductions**

Mr. Levin welcomed the Committee members and outlined the meeting's agenda. Mr. Levin noted that the Committee's recommendation on the cybersecurity policies had been approved by the NYeC Board.

**II. Proposed Policies on Disclosures**

Ms. Sutliff introduced the subject of proposed revisions to the policies regarding disclosures and noted that this topic had been discussed at the previous Committee meeting. Mr. Dworkowitz outlined the changes to the proposed disclosure policies that had been made since the previous meeting.

Ms. Shatzkin said she was struck by the new provision that would prohibit disclosures under the emergency access and disaster tracking exceptions. She said that while pushes might not exist for emergency access and disaster tracking today, it is possible the QEs could come up with a means of implementing such disclosures in the future. Mr. Check agreed and suggested revision Sections 1.2.3 and 1.2.4 of the policies to require attestations in the case of disclosures.

Ms. Johnson questioned why the proposed policy required patient consent to share patient information with out-of-state public health agencies. She said that one state's public health agency typically does not need patient consent to share information with another state's public health agency. Ms. Sutliff said they would need further discussions on this issue. Ms. Johnson agreed to research and then provide additional information about the issue for clarification.

Mr. Check suggested revising the draft disclosure policies to account for different use cases. Mr. Check suggested that the policies require recipients to have entered into a Data Use and Reciprocal Support Agreement (DURSA) with the Sequoia Project. Mr. Check said at least half the health information exchanges in the country had signed the DURSA, but he was unsure about individual providers. Ms. Warner offered to review the DURSA to determine if it would be useful in this context.

Mr. Check said in the use case where patient information was shared with an individual such as a relative, a lot of the requirements in the draft policies should not apply, such as the requirement that the QE enter into a contract with that individual.

Mr. Check recommended that the provision allowing for disclosures to researchers was not necessary, since the policies already allow for disclosures to researchers that are not participants. Mr. Belfort said this question would be reviewed.

Mr. Check also suggested that the policies should distinguish between the life insurance and disability insurance use cases. Mr. Belfort and Ms. Shatzkin said they did not think it was necessary to differentiate between these use cases.

Ms. Shatzkin asked if the policies should require that anyone who receives information from a QE should be a participant. Mr. Belfort said there are two issues- one for the class of individuals and entities that can never be participants, such as life insurers and family members, and the other for entities that could be participants if not for the fact they were located in other states. Mr. Belfort questioned whether the policies should require a tertiary medical center outside the state to become participants if they see only a small number of New York patients a year.

### **III. Disclosures and Audit Logs**

Mr. Dworkowitz described the proposed modifications to the policies regarding audit logs and disclosures.

Mr. Mahoney said the reference to a person's "name" in Section 6.1.4(b) should instead be a reference to "PHI."

Mr. Allen noted that if a QE is performing population health analytics on behalf of a Performing Provider System (PPS), then the QE is acting as a business associate of the participant, and the QE is analyzing the PPS's own data. He said in that case no consent has been required and there has not been a disclosure. Mr. Belfort agreed that in this scenario the QE is the vendor. Mr. Belfort said that the HIPAA framework was not particularly applicable since under HIPAA, disclosures for treatment, payment and health care operations did not need to be included in an audit log, but the policies required such disclosures to be included in the audit log.

Mr. Check said that he did not view the queries on the data set as involving only one participant's data, and that the data could be coming from multiple participants. He said in that case the draft policies made sense. Mr. Allen agreed. Mr. Belfort said that he thought this might be the right distinction, in that if data is taken from a participant and spit back right back to that participant such data might not be considered a disclosure.

Ms. Sutliff said they would pull together a small group to review this issue further. Ms. Shatzkin requested that draft 6.1.2(e) be reviewed as well.

#### **IV. Health Plan Participation**

Mr. Levin referred the Committee members to the paper provided on health plan use of data. Ms. Sutliff said there should be health plan voices on the Committee, and that they were also planning to have a health plan advisory committee in accordance with the 2020 roadmap. Ms. Sutliff said she wanted to hear the concerns of Committee members on allowing health plans greater access to the SHIN-NY.

Mr. Check said the initial understanding of the SHIN-NY was that it would be used for purposes of treatment and care management. He questioned the benefit of using the SHIN-NY for purposes of payment when the data is of uneven quality. Dr. Mead said that as a provider, he was concerned about health plans using the SHIN-NY for this purpose, since it could be used as another way to deny care.

Mr. Levin said Kaiser was an interesting model, and that Kaiser had been way ahead of the curve of identifying problematic drugs that should not be prescribed. He said there was value here, and the goal is grabbing that value and avoiding the traditional warring of clinicians and payers.

Mr. Belfort said this was an insular conversation because there were no payers participating. He said utilization review can be an important check on bad medicine that may not be reflective of most doctors but is reflective of some doctors. Mr. Belfort said the question was not whether utilization review is a good thing or bad thing, but whether the authorization form should contain a reference to all health plan functions or a subset of functions. Ms. Sumer-King agreed it was important to bring other stakeholders in the room, but she noted that participation in the SHIN-NY is optional for payers but required for providers.

Mr. Belfort said he was not sure this issue was the health plan's primary concern, and that their main concern may be getting consent.

Ms. Sutliff said that the conversation had been a valuable start, and that they would have more voices in the mix in 2018.

## **V. Closing**

Mr. Levin thanked everyone, wished the participants a great holiday, and closed the meeting.

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