

New York eHealth Collaborative Policy Committee Meeting
June 16, 2022
12 p.m. – 3 p.m.
Meeting Notes

A meeting of the NYeC Policy Committee was held on June 16, 2022. Present via telephone or videoconference were:

Policy Committee Voting Members

Art Levin, Chair, Center for Medical Consumers
Dr. Lawrence Brown, START Treatment & Recovery Centers
Dr. David Cohen, Maimonides Medical Center
Dr. Ram Raju, Health Disparities Consultant
Steve Allen, HealtheLink
Alan Cohen, JASA
Chuck Bell, Consumer Reports

Other Attendees

John Sheehan, Rochester RHIO/BOC Representative
Judy Mendoza, Rochester RHIO
Nance Shatzkin, Bronx RHIO
Liana Prosonic, HealtheConnections
Rachel Kramer, HealtheConnections
Elizabeth Amato, HealtheConnections
Patricia Burandt, HealtheLink
Dan Porreca, HealtheLink
Todd Rogow, Healthix
Magdalena Mandziewska, Healthix
James Kirkwood, NYS DOH
Jonathan Karmel, NYS DOH
Deirdre Depew, NYS DOH
Chelsea Sack, NYS DOH
Ken Wiczera, NYS DOH
Dan Schiller, NYS DOH
C.J. Barber, NYS OMH
Tammy Harris, OPWDD
Dr. Celia Quinn, NYC DOHMH
David Lee, NYC DOHMH
Dr. John-Paul Mead, Cayuga Medical Associates
Zeynep Sumer King, GNYHA
Puja Khare, GNYHA
Thadeo Salido, Aetna
Roger Benn, Excellus BCBS
Kate Beck, Healthfirst
Laurie Radler, Healthfirst
Phil Salemi, Independent Health

David Horrocks, NYeC
Cindy Sutliff, NYeC
Alison Bianchi, NYeC
Don Juron, NYeC
Ben Hanley, NYeC
Kathryn Lucia, NYeC
Julia Sisti, NYeC
Sam Roods, NYeC
Alex Dworkowitz, Manatt

The meeting was called to order by Mr. Levin at 12 p.m.

I. Welcome and Introductions

Mr. Levin welcomed the Committee members and provided an overview of the agenda, the meeting materials, and the meeting objectives.

II. Federal and State Updates

Ms. Bianchi said NYeC is finalizing a public comment letter to CMS on the Medicare Inpatient Prospective Payment System proposed rule. She said NYeC had also submitted a comment letter to NYS DOH on the state's Medicaid waiver demonstration. She observed that the state legislative session had concluded and it had been a relatively quiet session for health care.

III. DOH Update

Mr. Kirkwood said revisions to the SHIN-NY regulation hopefully would be scheduled for an upcoming state agenda. He said such regulatory changes would go through the normal public comment period. He noted that the regulatory changes would include the all-in consent model, which had been developed in part to support telehealth where it is difficult for a patient to sign a written consent. Dr. Raju observed that there were important privacy concerns about the use of telehealth, such as ensuring doctors do not provide telehealth from public settings.

IV. Health Plans: Utilization Review

Mr. Salemi explained that Independent Health was requesting a change to the SHIN-NY policies that would revise the definition of "care management" to include utilization review. He said health plans are charged with performing medical necessity review, and therefore they sometimes need to obtain information from providers under that review. He explained that the turnaround time for utilization review can be up to 45 days, and Independent Health had thought it would be in the best interest of their members if they could find the needed information through HealtheLink to better facilitate the process and reduce the time for a review and

determination. However, he noted HealthLink's policies prohibit the disclosure of information for utilization review purposes pursuant to the typical consent forms.

Mr. Salemi said quite often there is a perception that utilization review delays access to care. He added that the proposed policy change would reduce delays and would reduce the rate of denials of care, which can occur when the necessary information is not made available by providers.

Ms. Beck voiced support for Mr. Salemi's proposal. Ms. Mandzielewska said SHIN-NY consent forms would need to be revised if the proposal were adopted, noting one provision said signing the form would not impact payment for medical bills. Mr. Salemi agreed that language on the form would need to be revised.

Dr. Cohen said the current SHIN-NY policy explicitly excludes utilization review from care management. He expressed support for facilitating access, but said there is a dark side to utilization review, which can lead to denials. Dr. Brown said he could see the value of the proposal in reducing denials, but he was concerned about the other side of the coin. Dr. Brown asked if economically disadvantaged populations appealed denials of care at the same rate as the general population.

Mr. Bell said this would be a significant change in policy, and that there could be populations that could be disadvantaged by this change. He said he understood that patients win appeals about 50% of the time.

Mr. Horrocks said payers may be able to get the same information via other means if the disclosure does not occur through the SHIN-NY, and he expressed concern that rejecting the proposal would lead to driving traffic away from the SHIN-NY and towards unregulated networks. Mr. Rogow agreed, noting that the TEFCA purposes of use allow for disclosures for both payment and health care operations, and that utilization review falls under payment.

Dr. Raju said he agreed with the general sentiment, and that people view utilization review as a denial phenomenon. He said that if the all-in consent permits disclosures for utilization review purposes, patients may not sign the form, and doctors may instruct their patients not to sign it.

Mr. Levin said he was hearing strong feeling on both sides, and that additional data would be helpful. Ms. Sutliff said an ad hoc workgroup may be formed to address the issue.

V. Alternative Consent Policies

Mr. Dworkowitz described potential policy changes to address alternative consent forms after all-in consent was operationalized. He explained that the policy language would continue to permit the use of alternative consent forms only on a limited basis at such time.

Ms. Shatzkin questioned whether community-based organizations would be able to access SHIN-NY data under an all-in consent form, and therefore noted such organizations may need to use alternative consent forms.

Mr. Rogow asked whether the exception for health systems included organizations like DaVita and CVS. Ms. Sutliff said the definition was intended to apply to large hospital systems. Mr. Rogow noted that more flexibility may be warranted, noting DaVita is a large national dialysis provider that works in all 50 states and which has developed a consent form intended to apply to all health information networks, including eHealth Exchange and Epic Care Everywhere. He added that hospitals are a clear cut case, but there are other important cases as well.

Mr. Allen questioned the language at 1.3.6, noting that it may be impractical for some participants, such as pathologists, to present consent forms to patients. Ms. Radler asked how this would be operationalized in the case of a health plan.

Ms. Shatzkin asked whether organizations such as PatientPing would be able to present consent forms to patients. Mr. Dworkowitz responded that the policy only restricted the provision of SHIN-NY consent forms, not other forms.

Ms. Sutliff said they would provide updated language at the next meeting.

VI. Health Equity: Learnings from the Pandemic

After a break, Dr. Quinn, Deputy Commissioner, NYC DOHMH Disease Surveillance Unit, presented on data and equity related to the New York City COVID-19 response. She addressed how NYC DOHMH used RHIO data for COVID-19 surveillance, the city's efforts to improve race/ethnicity vaccination data, and other DOHMH projects to support health equity.

Dr. Quinn noted that DOHMH has been obtaining daily files from Healthix and Bronx RHIO of individuals diagnosed with COVID-19 and matched such files with their own data. She said the SHIN-NY data had important information on underlying conditions, hospitalizations, and race/ethnicity, which helped develop key metrics.

Dr. Quinn explained it was an important priority for the city to ensure its vaccination efforts reached all New Yorkers. She said that when the effort started, more than 30% of immunization records lacked race and ethnicity data, but through targeted outreach this rate improved significantly, dropping to 4%.

Mr. Horrocks said that due to the urgency of the pandemic, the SHIN-NY tried things that had not been tried before, and that there were additional opportunities to do the same for other public health priorities. He noted that some of those involved reportable conditions, while others did not. Dr. Quinn agreed.

Dr. Raju said DOHMH had done an excellent job during the pandemic. He said one mistake was closing down houses of worship, who are a critical connection for many communities.

VII. SHIN-NY Policy Modernization: Proposed Edits

Mr. Allen described three policy proposals aimed at clarifying certain aspects of the SHIN-NY policies.

First, Mr. Allen noted that the definition of de-identified data is different than the HIPAA definition, and questioned the rationale behind such a difference. Ms. Shatzkin responded that the policy reflected a lack of understanding in the early days of policy development and a desire to be extremely cautious. Following additional discussion, Ms. Sutliff observed that there did not appear to be any dissension on the issue.

Second, Mr. Allen noted the policies had recently been changed to remove the provision that said that affirmative consent is not needed to provide a count of patients who meet clinical trial criteria. He recommended that the policies be revised with the original language. Ms. Sutliff said the change was probably an oversight. Mr. Barber responded that OMH requires research to go through an institutional review board, and added there were concerns if the number was below 5 patients. Ms. Sutliff answered that the change would only allow QEs to provide a number of patients who might qualify for participation in a research study such that the researcher could determine the viability of a research study prior to beginning the research study.

Third, Mr. Allen referred to the policy provision on Medical Orders for Life Sustaining Treatment (MOLST). He noted that there was a lack of definitions in the section. Ms. Shatzkin asked whether the rules for MOLSTs should differ from the rules for other advanced directives. She recommended that they seek input on the topic from the broader community. Mr. Allen said HealtheLink years ago had built a link to the MOLST login page, but it was not used, since health care providers did not want to go through a second login to access a MOLST. He said it would be more useful if a practitioner would be able to see a flag that a MOLST exists within the QE's portal.

VIII. Closing

Mr. Levin said their next meeting would take place on July 20th. Mr. Levin thanked the Committee and adjourned the meeting.