CHCF DATA EXCHANGE EXPLAINER SERIES

APRIL 2022

by Karen Ostrowski, MBA; Rachel Goldberg, MPH, and Mark Elson, PhD

Governance Structures for Statewide Data Exchange in California

California Data Exchange Framework. Assembly Bill 133 (AB 133) mandates data sharing for most health care providers beginning in January 2024, requiring a finalized, signed data sharing agreement by January 2023. It also charges California Health and Human Services (CalHHS), together with a robust stakeholder advisory group, to identify a governance structure to guide policy decisions and oversee a Data Exchange Framework for California. The legislation provides a tremendous opportunity for the state to design an effective decisionmaking and regulatory body, embedded in statute, with transparent and conflict-free decisionmaking, and backed by funding sufficient to empower meaningful data exchange. This fact sheet highlights approaches to governance adopted by policymakers for other California executive branch organizations and health information exchange entities in other states. Essential principles for governance are outlined in Table 1.

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Table 1. Essential Principles for Statewide Data Exchange Governance

	**Authority Grounded in Statute** Legislation embedded in statute establishes the authority and responsibilities of the governing body or bodies.
	**Clear Decision Rights and Accountability** Statute defines a leadership role for state government, with the ability to craft policy and regulation (including to hold stakeholders accountable) and tap into federal and state resources.
	**Multistakeholder Participation** Mechanisms allow for broad and balanced stakeholder participation; interested parties can bring their expertise and perspectives.
	**Open and Transparent Processes** Regular and open public deliberation gives stakeholders access to decisionmakers and increases public understanding of how and why decisions are made.
	**Shared Appointing Authority with Conflict of Interest Protections** Statutory role for legislative and executive branches to appoint governing body members who serve the public interest and are free from financial conflicts of interest.

Background. More than a decade after the state received $38 million in federal funding for health information exchange implementation under the HITECH (Health Information Technology for Economic and Clinical Health) Act, California's systems of data exchange remain highly fragmented. Unlike many other states, California chose early on to allow stakeholders to govern themselves, providing grants and guidance for interoperability efforts rather than direct management. Regional health information exchange organizations (HIOs) have effective local governance models that include data sharing agreements and policies. However, they operate independently from one another and participation is voluntary, leading to suboptimal alignement and scale at the state level. National networks also play an important role in much of the state, especially among some provider organizations such as large hospital systems. However, without a statutory role for state government and durable state-level governance, California lacks the means to shape the data exchange landscape to address key gaps and support state data sharing policies and priorities.

Considerations for successful governance for statewide data exchange in California. Stakeholder interviews across California and the recent CHCF publication ***Designing a Statewide Health Data Network: What California Can Learn from Other States*** indicate that effective governance entities can advance policy and priorities, encourage participation through rulemaking authority, and access federal funding on behalf of participants in the state's data exchange networks. Effective governance relies on a set of essential principles (Table 1).

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Principles at play in statewide HIE governance. These essential principles are represented in the governance design of current California executive branch organizations (Table 2) and aspects of HIE governance established in states outside of California (Table 3). These examples vary in the degree of alignment with the essential principles and provide a range of options for the state and its advisory group to consider in crafting the optimal approach to move California beyond its decentralized data exchange landscape.

Table 2. California Governance Models

AUTHORITY GROUNDED IN STATUTE	CLEAR DECISION RIGHTS AND ACCOUNTABILITY	MULTISTAKEHOLDER PARTICIPATION	OPEN AND TRANSPARENT PROCESSES	SHARED APPOINTING AUTHORITY WITH CONFLICT OF INTEREST PROTECTIONS
Covered California (Government Code § 100500 et seq.)				
Statute delegates authority to a small (5-member) quasi- independent public entity with a governing board appointed by the executive and legislative branches.	Statute establishes governing board as responsible for all decisionmaking, including appointment of executive director to manage day-to-day operations.	Stakeholders participate directly with the governing board at public meetings and via subcommittees and workgroups.	As a public entity, Covered California is subject to the Bagley-Keene Open Meeting Act (all meetings are open to the public with statutorily required advance notice), with some limited ability to enter closed session on contracting and rate-setting matters.	Governor and legislature share appointments to governing board; two gubernatorial appointees, one Senate Rules Committee appointee, one Assembly Speaker appointee, and a voting ex-officio member, the Secretary of Health and Human Services. Statute describes intended characteristics of appointees. Conflict of interest provisions, intended to prevent self-dealing, prohibit appointing members who work in certain health care sectors and have direct or indirect economic interests. All are also subject to a one-year ban on contracting with the exchange after serving as a board member.
Commission on Emergency Medical Services (Health and Safety Codes § 1999.56 and § 1797.105)				
Statute establishes a 19-member stakeholder commission.	Statute grants the commission the authority to review and approve "regulations, standards, and guidelines" developed by the California Emergency Medical Services Authority (a department within CalHHS) and authorizes the commission to conduct appeals of EMSA determinations related to local EMS plans.	Statute specifies the types of stakeholders and interest groups to be appointed to the commission. Two of the 19 members are designated as "public members."	Commission is subject to the Bagley-Keene Open Meeting Act (all meetings open to the public with statutorily required advance notice).	Commission members are appointed jointly by the governor and legislature. The governor appoints the EMSA director. Confirmed by the senate, the director is responsible for day-to-day management, and reports to the CalHHS secretary. California financial conflict of interest prohibitions apply to the EMSA director and CalHHS secretary.
Data Exchange Framework Stakeholder Advisory Group (governance option reviewed at March 3, 2022 meeting)*				
Need for statute not specified.	"CDII [Center for Data Insights and Innovation], as an Office within CalHHS, would oversee implementation of the Data Sharing Agreement and enforce policies and procedures (P&Ps) and requirements for entities subject to AB 133's data sharing mandate."	A stakeholder advisory group tasked with making "recommendations to CDII director for consideration" to be appointed by CalHHS. A CalHHS departmental advisory group comprising representatives from across CalHHS is to be convened by CDII.	Advisory groups and subcommittees subject to open meeting rules (e.g., Bagley-Keene).	Represented stakeholders may be organizations with direct interests in data exchange, subject matter experts, advocates and consumers, or some combination.

* ***Data Exchange Framework Stakeholder Advisory Group Meeting #6*** (PDF), California Health & Human Services Agency meeting, March 3, 2022.

Table 3. Examples of Health Data Exchange Governace Structure from Outside of California

AUTHORITY GROUNDED IN STATUTE	CLEAR DECISION RIGHTS AND ACCOUNTABILITY	MULTISTAKEHOLDER PARTICIPATION	OPEN AND TRANSPARENT PROCESSES	SHARED APPOINTING AUTHORITY WITH CONFLICT OF INTEREST PROVISIONS
Michigan				
In 2006, Michigan law established the Michigan Health Information Technology Commission (HITC), which created and oversees the Michigan Health Information Network (MiHIN), a 501(c)(3) that contracts with the state to provide HIE services.	The Michigan Department of Health and Human Services participates on HITC, manages the grants and contracts it awards to MiHIN, and requires health plans to give incentives to providers to participate in data exchange activities.	Statute identified 13 public and private members that advise on policy and priorities for MiHIN. MiHIN has a 20-member board of directors, consisting of state officials and network participants, that oversees operations.	HITC convenes public meetings, posts meeting materials and reports on its website, and offers regular public comment periods.	State governor appoints commissioners.
Maryland				
Statute designated the Maryland Health Care Commission (MHCC), an independent regulatory agency, to identify and establish a health data network organization to coordinate statewide data exchange. The Chesapeake Regional Information System for our Patients (CRISP) was established as the state-designated entity in response to an RFP.	MHCC's policy board has oversight for and advises on statewide health data network activities. MHCC requires all health care payers to submit claims data to Maryland's all-payer claims database; the claims are integrated with clinical records through CRISP.	A 15-member multi-stakeholder advisory group governs MHCC. CRISP has its own 24-person board of directors, a board of advisors, and five advisory committees to provide guidance and input.	Commission and HIE policy board meetings are open to the public, and materials are posted on the website.	The governor appoints 15 commissioners to govern MHCC, with advice and consent from the Maryland senate.
New York				
Statute grants regulatory and oversight authority to the New York State Department of Health (NYSDOH), which established the Statewide Health Information Network for New York (SHIN-NY).	NYSDOH relies upon the New York eHealth Collaborative (NYeC), a 501(c)(3), to assist with governance of the network and contracting with Qualified Entities (QEs). State regulation requires that certain providers connect and exchange data with QEs and SHIN-NY, and incentives are available to help offset providers' costs of connecting to the network.	NYeC is governed by a 16-person board of directors with representation from different sectors of the health care industry. In partnership with NYSDOH, NYeC convenes several committees of representative stakeholders with an interest in health information exchange via SHIN-NY.	SHIN-NY is governed by an open and transparent process, known as the Statewide Collaborative Process, that brings together stakeholders for input and expertise on SHIN-NY implementation, policy, and technical standards.	NYeC appoints its own board of directors.

About the Author

Karen Ostrowski, MBA, vice president of policy innovation at Intrepid Ascent, developed this fact sheet with Rachel Goldberg, MPH, and Mark Elson, PhD. **Intrepid Ascent** supports communities in the exchange and use of data to improve health.

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The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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