CHCF DATA EXCHANGE EXPLAINER SERIES

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Incentives for Participation in California's Data Exchange

Background. Data exchange in California has yet to approach its full potential, with participation concentrated in specific networks and communities and limited to specific data types. Financial and regulatory incentives that could drive broader participation are not aligned across organizations in California or do not currently exist. Other states, however, have demonstrated that exercising a coordinated and multifaceted strategy to incentivize data exchange can alter the trajectory of adoption.[1] Assembly Bill 133, passed in July 2021, presents an opportunity for policymakers to take a comprehensive approach to encouraging data exchange in California. This fact sheet highlights top approaches that other states have taken to incentivize participation in data exchange as described in the paper ***Expanding Payer and Provider Participation in Data Exchange: Options for California*** and highlights opportunities for California to do the same.

California's Data Exchange Framework. AB133 establishes a mandate for data sharing for most health care providers beginning in January 2024, with the requirement to sign the finalized data sharing agreement by January 2023. Experiences in other states demonstrate that a broadly defined mandate alone will not be sufficient to achieve ubiquitous participation in data exchange.

Considerations for successfully incentivizing data exchange in California. States have used a series of approaches to drive broad adoption of data exchange (see Table 1). Their experiences suggest that using these approaches in an orchestrated fashion — with a governing entity at the controls — can successfully drive data exchange adoption.

Table 1. Approaches to Advancing Data Exchange

	**Advisory Councils** Advisory groups that include both state officials and members of the public lend diverse and relevant experience to state decisionmaking organizations.
	**Industry-Led Quality Collaboratives** Industry collaboratives incentivize data exchange adoption when they incorporate data exchange into their broader measure sets.
	**State Contracting** State agencies may use their purchasing power to promote and require data exchange through state contracts.
	**State Regulations and Rulemaking** State agencies and regulators may promulgate rules requiring or promoting data exchange.
	**Executive Orders by the Governor** Governors have authority to direct state regulatory agencies and purchasers to advance data exchange.
	**State Legislative Activity** State legislatures have authority to require data exchange via legislation.
	**Funding for Data Exchange Infrastructure and Service Development** Funding enables organizations to invest in data exchange infrastructure when cost is a significant barrier.

Table 2 outlines the pros and cons of adopting each approach to incentivize participation in health information exchange (HIE) as well as opportunities for the Data Exchange Framework of the California Health and Human Services Agency (CalHHS) to improve upon California's existing efforts.

Table 2. Approaches to Advancing Data Exchange: Pros, Cons, and Implications for California

APPROACH / PROS AND CONS	CALIFORNIA EXAMPLES	KEY OPPORTUNITIES
ADVISORY COUNCILS **Pros.** Can garner broad stakeholder input and support for prioritizing, shaping, and revising state policies on data exchange, and can also provide an avenue for stakeholder oversight of state-led data exchange programs and initiatives. **Cons.** Without policymaking or enforcement authority, an advisory council's recommendations cannot compel industry participants to act.	**The Data Exchange Framework (DxF) Stakeholder Advisory Group.** A diverse group of representatives providing input to recommendations by the state by April 2022. It sets the stage for future data exchange regulation, legislation, and programs. **The California Association of HIEs (CAHIE).** A nonprofit coordinator of HIE stakeholders, including state agency participation, it has no special designation from the state or any role shaping state policy or administration.	Create a permanent advisory body, similar to the DxF Stakeholder Advisory Group or CAHIE, designated to inform state action on data exchange.
INDUSTRY-LED QUALITY COLLABORATIVES **Pros.** Collaboratives allow industry stakeholders to jointly develop programs that align care delivery and data exchange participation with payment incentives. **Cons.** Collaboratives are typically voluntary and cannot compel participation; they do not typically reach all relevant stakeholders.	**The Integrated Healthcare Association's "Align. Measure. Perform."** A commercial health maintenance organization program that covers health plans and providers serving 13 million Californians, with an industry-curated measure set that tracks the quality, resource use, and cost measures that have the biggest impact on care outcomes. **The Purchaser Business Group on Health's "California Quality Collaborative."** Helps participating purchasers to set policies and contracts with their carriers. Supports care redesign and works in the delivery system to improve quality and value.	Reach out to existing collaboratives to drive — and benefit from — stakeholder data exchange participation aligned with the Data Exchange Framework.
STATE CONTRACTING **Pros.** A contract is an agreement voluntarily entered into by two or more parties. Health plans and providers are accustomed to receiving direction through state contracts. Contracts offer the state the opportunity to assure uniform implementation and provide the ability to increase performance standards over time. **Cons.** State purchasers must enforce contractual requirements to ensure they are effective, which can be difficult and carries some risks. Health plans may elect to forego participation in state-sponsored programs rather than comply.	**DHCS Medi-Cal Managed Care Contracts.** Represent a state contracting mechanism with potential to drive HIE adoption, including through initiatives such as CalAIM (California Advancing and Innovating Medi-Cal). Generally, the public purchasers (DHCS, Covered California, California Public Employees' Retirement System) represent 40% of the state's contracting power and can incorporate requirements for data exchange participation into contracts.	Partner with public purchasers to ensure that contracts include data exchange participation aligned with the Data Exchange Framework.

Table 2. Approaches to Advancing Data Exchange: Pros, Cons, and Implications for California, *continued*

APPROACH / PROS AND CONS	CALIFORNIA EXAMPLES	KEY OPPORTUNITIES
STATE REGULATION AND RULEMAKING **Pros.** Regulatory rulemaking tasks state entities with outlining how a statute will be implemented and would allow state agencies to consider aspects of interoperability most critical to their goals and priorities and to tailor requirements accordingly. It is a transparent process with opportunities for public participation. **Cons.** The regulatory process is slow. Rapid implementation schedules usually require that policymakers grant an "emergency exemption" to the rulemaking process. Such exemptions restrict public comment. Regulations once adopted are slow to amend.	California state agencies have used rulemaking authority to require electronic reporting of health information to the state, such as communicable diseases and immunizations.	Leverage state agencies' rulemaking authority to require that electronic data, such as COVID-19 vaccination status, are provided to the state and made available to providers through standard industry data exchange best practices aligned with the Data Exchange Framework.
EXECUTIVE ORDERS BY THE GOVERNOR **Pros.** A governor's executive order can direct the activities of state entities within the executive branch to encourage participation in HIE. An executive order can be done quickly, requiring only the governor's signature. **Cons.** An executive order, which can be developed without broad stakeholder input, may face resistance from those it impacts. Executive orders may invite, but do not have the power to compel, actions of the private sector or local governments. These orders can be rescinded or ignored by subsequent administrations.	In 2007, Governor Arnold Schwarzenegger issued an executive order calling for "100% electronic health data exchange" within 10 years. The order identifies key actions, including providing state leadership, taking advantage of the state's purchasing power, developing a quality reporting mechanism through the Office of the Patient Advocate, and strengthening the ability of the Office of Statewide Health Planning and Development to collect, integrate, and distribute data.[2] There have been no recent executive orders issued on data exchange.	The process for stakeholder input and CalHHS recommendations to the legislature established by AB 133 provides a pathway for future legislation; an executive order presents a fallback option for the administration to consider if this process fails.
STATE LEGISLATIVE ACTIVITY **Pros.** Legislation passed by the legislature and enacted by the governor creates a code of conduct or action that is binding or enforceable. Statute is very durable; any changes or modifications require amendment via a subsequent piece of legislation. The enactment of laws is a public process and points of influence are broadly understood. Statutes often leave the most nuanced and controversial topics to be worked out via the regulatory process. Legislation can allocate public resources to a project or goal. **Cons.** If legislation is not accompanied by a meaningful, enforceable incentive or penalty, it will likely not have a significant or immediate impact on the market.	**AB 133** included data exchange legislation that required the creation of a Data Exchange Framework for California and mandates for participation. While it leaves major questions to be decided as part of the development of the framework, it created a process for the legislature to receive input from stakeholders and CalHHS that it may consider for future legislation.	Propose legislation that would realize the implementation of the Data Exchange Framework, including setting up a governance structure at the state with formal relationships with purchasers and the delivery system to continue to refine and amend policies and legislation.
STATE FUNDING FOR DATA EXCHANGE INFRASTRUCTURE AND SERVICE DEVELOPMENT **Pros.** State resources can help providers overcome the interoperability cost barrier via grants, performance-based contracts, matching funds, or other financial mechanisms. These funds would be included in the state budget and require legislative approval and governor's signature. **Cons.** One-time funding does not address sustainability. If data sharing networks fail to demonstrate value, participation will stall and lessen over time.	**The California HIE Onboarding Program (CalHOP).** Administered and funded by the California Department of Health Care Services (DHCS) (2019–21), CalHOP provided $50 million in funding for hospitals and ambulatory providers to onboard qualified health information organizations (HIOs).	Commit state funding to drive data exchange participation; leverage federal match wherever possible. Develop a sustainability plan that includes financial participation from the commercial sector and participants.

Designing and implementing data exchange incentives. The paper *Expanding Payer and Provider Participation in Data Exchange: Options for California*[3] presents the experiences of five states — Florida, Maryland, Michigan, Minnesota, and North Carolina — and their efforts to incentivize data exchange. The experiences of these states suggest that a comprehensive strategy that integrates multiple approaches to driving data exchange adoption is more effective than employing any one initiative in isolation.

Successful strategies from Michigan and North Carolina are outlined below. Both states implemented a comprehensive strategy to data exchange adoption through mutually reinforcing approaches that included mandates (whether legislative or through rulemaking), a governance mechanism for oversight and enforcement, funding, contracting, and aligned collaboratives. Table 3 shows this mix of incentive approaches, as well as each state's HIE model. In California, AB 133 provides the state with the opportunity to pursue a similarly coherent strategy, one that leverages multiple approaches to driving data exchange while also acknowledging California's size and diversity, existing data sharing infrastructure, and local delivery system objectives.

Table 3. A Comparison of Data Exchange Models and Approaches in Michigan and North Carolina

	MICHIGAN	NORTH CAROLINA
State Data Exchange Model	Regional HIOs connected by the Michigan Health Information Network (MiHIN).	A single state-designated HIO, NC HealthConnex.
Public-Private Advisory Council	The Michigan Health Information Technology Commission serves as an advisory body for advancing HIE in the state.	The North Carolina Health Information Exchange Authority (NC HIEA) administers the HIE Act and oversees NC HealthConnex.
Industry-Led Quality Collaboratives	Hospitals participating in a Blue Cross quality collaborative receive points toward pay-for-performance bonuses for meeting the HIE quality measures based upon data exchange with MiHIN.	Voluntary admission, discharge, and transfer initiatives in Medicaid and State Health Plan.
State Contracting	Medicaid managed care contracts require contracted health plans to actively participate in MiHIN and to incentivize their provider networks to connect with qualified HIE organizations.	Blue Cross Blue Shield of North Carolina rejects all State Health Plan claims received from providers not compliant with the HIE Act.
State Regulation and Rulemaking	Medicaid requires managed care organizations to incentivize provider participation in state HIOs.	N/A
Executive Order by Governor	N/A	N/A
State Legislative Activity	N/A	The statewide HIE Act required 98% of providers to connect to the state-designated HIE, NC HealthConnex, by 2020 or lose payments for state-funded health care services.
State Funding for Data Exchange Infrastructure and Service Development	MiHIN is funded through state contracts, subscription fees from regional HIOs, and contributions from payers.	No fee for organizations to connect to NC HealthConnex. NC HIEA and NC HealthConnex are funded by the state through a $9 million annual allocation from the general assembly, with an initial allocation of $45 million from state and federal funding in 2017.

Note: N/A is not applicable.

About the Author

Mark Elson, PhD, CEO of Intrepid Ascent, developed this fact sheet with Alexandra Milutin, MHA , and other members of his team. **Intrepid Ascent** supports communities in the exchange and use of data to improve health.

About the Foundation

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.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. ***Expanding Payer and Provider Participation in Data Exchange: Options for California***, California Health Care Foundation (CHCF), November 2019.
2. ***A Timeline of Health Data Exchange in California***, CHCF, July 2021.
3. *Expanding Payer*, CHCF.