CALIFORNIA MEDICAL ASSOCIATION

MEMORANDUM

To: John Ohanian, Chief Data Officer, CHHS
From: David Ford
Date: December 23, 2021
Re: CMA Feedback on DxF Committee Materials

On behalf of the California Medical Association, I would like to offer the following comments and suggested edits on the materials provided for the December 14, 2021, meeting of the Data Exchange Framework (DxF) Working Group:

Gaps and Opportunities

Gap #1 – EHR Adoption

CMA strongly supports the concept of a multi-payer program to promote EHR adoption. We would like to be partners in designing and implementing such a program. When considering the design of this program, we ask CHHS to consider the following:

- **Not all physicians were eligible for the Meaningful Use Incentive Program under HITECH**: For example, many pediatricians did not qualify for Meaningful Use incentives, as they do not participate in Medicare and may not have the Medi-Cal patient volume to qualify. A new EHR adoption program cannot assume that physicians received incentives under the HITECH program.

- **Many physicians who have adopted EHRs may not have systems that support robust data exchange:** Many physicians who have adopted EHRs may be seeking to adopt a more robust system that supports data exchange. Some of the most popular EHRs among small practices do not participate in the national data sharing networks and are among the hardest programs for which to build HIE interfaces. Any EHR adoption program should consider opportunities to assist physicians with migrating to more robust platforms.

- **EHR adoption can facilitate value-based care arrangements:** Moving physicians to EHRs and encouraging them to exchange data help physicians gather and use data to improve patient care. This creates opportunities for physicians to participate in value based care.

Gap #2 - Data Exchange Capacity at Many Health Care and Human Service Organizations

As the originators of the California HIE Onboarding Program (Cal-HOP), CMA strongly supports the concept of creating a successor program that would support physicians and

other providers that were not reached previously. Unfortunately, the implementation of Cal-HOP was delayed by more than two years, and the program finished having spent approximately half of the money it was originally allocated. Many physicians who could have been helped by Cal-HOP still require assistance to connect to HIOs and other forms of data exchange.

CMA looks forward to working with CHHS and other interested stakeholders to design and secure funding for this technical assistance program.

Gap #3 – Event Notifications

CMA supports the concept of incorporating federal event notification rules into state law and regulation, and potentially expanding them to cover additional entities. These event notifications allow physicians to coordinate with other providers, and to provide appropriate follow up care.

In addition, CMA believes that the state should consider other components of the 21st Century Cures Act Final Rule and the Interoperability and Patient Access Rule that should be incorporated into state law and regulation. For example, the expanded use of application programming interfaces (APIs) could facilitate patient and provider access to data without the need to build extensive new infrastructure.

Gap #4 – Public Data Exchange Capacity Building Program

CMA supports the concept of incorporating social determinants of health (SDoH) data into health information exchange. However, we defer to our colleagues in the public sector as to the details of this portion of the framework.

Principles of Data Exchange

CMA continues to be strongly concerned about Principle #8. We acknowledge and support the desire to have safeguards in place for the security of patient data. However, we feel that this principle needs to reflect the substantial civil and criminal penalties that are already in place for misuse of patient data under HIPAA, the 21st Century Cures Act Final Rule, the Confidentiality of Medical Information Act (CMIA), and the California Consumer Privacy Act (CCPA).

Given this existing framework, CMA had previously suggested striking Principle 8 completely. However, given the concerns raised by other members of the DxF Working Group, we are offering these edits to Principle #8. We are attempting to balance stating the need to enforce existing law, without adding new requirements on physicians and other providers:

> *Principle 8: Accountability: All entities participating in the collection, exchange, and use of health and human service information must act as responsible stewards of that information and be held accountable for any use or misuse of information other than for authorized purposes in accordance with state and federal law ~~and California's Data~~*

~~*Sharing Agreement and Data Exchange Framework policies.*~~

(**Rationale**: This final clause seems to indicate that the DSA will be creating new privacy requirements for data exchange, above state and federal law. As stated above, existing law has substantial safeguards in place for patient data.)

- ~~*All entities participating in the collection, exchange, and use of health and human service information should promote and improve data sharing practices so that we may gain greater insight into the needs of the people we serve and can better meet individuals' whole person care needs.*~~

  (**Rationale**: Gaining better insight into patients' needs is a laudable goal, but it doesn't appear to fit with the principle of "accountability.")

- *We should ~~establish policies enforcing~~ enforce existing laws (e.g., HIPAA, federal information blocking rules) and legal requirements that align with industry standards and stakeholder best practices, and that hold all data sharing participants accountable for safeguarding the collection, exchange, and use of health and human service data.*

  (**Rationale**: This suggested edit clarifies that the intent of the DxF is to enforce existing law, not create new requirements.)

- *Entities that collect, access and use health and human service data and the government organizations that oversee them must be accountable for enforcing legal protections of health information exchange for all Californians in accordance with state and federal law ~~and California Data Exchange Framework and Data Sharing Agreement policies.~~*

  (**Rationale**: See comments above regarding existing law and the Data Exchange Framework.)

- ~~*We must ensure reasonable legal and financial remedies to address breaches or violations are available.*~~

  (**Rationale**: We, as the DxF Working Group, do not need to ensure that there are legal and financial remedies in place; they already exist in state and federal law. This creates the impression that the Working Group will be creating new law, which is not the intent of AB 133.)