CALIFORNIA MEDICAL ASSOCIATION

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RE: CMA Comments on the Draft Data Exchange Framework (DxF) Legislative Report

John:

Thank you for the opportunity to comment on the Draft DxF Legislative Report, mandated by Assembly Bill (AB) 133. This report marks an important milestone in our shared work of bringing robust data exchange to all sectors of the health and human services marketplace in California.

CMA respectfully offers the following comments on the draft document[1]:

Comment #1: Slides #24-26, on governance, need extensive rewrites to avoid the appearance of a drastic overreach by CDII and the Advisory Group.

As was shown in the last DxF Advisory Group meeting, a large percentage of the group believes that this Governance Proposal is a drastic overreach and is far out of line with the letter and the spirit of AB 133. The statute calls for the Advisory Group to:

> (J) Assess governance structures to help guide policy decisions and general oversight. [HSC 130290 (J)]

The intent of this subsection is for the Advisory Group to assess the existing legal structures that govern data exchange (HIPAA, CMIA, Information Blocking, TEFCA, etc.) and how they guide the work that needs to happen moving forward. This proposal deviates from that intent by proposing to create a new body with regulatory authority.

[1] Comments are presented in order of priority, not in the order they appear in the document.

Physicians and other medical providers already operate under a substantial and long-established legal framework that supports data exchange. And that framework is set to grow at the federal level when the Health and Human Services Office of the Inspector General (HHS OIG) finalizes the rules outlining the penalties for Information Blocking. Creating the new state-level entity to oversee medical providers would be duplicative, burdensome, costly and unnecessary.

CMA would support establishing a coordinating entity that could generally oversee the function of the DxF moving forward, mostly to ensure that it continues to be aligned with other state data efforts (see Comment #2, below). To bring this proposal more into line with that vision, CMA suggests the following edits:

1. **Slide #24: Eliminate #1.** This could be replaced with something to the effect of: "Oversee general function of the Data Exchange Framework and assess alignment with other state data sharing efforts."

2. **Slide #25: Eliminate Box #4.** This proposes to allow the Governance Structure to create "other data sharing P&Ps and requirements." As physicians will be required to execute the DSA, this makes the Governance Structure a regulatory body. As noted above, CMA opposes this concept.

3. **Slide #26: Eliminate #3 ("Enactment of data sharing P&Ps and Requirements") and #5 ("Enforcement and monitoring compliance with P&Ps, requirements and guidelines").** These functions, again, speak to regulatory authority.

Finally, CMA must point out that whatever appears in this document will be viewed by the Legislature as the consensus work project of the Advisory Group. As noted above, a large percentage of the Group strongly objects to this proposal, and made those objections known in an open meeting. Presenting this document, as written, risks that disagreement spilling over into the legislative process.

Comment #2: Missing from this slide deck is an overarching vision of how the DxF coordinates with and supports other CHHS Data efforts.

In private conversations, members of the CHHS Team have expressed to CMA that the intent of the Data Exchange Framework is to create a legal structure under which HIPAA-covered entities can exchange data with non-HIPAA-covered entities, such as counties and public health departments. There is logic to this approach, as CalAIM will require a higher level of coordination between medical providers and social determinants of health (SDoH) organizations than is currently possible. This context changes how organizations represented in the Advisory Group see the governance discussion, the template Data Sharing Agreement (DSA), and the work of the Digital Identity focus groups.

And yet, this crucial piece of context has been completely absent from the conversations in the Advisory Group, and it is not apparent in the draft presentation. As the Legislature is

going to be asked to approve the work product of this Advisory Group, they should be empowered with knowledge of the whole strategy.

CMA strongly recommends that CDII add slides to this presentation to place the DxF work in the proper context, tying it to CalAIM and other state data efforts.

Comment #3: On slide #13, Opportunity A should be expanded to include HIPAA-covered entities that were not able to access the federal HITECH Incentives.

CMA strongly supports the concept of a multi-payer incentive program to support EHR adoption. And we acknowledge the need that exists to support the non-HIPAA-covered entities, especially given the context in Comment #1, above.

However, as we discussed when this was before the DxF Advisory Group, there is still substantial need for incentives and support among many physicians, as well. For example, many pediatricians did not qualify for the federal Meaningful Use Incentive Program, as they do not see Medicare patients in their practices. In addition, many physicians who did adopt an EHR system for the purposes of the EHR Incentive Program may have invested in substandard systems that cannot enable them to engage in robust data exchange. Both of these groups could benefit from additional support that a multi-payer incentive program could bring.

CMA suggests that this slide be amended to include the notion of supporting physicians and other HIPAA-covered entities, as well as the groups currently listed. We raised this in the Advisory Group and find it unfortunate that it is not reflected in this report.

Comment #4: If it is the intent of CDII to present an HIE funding plan to the Legislature, slide #14 would be an ideal place to begin that conversation.

CMA supports the Legislature considering a Health and Human Services Onboarding and Technical Assistance Program, as described on Slide #14. As you are aware, the state undertaking such a program is a requirement of AB 133 [Health and Safety Code 130290(g)].

Implementing such a program requires funding. There are currently two proposals in front of the Legislature to establish that funding, one sponsored by CMA and another put forward by a coalition led by Manifest Medex. To date, however, the Administration has not engaged in these conversations, nor has it been a topic of discussion at the Advisory Group.

If it is the intent of the Administration to present a funding plan to the Legislature, this slide would be an ideal place to introduce that concept. There would not need to be details; something as simple as “funding plan to be included in the May Revise” would alert legislative leaders that something is coming and set the stage for further discussions. It would also allay the concerns of the Advisory Group members who have been seeking assurances that funding will be discussed by the Advisory Group.

Comment #5: Slide #16 should reference badly needed upgrades to the state's public health data infrastructure.

For the purposes of CalAIM, creating strong data linkages to county health IT infrastructure is very important. CMA supports the concept of leveraging federal funding to build out these important components of the health care system, as called for in Opportunity A on slide #16.

The state, however, should also be considering how to use that funding to improve its own public health data infrastructure. Through the course of the pandemic, we have learned much about the limitations of CDPH's reporting systems, including CalREDIE and CAIR. Most importantly, these systems should be modernized, to improve the bidirectional flow if information to and from health care providers.

Thank you in advance for your consideration of our comments. Please feel free to contact me with any questions or concerns.