February 14, 2023

John Ohanian
Chief Data Officer
California Health and Human Services Agency
1205 O Street
Sacramento, CA 95814

Subject: Feedback on Draft Policies and Procedures

Dear John:

The California Association of Public Hospitals and Health Systems appreciates the opportunity to provide feedback on the following draft Policies and Procedures (P&Ps):

- California Information Blocking Prohibitions
- Technical Requirements for Exchange
- Real-Time Exchange
- Amended Privacy Standards and Security Safeguards

In addition to the comments on the attached spreadsheet, we would like to highlight the following:

- **California Information Blocking Prohibitions** – As we have noted in our previous public and written comments, we support alignment of the Data Exchange Framework (DxF) with national standards and federal law/requirements. This draft does not allow for the use of "fees exception" allowed under federal law for access to health data. The federal government allows actors to provide information technology services for interoperability/data exchange and to invoice health partners who want to leverage that offering. As a result, it would become cost prohibitive for providers to provide these services without reimbursement for the cost. Further, it could potentially disrupt the mutually beneficial agreements and data exchange between health systems and medical groups.

- **Technical Requirements for Exchange** – We have the following feedback on this draft P&P:
  - Interface with Qualified Health Information Organizations (QHIOs) – We have a number of concerns with these requirements because they conflict with participants' ability to comply with the DxF without onboarding to a QHIO, and could result in significant ongoing costs for hospitals, data security issues, and duplicative infrastructure and ADT alerts.

Specifically, the draft notes that "the Participant Hospital must send electronic Notifications of ADT Events to at least one Qualified HIO…" This would infer that hospitals cannot meet the DxF requirements without onboarding with a QHIO. This is in direct conflict with the ability for hospitals to use their own technology to meet the DxF requirements. Further, this would result in legal agreements with QHIOs and significant ongoing costs for hospitals to implement and maintain compliance with this proposed requirement.

Many hospitals also use Direct Messaging for ADT notifications, as required by the federal 21st Century Cures Act and Office of the National Coordinator/Centers for Medicare and Medicaid Services (CMS) rules. Currently, these notifications are targeted to providers and organizations that are known to have a direct relationship with the patient. It is not clear whether or how QHIOs, who do not have a direct relationship with the patient, will similarly protect the information.

In addition, many hospitals currently contribute all ADT notifications that support compliance with the 2021 CMS Interoperability and Final Access rule to a vendor that may or may not apply to become a QHIO. This requirement could potentially result in requiring hospitals to build duplicative interfaces to comply with the DxF and federal requirements.

Lastly, requirements in this P&P could result in hospitals receiving the same ADT multiple times from multiple sources, which could be extremely burdensome to manage and would create additional, unnecessary, and unhelpful noise for providers to cut through. We would urge against this.

- QHIO transparency – We recommend making changes to help support greater data security and increase transparency. Given the proposed technical requirements, and as envisioned by this draft policy, data hubs like the QHIOs will gain significant data but also include risk to Participants depending on how they are structured. As such, we would recommend audits from QHIOs to identify who has pulled data and by what volume, annual security risk assessments for QHIOs to ensure data security, and transparency in the QHIO process, including public posting of reasons for denials and list of approved and denied QHIO applicants.

- Requests for information – We are concerned with the widespread allowance of broadcast queries, which could be too overwhelming for some providers to respond to and could compromise existing data sharing activities. We recommend delaying this type of requirement until after the DxF has been implemented and providers are further along in their data exchange capabilities.

- **Real-Time Exchange** – We support that this draft does not specify exact timing expectations but are concerned that some definitions are defined too broadly and

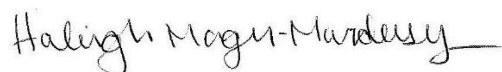
are not reflective of existing technical standards or functionality. The draft currently reads "without delay" or "at the time of the event." Because there are numerous variables that impact real time data exchange transactions, we support the approach to be less prescriptive, given latency with existing connections that may be outside a Participant's control. In addition, interfaces are often slowed by volume constraints, which would be similarly unpredictable for QHIOs.

The draft notes, "In response to an Order for services or a Request for Services, Participant(s) must share the Health and Social Services Information associated with the Order or the Request for Services without delay." Order for services is defined too broadly in the definitions of the P&P and it does not reference any existing technical standard or functionality. As such, it could mean anything from a medical referral to social services or imaging orders. Moreover, there is currently no standard in place to do this type of order and response model either between the same vendor health providers or between different vendor systems. This item should be better defined and narrowed to use cases that have demonstrated technical viability and an agreed upon standard of exchange.

- **Amended Privacy Standards and Security Safeguards** – We have a number of questions regarding this P&P. Because acute psychiatric hospitals are required to participate in the DxF, does this mean all participants are required to freely exchange psychiatric notes and related data? Currently, most organizations block this data from health information exchange responses or restrict the data in some way. Further, how will data for minors or potentially sensitive encounters (e.g., gender identity care, reproductive care, etc.), be managed?

Thank you again for the opportunity to provide input on the draft P&Ps. We look forward to your continued partnership on the DxF and as the Data Sharing Agreement is finalized.

Sincerely,



Haleigh Mager-Mardeusz
Associate Director of Policy
California Association of Public Hospitals and Health Systems
hmagerm@caph.org