AMERICA'S PHYSICIAN GROUPS

December 21, 2021

John Ohanian
Chief Data Officer
Center for Data Insights and Innovation (CDII's)
California Health and Human Services Agency (CalHHS)
1600 9th Street, Suite 460
Sacramento, CA 95815

Re: Joint America's Physician Group (APG) – MedPOINT Management (MPM) Comments on Data Exchange Gaps and Opportunities

Dear Mr. Ohanian:

Thank you for the opportunity to comment further on the December 14th Advisory Group (AG) discussion of potential technical infrastructure opportunities to address HIT capacity gaps. APG and MPM recommend the prioritization of the following gaps and opportunities in the Data Exchange Framework process.

During the presentation, you requested feedback from AG Members on four identified gaps and opportunity issues outlined below. MPM's Dr. Rahul Dhawan provided comments on the first and the fourth and we wanted to use this opportunity to amplify and expand on the comments he made on #1 and #4 and comment on Issues #2 and #3 as follows.

1. **EHR Adoption**: We agree that a multi-payer EHR incentive program would be helpful. However, the citing of the HITECH Act points out further gaps within its scope. While the ACA did focus on building more integrated and coordinated care delivery, its precursor, the HITECH Act did not facilitate those outcomes. Specifically, during the HITECH funding phase, Independent Practice Associations (IPAs) and other physician organizations were not prioritized for common electronic health record acquisition but rather, funding was directed to individual and small practice physicians. IPAs and multispecialty medical groups are the organizations that MCPs most often contract with for care delivery within the Medi-Cal system.

   The omission of these contracting-level provider organizations resulted in a situation, highlighted by the Inland Empire Health Plan, where its entire physician network currently uses 410 unique EHR systems. Fragmented EHR adoption within the physician community has decreased the ability of Medi-Cal provider networks to exchange patient information, conduct proper care coordination and report on performance metrics. Greater emphasis on common EHR adoption at the organizational contracting level for providers (Risk-Bearing Organizations – RBOs) will result in better training,

maintenance, and usage of these systems for health information exchange. Indeed, several dozen larger physician organizations across California demonstrate such common usage of these systems to significant effect for Medicare Advantage and employer-sponsored patient populations and should be incorporated in the Medi-Cal managed Care delivery system as well.

The question of whether a requirement for these systems should be certified is also a prominent issue. We believe that transitioning out of existing, fragmented individual practice EHR systems to fewer, more common, widely adopted systems at the contracting organization level will improve usage and effectiveness and increase the percentage of certified systems across the state. In other words, prioritizing common adoption at the contracting organization level can address several existing gaps cited under Opportunity #1.

2. **Data Exchange Capacity at Many Health Care and Human Service Organizations**: You have asked us which data beyond health information should be shared for specified purposes between various entities. The inability of county and regional public health departments to communicate with community physicians and to push data to them was quite a problem during the initial outbreak of the pandemic, this also occurred again when the vaccines became available. Prioritized funding of data exchange for public health organizations is critical to competent, organized health care system response to public health emergencies. One key element of data exchange relates to the issue of the need for accurate and timely information on provider identities and practice locations. Many public health departments lacked access to this information during the pandemic. CalHHS and Manatt are familiar with a prior effort by the Department of Managed Health Care to implement a more reliable provider information registry, which resulted in the creation of the Integrated Health Association's (IHA's) Symphony registry and database. Mandatory participation in a common electronic provider registry is essential to the determination of the workforce available to combat future public health emergencies.

   Moreover, better data storage and exchange within the Medi-Cal system, such as more real-time availability of member eligibility, is also critically important for the ability of the plan and provider networks to address gaps in access to care.

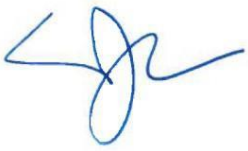
3. **Event Notifications**: CDII's summary of Gap #3 assumes that current event notifications "are mostly limited to transitions from acute care facilities…" This is not a universal process and notifications to treating providers in this specific area remain a gap and, unfortunately, a frequent practice. Our key priority within the DxF framework process is to achieve universal, real-time notification of patient admissions to emergency departments, inpatient facilities, pending patient discharge (among others), and obtaining access to patient discharge summaries and orders by treating physicians and the broader care teams. There is no lower-hanging fruit in the health care system than the ability to improve on the decrease of avoidable admissions and readmissions. It saves lives and frees up financial resources for other effective care coordination activities.

4. **Intra & Inter-Sector Data Exchange**: We believe it necessary and highly relevant to acknowledge the fact that this State and stakeholders across the spectrum have collectively embraced the Social Determinants of Health paradigm; in which **the overall needs of patients are paramount.** The CalAIM and Data Exchange Framework are two leading initiatives in the quest for historic transformation. They are foundational as are other important efforts aimed at ensuring the highest quality, affordable, and cost-effective delivery of care are and services to Californians.

   Our prior comments under Gap #2 apply to this section as well.

Thank you for the opportunity to provide further comments on these important issues. As always, let us know if you have any questions or need additional information. Happy Holidays to the CalHHS Team!

For America's Physician Groups:



William Barcellona
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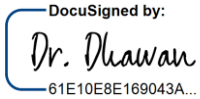
For MedPOINT Management:



Rahul Dhawan, M.D.
Associate Medical Director

CC:

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