Manifest MEDEX

John Ohanian
Chief Data Officer and Director
Center for Data Insights and Innovation
California Health and Human Services Agency

Re: Opportunities to Address Health Information Infrastructure Gaps

Dear Director Ohanaian:

Manifest MedEx (MX), a statewide non-profit health data network in California, is honored to collaborate with you and our partners on the Data Exchange Framework Stakeholder Advisory Group. We share a vision of a healthier California for all enabled by data sharing. We are inspired by the proposals you shared to address the key infrastructure gaps that obstruct our shared vision.

While all four priorities your team outlined are compelling and urgent, we devote our comments here to *Opportunity #2: HIE On-Boarding Program, Qualified Networks and State Data Sharing Requirements*. We believe these initiatives are the headwaters for making progress on all other fronts: incenting all providers to adopt interoperable EHRs, fixing event notifications gaps across the delivery system, and building capacity within public health and human service organizations for robust data sharing with the health care community.

<u>Designating Qualified Information Exchange Intermediaries Is a Must</u>

We respect the intent of AB 133 to adhere to a Framework that is "technology agnostic." But the present reality of our information-poor environment stems from the opposite extreme: a dizzying array of data "sharing" options that are disparate, disconnected, and fragmented. As an example, if a primary care provider wanted to receive admit, discharge, transfer (ADT) alerts for <u>all</u> her patients' emergency department visits and hospitalizations, she might have to join multiple HIEs and also negotiate separate arrangements with scores of hospitals not participating in any of these networks. That is not a workable solution.

A designation approach for qualified health information exchange intermediaries can help solve this problem if four conditions are met:

1. Providers and plans should be able to join one qualified intermediary and receive all the data they need for their patients from that source. Likewise, they should get credit for meeting AB 133 data sharing requirements if they share all required data with one qualified intermediary.

2. Qualified intermediaries will aggregate data for their participating providers and plans to create usable longitudinal records for patients. This is a critical component for success. Providers can only improve the health and care of patients if they have access to patient data that has been unified, cleaned, and matched. Sharing of data without services that make that data usable and actionable does not provide the value that California hopes to gain from these initiatives.

3. Qualified intermediaries must share data with each other. This can be accomplished relatively simply, using existing frameworks:
    a. All qualified intermediaries must participate in eHealth Exchange/Carequality and respond to all treatment, payment, operations, patient access and public health queries on those networks. Currently most participants only respond to treatment queries.
    b. All qualified intermediaries must share ADT data (and potentially other real time data like ORUs) with each other for shared patients, potentially using the Patient Centered Data Home framework.

4. Any provider that does not join a qualified intermediary must meet the conditions of #3 directly by participating in national networks, responding to all treatment, payment operations, patient access and public health queries from qualified intermediaries on those networks, and sharing real time ADT data with all qualified intermediaries for shared patients.

A FHIR API data sharing approach is an intriguing alternative. However, as was discovered for the Trusted Exchange Framework and Common Agreement (TEFCA), this approach is not yet mature and adopted enough to support the dependable and ubiquitous data sharing we need today. We can certainly update the requirements over time as new data sharing alternatives reach the needed scale and adoption.

We recommend leveraging eHealth Exchange/Carequality as the designated network for CCDA query because it is already in wide use by California providers and heath information exchanges. California's CTEN is a trust framework but is not an operational data sharing network. Likewise, TEFCA is not yet established, and it is unclear what its adoption and use will be.

Applying these core tenets to our previous scenario means that an ambulatory provider using an HIE that is a qualified intermediary will receive event notifications from all California hospitals treating her patients, including from hospitals that use a different qualified intermediary. The provider can share data with that one qualified intermediary, knowing that her chosen intermediary will make that information available to providers and plans using other qualified intermediaries. This approach also offers a cost-effective and time-efficient blueprint for executing the Data Sharing Agreement: a provider or plan will comply simply by joining and sharing data with (or becoming) a qualified intermediary.

To designate qualified intermediaries, California can leverage the approach it used to qualify health information organizations for Cal-HOP, adding new requirements around sharing data with other qualified intermediaries and integrating and unifying both claims and clinical data to create usable longitudinal records.

The above concept, whereby providers and plans can select a single qualified intermediary as an onramp to exchange usable information statewide, is aligned and consistent with the approach the federal government is taking through TEFCA. However, we do not recommend adopting the TEFCA

agreement as the California Data Sharing Agreement as it will not require sharing of all critical types of data for all needed purposes outlined in AB 133. It is also still quite nascent—it has not yet been released or adopted.

Invest Public Dollars in Connecting Providers to Qualified Intermediaries—but Also Fund the Infrastructure for Data Usability

We completely agree with the premise of *Opportunity 2a*: the job of connecting providers to HIE is far from complete, especially for safety-net and small practices, behavioral health clinics, Medi-Cal plans and skilled nursing facilities. Moreover, HIEs have developed skills and capacity for this work through Cal-HOP. The program made remarkable strides despite a substantially delayed launch, the pandemic's disruption, and the resulting truncated implementation period.

In just over a year of implementation, California's HIEs earned nearly $24 million in 9-to-1 federally matched funds and connected hundreds of provider organizations across California. We have learned from and can now expand upon this experience.

There must be a successor to Cal-HOP, but it needs to be restructured into three pieces to meet the needs of California and the evolving federal funding landscape:

- DHCS should invest in a data sharing incentive program for Medi-Cal providers, copying the successful programs in the Inland Empire, Arizona, and Michigan. Under this program providers would receive incentives for joining and sharing required data with a qualified intermediary. The program could be funded through regular Medicaid FMAP, like in Arizona. Notably, Medicaid MES funding cannot be used to incentivize or pay providers, as was often done under "provider onboarding" programs funded by HITECH.

- DHCS should use Medicaid MES funding to pay for the technical work to connect Medi-Cal providers and plans to qualified intermediaries. If tied to a Medicaid business purpose such as care coordination, this source of 90-10 funding can pay the qualified intermediary costs to build data connections, onboard providers and plans to services, pull patient panels and integrate and match data. Once these functions are certified, MES funding can also be used for the ongoing costs of maintaining and upgrading data connections.

  This approach is aligned with the restrictions on MES funding discussed above and the distribution of effort to connect providers to qualified intermediaries. MX and other HIEs currently do the heavy lifting to connect to ambulatory EHRs. Our ambulatory providers pay no fees to MX or to their own vendors and do not need technical staff or capabilities to share data with MX.

- DHCS should also use MES funding to support the data infrastructure qualified intermediaries provide for aggregating, matching, cleaning and securely storing data from disparate sources to create usable longitudinal records. This infrastructure is critical to meet all the goals of CalAIM including population health management, coordinating care

for vulnerable patients, and improving healthcare quality. These qualified intermediary organizations also provide critical data governance functions and support needed bidirectional data sharing between public health (and other public entities) and clinical and health plan teams.

We call for a funding model that recognizes and supports the ongoing costs of this critical data curation and management infrastructure, jointly enabled by qualified intermediaries. These entities will gather, curate, and share unified health records needed by health care, public health, and human service organizations and by patients themselves. Qualified intermediaries require ongoing public investment to stand up and sustain this critical infrastructure.

This triad of programs, along with the process for designating qualified intermediaries, should be funded in the Governor's budget with an allocation of $100 million that will be generously matched with federal Medicaid resources.

In this letter we offer quite specific recommendations for establishing and funding these programs. That is not because there is only one way to implement them, but because the realities on the ground, success of other states and requirements of federal funding point to certain promising approaches.

Secretary Ghaly has reiterated that the Data Sharing Framework must uphold the usability of health information for all Californians. This means our definition of "data sharing" cannot end at the mere back-and-forth transfer of raw piecemeal throughput. Instead, it must encompass matching, cleaning, securing, attributing, and combining data—in other words, processing it as fuel for *insights* that not only support treatment, but drive whole-person care coordination, population health, better provider and member experience with health plans, care gap closure, and quality improvement.

Thank you for including us at your table for this exciting conversation. We applaud your team for developing these four flagship opportunities and will join all efforts to realize them through the Advisory Group discussions and the upcoming state budget cycle.

Sincerely,

Claudia Williams
Chief Executive Officer

CC: Dr. Mark Ghaly, Secretary, California Health and Human Services Agency