January 2, 2022

John Ohanian
Chief Data Officer
Director, Center for Data Insights and Innovation (CDII)
California Health and Human Services Agency (CalHHS)

Re: Achieving Health Equity Through the Qualified Health Information Organization (QHIO) Program

Dear John:

The California Association of Health Information Exchanges (CAHIE) urges CDII to revise its Core Concept #2 for the QHIO Program which states: QHIOs must be organizations incorporated in the United States with current data exchange customers in California.
Our HIE members include California's not-for-profit HIOs, who cover the breadth and depth of data-sharing needs from Los Angeles County and the Inland Empire to the Central Coast and North Central Valley. We serve on the DxF Implementation Advisory Committee and DSA Policies and P&P Subcommittee and our recommendations are informed by the most pressing challenges faced by our participant-stakeholders. An inclusive and equitable DxF must overcome the persistent digital disparities experienced by many groups required as signatories California's Data Sharing Agreement. This can be achieved through a QHIO program that assures those historically excluded from robust health data exchange, and the Californian's they serve, are not disproportionately left behind.

I. Health Equity as a Guiding Principle for QHIO Designation

We applaud CDII for recently adopting *equity*—"creat[ing] opportunities for all signatories to successfully participate in the DxF"—as a guiding principle for the QHIO Program. It is now incumbent on CDII and stakeholders to consider the implications of fully realizing the equity principle:

1. First, to serve all potential signatories, a QHIO clearly must support data exchange for all Required Purposes under the DSA.

2. Second—because CalHHS leaders have repeatedly framed the DxF/DSA as "building blocks" for advancing CalHHS' Guiding Principles and Strategies—a QHIO must be able to support these Required Purposes in that context**.** This means having both a mission and capability to support CalAIM and the rest of California's flagship health equity and quality initiatives.

II. California needs QHIOs to provide the Digital Safety Net for the DxF

This two-part notion of digital equity raises the stakes for a QHIO process that ensures California has a *baseline health data utility infrastructure*. It requires an ability to connect and support critical stakeholders within California's data sharing ecosystem for **CalAIM**. Specifically, these include health plans that require data cleaning and curation services, providers that are not connected to major EHR systems, and CBOs that are new yet crucial participants in data exchange. CDII must approach QHIO designation as an opportunity to create a digital data-sharing safety net for these CalAIM partners across the state.

III. National Networks Cannot Provide This Safety Net

The proposed **Core Concept #2**—that "*QHIOs must be organizations incorporated in the United States with current data exchange customers in California*"—undercuts the value proposition and participation levels that are necessary for a digital safety net to take hold and thrive. The draft concept is overly broad and (as one public commenter put it at the first IAC meeting) would "assure [California includes] the large established federated exchange networks within the definition of QHIOs—eHealth Exchange, CommonWell Health Alliance, Epic Care Everywhere, [and] DirectTrust."

Indeed, these types of intermediaries—which include for-profit, publicly traded or financed by venture capital, and national or multistate in their focus—have "current data exchange customers in California." Those customers tend to be concentrated among large and sophisticated health systems. Such entities are not the intended beneficiaries of the QHIO Program. Because no DSA signatory will be required to use a QHIO, but can use another technology vendor, those vendors should not be awarded QHIO status without achieving the entirety of requirements. To the extent national networks and commercial vendors can enable major health systems to share the data required for the DxF, they are already accounted for as allowable technologies under AB 133 and do not need to be designated as QHIOs to be used for compliance. Not every possible method of exchange needs to, nor should be, encompassed by the QHIO Program.

Through the DxF, CalHHS has an unprecedented opportunity to pursue **inclusive** and **equitable** access to health data exchange by setting a different benchmark for what a QHIO must demonstrate and support, beyond EHR-centric compliance for well-resourced providers. We encourage CalHHS to design and leverage QHIO designation to provide digital equity, with QHIOs as health data utilities inclusive of those historically excluded from data exchange, such as healthcare providers, health plans, Medicaid agencies, and public health departments towards the broader success of California's ambitious health quality, equity, and transformation agenda.

Achieving digital equity for health plans requires key QHIO capabilities

To illustrate one crucial example: it greatly matters for CalHHS' goals *how successful health plans are* in getting the information they need to improve health equity, population health, and quality outcomes. California's managed care system is on track to oversee care for over 90 percent of Medi-Cal enrollees. CalAIM and the DHCS Comprehensive Quality Strategy will further ramp up plans' need to use digital health data to inform care coordination, equity, and quality. The plans must *be given access to* timely and complete clinical data from providers for care coordination, quality improvement (e.g., HEDIS reporting and care gap closure), and population health management—all of which fall within the "Health Care Operations" subcategory of Required Purposes under the DSA.

California HIOs are uniquely positioned to provide a balanced and equitable data sharing approach inclusive of all segments of the population regardless of coverages and have honed their mission and capabilities to serve the whole population. Key attributes of California HIOs that support QHIO equity criteria include:

- CA HIOs have the distinctive ability to aggregate and present SDOH data which is varied and temporal
- CA HIOs can uniquely present SDOH with real time clinical data or public health data
- California HIOs serve public health, mental health, substance use disorder services, counties, small practices and the largest health systems, as well as deliver SDOH and SOGI.
- CA HIOs are community focused and governed by its local participants, recognizing that community level collaboration and direction is critical
- CA HIOS are best suited to tailor programs and services with a community orientation
- CA HIOs minimize the challenges associated the federated health care delivery system at the national and state levels
- CA HIOs are the only entities serving both the Health and Human services organization which are siloed due to government organizational and funding structures
- CA HIOs capabilities are not limited to clinical data and have the ability to clean, curate, match, manage and process all types of data to achieve health equity

As we summarize below, national networks and for-profit vendors *do not come close* to meeting the data exchange, quality, or governance needs of health plans and other CalAIM partners as reflected in CalHHS' strategic priorities and investments.

National networks cannot deliver these capabilities

Health plans *cannot* use national networks to obtain needed clinical data for health plan payment and operations purposes because the providers participating in those networks typically only respond to treatment queries from other providers, and not to payment and operations queries from payers. National networks also struggle with appropriate levels of patient matching.

The limitation also applies in the other direction. Plans cannot use national networks to make non-clinical administrative data—such as claims, encounters, and medication fills—visible to providers in ways that could provide important insights into their patients' needs.

Lastly, national networks only allow participants to look up single patient clinical records. They do not support the data aggregation, cleaning, matching or analysis that plans need to make data useful for identifying high-risk patients, measuring and improving quality, or implementing value-based payment models—such as CalAIM, DMHC's Health Equity and Quality measures, and Covered California's Quality Transformation Initiative.

IV. For-profit or non-California-focused enterprises are a poor fit for QHIOs

Every QHIO should *at a minimum* commit to CalHHS' vision to enable the exchange of health and social service information across our state's communities in a manner that improves and enhances the health and wellbeing of Californians. For-profit vendors do not possess the transparent governance or public service orientation required for public trust in this pivotal role. Their decisions are consistently motivated by shareholder demands and other commercial interests that may conflict with or impede the state's transformation agenda. And while some national networks are nonprofit, they follow their

governance processes based on national policymaking with no clear mechanism to accommodate our state's requirements, concerns or priorities.

V. California's non-profit HIOs have missions and capabilities to be QHIOs

California is well established in pursuing health and social transformations like CalAIM that are rooted in whole-person care. Rather than setting the stage for safety-net providers to migrate toward national networks and for-profit vendors, for which the state has no governance stake, CDII must develop a set of essential organizational criteria for QHIOs—namely **being California-based, mission-driven, and non-profit, community governed.**

California's HIOs *do* specialize in the data management and curation to help health plans meet population-level objectives. We connect, clean and aggregate clinical and administrative health records to support both providers and health plans in treatment, care coordination, population health, and quality improvement. We are vital to helping transmit and integrate claims and encounter data into providers' patient care workflows. And we already connect many social, behavioral, and public health stakeholders and continue to grow that connectivity in support of healthier communities.

CAHIE's HIO members have shown the ability and determination to serve these key DSA Participants for CalAIM and other health quality and equity initiatives. Therefore, focusing the QHIO designation process on California's HIOs helps foster the growth of a digital safety net. We respectfully ask CDII to revise Core Concept #2 to reflect this standard.

Sincerely,

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