Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

NOTICE OF PUBLIC MEETING

Data Exchange Framework (DxF) Stakeholder Advisory Committee Meeting #4

October 15, 2026
Draft Meeting Minutes

DxF Stakeholder Advisory Committee Voting Members Attending In-Person: Dr. Jennifer Sayles, PopHealth Learning Center (Chair); Joan Allen, SEIU UHW; William Barcellona, America's Physician Groups; Colleen Chawla, San Mateo County Health; David Ford, CMA Physician Services Organization; Aaron Goodale, MedPOINT Management; Katie Heidorn, California Health Care Foundation (Vice Chair); Andrew Kiefer, Blue Shield of California; Ali Modaressi, LANES; Lucy Saenz, California Primary Care Association; Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN); Lee Tien, Electronic Frontier Foundation.

DxF Stakeholder Advisory Committee Ex Officio Members Attending In-Person: Amanda Levy, California Department of Managed Health Care (DMHC); Charles Raya on behalf of Taylor Priestley, Covered California; Shannon Rohall, California Department of Social Services (DSS); Jared Shinabery, California Public Employees' Retirement System (CalPERS); Joe Sullivan, California Emergency Medical Services Authority (EMSA).

Attending Virtually: Dr. Scott MacDonald, UC Davis Health; Eric Nielson, County Welfare Directors Association of California (CWDA); Mark Savage, Savage & Savage LLC; Yvonne Choong, California Association of Health Facilities; Sophia Chang on behalf of Rebecca Fisher, California Department of Public Health (CDPH); Dr. Linette T. Scott, California Department of Health Care Services (DHCS).

Members Not in Attendance: Julie Silas, Homebase; Ann M. Nakamura, California Department of Developmental Services (DDS); Janna Lowder-Blanco, California Department of State Hospitals (DSH); Elizabeth Basnett (EMSA). Rebecca Fisher and Taylor Priestley were represented by the alternates listed above.

Presenters: Michael Valle, Assistant Director, HCAI; Jacob Parkinson, DxF Program Director, HCAI; Dr. Jennifer Sayles, CEO, PopHealth Learning Center (Chair); Katie Heidorn, Director, State Health Policy, California Health Care Foundation (Vice Chair); Athena Chapman, President, Chapman Consulting.

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Public Attendance: A total of 58 public attendees.

Agenda Item I: Welcome and Introductions
Jennifer Sayles, MD, MPH, Committee Chair
Dr. Jennifer Sayles, Committee Chair, called the meeting to order, welcomed advisory committee members and members of the public, and conducted a roll call of voting and ex officio members. A quorum was established. Meeting participation procedures and opportunities for public comment were reviewed.

Dr. Sayles asked for a motion to approve the minutes from the August 20, 2026, DxF Stakeholder Advisory Committee meeting. Lucy Saenz, California Primary Care Association, moved to approve the minutes, and Kiran Savage-Sangwan, CPEHN, seconded the motion. Committee discussion and public comment were invited before a roll-call vote.

The following members voted to approve the August 20, 2026, meeting minutes: Dr. Jennifer Sayles (Chair), Joan Allen, William Barcellona, Colleen Chawla, Yvonne Choong, Aaron Goodale, Katie Heidorn, Andrew Kiefer, Dr. Scott MacDonald, Ali Modaressi, Eric Nielson, Lucy Saenz, Mark Savage, Kiran Savage-Sangwan, and Lee Tien. David Ford abstained. Julie Silas was absent from voting.

The motion to approve the August 20, 2026, meeting minutes carried by a vote of 15 in favor, none opposed, and one abstention.

Questions and comments from the committee:
There were no substantive questions or comments on the minutes from the advisory committee.

Public comment:
A member of the public asked about virtual participation and the ability to appear on video. Staff clarified that public attendees could not enable video.

Agenda Item II: Department Updates
Michael Valle, Assistant Director
Michael Valle, Assistant Director, provided updates on behalf of Director Elizabeth Landsberg. He reviewed HCAI's support for financially distressed hospitals, including $25 million distributed to four nonprofit hospital facilities through the 2026 Distressed Hospital Small Grant Program. He also described additional hospital grant funding in the 2026–2027 state budget, including an initial $85 million and the option for a further $50

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

million. Applications are due November 9, with award determinations anticipated in December.

Mr. Valle described work to establish a health care access stability unit supported by a $10 million appropriation. Its work would include assessing hospitals' strategic importance, planning for continuity of critical services, and providing technical assistance. HCAI was reviewing stakeholder survey responses to inform this work.

Mr. Valle also reviewed California's implementation of the federal Rural Health Transformation Program, including the state's $233.6 million first-year award. He described initiatives addressing care models, workforce development, and technology and tools, including electronic health record (EHR) modernization and a Tribal health set-aside. Demand exceeded available funding, and HCAI was finalizing first-year awards while preparing for the second budget period. The next Rural Health Policy Council meeting was scheduled for October 27, 2027.

Mr. Valle announced that Director Landsberg had appointed Katie Heidorn as Committee Vice Chair. Ms. Heidorn would preside during the afternoon following Dr. Sayles's departure.

Questions and comments from the committee:
A committee member asked whether federal funding included unusual terms or conditions. Mr. Valle noted that HCAI was working through federal requirements and did not anticipate substantial impacts on the submitted projects. He offered to share additional information as it became available.

Public comment:
A member of the public raised concerns about hospital loan forgiveness and changes to related legislation affecting a Fresno-area hospital.

Agenda Item III: HCAI DxF Program and Participant Verification Updates
Michael Valle, Assistant Director
Jacob Parkinson, DxF Program Director
Mr. Valle reviewed the committee's work plan and the July 1, 2027, legislative report deadline. He noted that recommendations on individual-level demographic and health-related social needs (HRSN) data had an earlier publication deadline of January 1, 2027. He introduced public accountability and enforcement as an additional discussion

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

area and encouraged members to consider implementation costs and unintended consequences.

Jacob Parkinson, DxF Program Director, reviewed Participant Verification and proposed policy changes intended to address trust in exchange. Under the proposed approach, Participants could choose whether to exchange with signatories undergoing verification. Verification would establish whether an organization was a legitimate health or social services organization, government agency, or supporting vendor. HCAI planned to refine the procedure, identify verification status in the signatory list and Participant Directory, and release related Policy and Procedure amendments for public comment.

Mr. Parkinson announced the selection of 17 members for the 2026 Standards Workgroup, which would advise on a roadmap for Fast Healthcare Interoperability Resources (FHIR) adoption. Topics would include priorities, adoption strategies, cost mitigation, transition from legacy approaches, and implementation timing. Six public meetings were planned beginning October 28, 2027, and concluding in February, with advice expected to return to the Advisory Committee in spring 2027. Advisory Committee members were advised that they could observe or view recordings but should not participate in the workgroup's public comment or question-and-answer periods because of Bagley-Keene open-meeting concerns.

Questions and comments from the committee:
Members asked whether the proposed change to exchange obligations was already in effect and whether HCAI was monitoring its impact. Mr. Parkinson clarified that verification was already being applied to new signatories, while verification of previously enrolled signatories remained to be completed. One signatory had been identified publicly as non-verified. Amendments clarifying exchange obligations were still forthcoming.

Public comment:
A member of the public described being denied services after declining to sign a release of information and raised concerns about patient choice.

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Agenda Item IV: Qualified Health Information Organization (QHIO) Program Evolution: Recommendation Determination
Jacob Parkinson, DxF Program Director
Mr. Parkinson reviewed the QHIO Program's goals of supporting statewide exchange of health and social services information and helping Participants meet DxF requirements. He recapped concerns regarding sustainability, reciprocity, voluntary adoption, service gaps, trust, and oversight, along with the committee's August feedback.

Mr. Parkinson explained the three DxF exchange types: Request for Information, Event Notification, and Information Delivery. He distinguished requests for an individual's information, hospital and emergency department event notifications based on patient rosters, and delivery of information associated with orders or referrals. He described differences in support for these services across QHIOs, national networks, and other intermediaries.

The first proposal would establish minimum operating thresholds for full-service QHIOs for Request for Information and Event Notification. Full-service QHIOs would continue to support Information Delivery without a minimum threshold for that exchange type. Illustrative thresholds included serving 25 Participants for requests and obtaining events from 15 event-source Participants. HCAI estimated that four of eight current QHIOs might meet those examples, while emphasizing that the thresholds were not final and the available data had limitations.

The second proposal would establish a Recognized Specialist program for organizations supporting particular exchange types. Specialists would meet applicable operating, privacy, security, and pricing requirements and exchange with QHIOs and other Specialists without charging those intermediaries. Mr. Parkinson used event notifications to illustrate how recognition could connect existing services to broader statewide exchange. Participants using a Specialist would remain responsible for arranging other required exchange services.

Mr. Parkinson also introduced proposals concerning required use of designated exchange services and pricing transparency. A required-use approach could include QHIOs, Recognized Specialists, and nationwide networks, depending on the exchange type, and would require legislation. The pricing proposal would require QHIOs and any Recognized Specialists to publish service prices.

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Questions and comments from the committee:
Members discussed the original network-of-networks model and the intended value of obtaining broad access through one connection. Members emphasized the importance of supporting existing trusted relationships, reducing duplicate connections and reconciliation work, and maintaining a sustainable model for both large and small organizations. Several members questioned whether specialization could leave essential full-service capabilities underfunded, while others recognized its potential to bring additional data into the network minimize burden for organizations using intermediaries outside of the program.

Members asked how thresholds would demonstrate meaningful capability and how they could affect Participants using QHIOs that might not qualify under new criteria. Staff shared preliminary Participant Directory estimates that approximately 1 percent of acute care settings used a potentially affected QHIO for Event Notification and approximately 5 percent of Participants used one for Request for Information. Members emphasized the limitations of Directory information and the need to assess service quality, coverage, and actual exchange.

Members discussed population-level exchange, unsolicited information, and longitudinal care coordination. They requested clearer descriptions of the relationship between individual requests, panel-level workflows, Information Delivery, and permitted or required exchange purposes. HCAI clarified existing exchange pathways under the DxF and how those may or may not support the described population health use case, noting that additional exchange purposes may need to be considered

Members also raised privacy and cybersecurity concerns, including ransomware, evolving technologies, and the resources required to maintain safeguards. HCAI referenced existing QHIO security requirements, including HITRUST r2 certification and keeping data within the United States. Members suggested considering security capability alongside operating thresholds and recognizing its ongoing costs.

A member representing community health centers described health center experience with implementation, participation fees, interfaces, EHR configuration, staffing, and maintenance. The member relayed examples from limited survey responses of monthly QHIO fees ranging from below $10,000 to approximately $50,000. The member

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

emphasized that external portals, manual retrieval, and referral-management work could limit the value of connectivity without additional operational support.

A member representing physician practices described costs and implementation barriers for independent practices, including setup, EHR connections, security assessments, compliance work, and staff time. The member reported first-year budgeting ranges of approximately $5,000 to $23,000 for a solo physician, $10,000 to $36,000 for practices with two to five physicians, and $15,000 to $48,000 for practices with six to ten physicians. The member noted uncertain return on investment and vendor scheduling delays, as well as some health plan funding and incentives.

A member representing long-term care facilities emphasized that many skilled nursing facilities already exchanged through their EHR vendor and nationwide networks. The member cautioned against equating low QHIO use with lack of exchange or requiring duplicative connections. Other members highlighted similar affordability and technology barriers for community-based organizations (CBOs) and social services organizations. Members requested further consideration of financing, public support, reciprocity, and the value of a single connection.

Public comment:
Public commenters offered differing views on minimum thresholds and specialization. Some supported stronger evidence of operating capability and accountability. Others questioned whether the proposed thresholds were sufficient, whether affiliated and independent connections should be distinguished, whether the same Participants could count toward multiple QHIOs' thresholds, and whether the proposals addressed the underlying exchange problems.

Commenters described existing exchange through PointClickCare, Carequality, and other networks and supported accommodating compliant arrangements. Some supported event-notification Specialists; others cautioned that a separate recognition track could increase fragmentation or undermine full-service QHIO sustainability. Commenters discussed the advantages of endorsing California-based QHIOs because it results in the data remaining with California entities, rather than entities based out of state. Commenters described patient-matching and geographic coverage challenges, limited provider control over EHR choices, and potential duplication of contracts and costs.

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Commenters raised concerns about the reliability of Participant Directory information, reported refusals to exchange between intermediaries, and the need to assess actual performance across the ecosystem. Suggestions included broader analysis of existing networks, independent review of Directory data, and examination of QHIO withdrawals and closures. Commenters also discussed cost recovery, public funding, and possible antitrust concerns with individual price publication, suggesting aggregated pricing information published by a third party entity as an alternative. A member of the public questioned proceeding to a vote before addressing patient impacts and accountability.

Following the discussion and public comment, Dr. Sayles and HCAI agreed not to proceed with either planned QHIO vote. Dr. Sayles identified a goal of returning to the issues more holistically in December, informed by additional consideration of the interrelated proposals. The exact scope of any December vote remained open. Neither proposal was adopted.

Agenda Item V: Public Accountability and Enforcement
Jacob Parkinson, DxF Program Director
Following lunch and Dr. Sayles's departure, Vice Chair Katie Heidorn reconvened the meeting and conducted roll call. A quorum was reestablished.

Mr. Parkinson outlined the planned accountability discussions: current compliance and enforcement mechanisms in October, public purchaser contracting in December, enforcement options in February, and recommendations for the legislative report in April.

HCAI was preparing to publish the first list of entities deemed noncompliant with Data Sharing Agreement (DSA) signing requirements on January 1, 2027. Mr. Parkinson described December 1, 2026, as a tentative signing cutoff to allow reconciliation before publication. The first posting would cover entities whose signing deadlines were on or before January 1, 2027; entities with July 2027 deadlines would be considered for the July update. HCAI was developing procedures for updates, explanations, appeals, and statements of extenuating circumstances, as well as a methodology for identifying required signatories.

Mr. Parkinson presented signing rates as of September 30, 2026, which varied substantially by entity category. The analysis showed higher signing rates among hospitals and skilled nursing facilities and lower rates among clinical laboratories,

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

emergency medical services, and physician organizations. He described potential contractual, corrective, operational or financial, and licensing or credentialing enforcement mechanisms, noting that authority varied by agency. Regulating agencies had committed to outreach and referrals to HCAI resources but expressed concerns about using enforcement mechanisms without explicit statutory authority.

Questions and comments from the committee:
Members welcomed the signing analysis and asked how it related to the number of patients served or volume of data held by signed entities. HCAI described overlapping categories, including organizations holding clinical laboratory registrations, and the breadth of the clinical laboratory denominator. Members also raised outreach gaps, confusion following ownership changes, and opportunities to communicate through licensing boards during renewals.

Members emphasized that signing the DSA did not establish that an organization was fulfilling its exchange obligations. They requested a common definition of active participation and exchange compliance, specific monitoring measures, and an authoritative source of information that public purchasers and providers could use consistently.

Representatives of Covered California, CalPERS, and DHCS described existing contractual requirements and implementation approaches. Covered California was considering future contract provisions and collecting information on hospital exchange. CalPERS supported alignment among purchasers and highlighted downstream provider challenges. DHCS described managed care contract requirements, reporting, performance monitoring, and corrective action processes.

HCAI noted limitations existing enforcement authority.

The representative of DMHC described outreach to unsigned plans, noting that the list included Medicare Advantage and restricted arrangements. They offered to follow up on additional outreach results. Members also asked about fee-for-service providers,

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

downstream contractual obligations, and whether quality measures could help demonstrate the value of data sharing.

Public comment:
Commenters urged HCAI and purchasers to assess meaningful exchange and the proportion of relevant data held by signed entities. Some suggested hospital event notifications as a verifiable monitoring mechanism and raised possible licensing or legislative approaches. Others cautioned against requiring QHIO-only connections where compliant exchange already existed and called for accountability across all intermediaries.

Commenters also requested clearer treatment of narrowly focused providers holding clinical laboratory registrations, describing limited testing, county-mandated systems, uneven outreach, and potentially duplicative reporting or contracting requirements.

Another member of the public raised concerns about patient consequences, the legal basis for proposed approaches, and access to the meeting recording.

Agenda Item VI: Individual-Level Demographic Data and Health-Related Social Needs (HRSN) Data Part 1
Katie Heidorn, MPA, Committee Vice Chair
Jacob Parkinson, DxF Program Director

Mr. Parkinson reviewed the committee's charge to develop recommendations regarding individual-level demographic and HRSN data collection by January 1, 2027. October's discussion was intended to identify scope, feasibility, and implementation considerations so HCAI could prepare more formal recommendations for December. Recommendations could address statutory changes, training and technical assistance, and collection best practices.

Mr. Parkinson recapped the August discussion, including gaps in sexual orientation and gender identity, disability, and HRSN information; inconsistent documentation; workflow burdens; consent; and trust. He reiterated that current DxF requirements generally concern exchange of information that a Participant maintains and may legally share, rather than a new requirement to collect information it does not otherwise maintain.

Mr. Parkinson also summarized feedback HCAI collected individually from members after the August meeting, including suggestions to build on existing standards, reduce

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

duplicate collection, provide practical tools and implementation funding, clarify collection expectations and privacy safeguards, support referral and housing partnerships, and involve patients and CBOs in design and governance. These responses reflected individual member perspectives and did not represent committee consensus.

Drawing on August presentations, committee discussion, and subsequent member feedback, HCAI presented four potential recommendation concepts to provide a starting point for members to refine and prepare for voting in December 2026: National Standards and Collection Best Practices; Data Completeness and Collection Expectations; Privacy, Transparency, and Community Participation; and Targeted Implementation Support. Members were invited to assess the concepts' scope, feasibility, and implementation needs and to suggest revisions or additional concepts. The first two concepts were discussed before the break. Potential approaches included a reference guide connecting data elements to standards and collection practices, assessment of current completeness, benchmarks, and possible legislative collection requirements that consider entity types and readiness.

Questions and comments from the committee:
Members distinguished collection methods from storage and transmission standards. A member representing health systems supported standardizing storage and transmission while allowing collection methods to vary by population and resources. Members also discussed potential uses of artificial intelligence to reduce workload and the associated need for privacy, security, transparency, and contractual safeguards.

Members emphasized workforce capacity and the practical challenge of asking sensitive questions without resources to respond to identified needs. They called for staff training, effective referral pathways, and alignment with Hospital Equity Measures, the Health Care Payments Data Program, health plan quality reporting, housing programs, and other state initiatives to reduce duplication and inconsistent categories.

Several members supported clearer collection expectations, particularly for basic demographic and language information, and suggested phased implementation. Members discussed the usefulness of self-reported data, standardized categories, and existing purchaser benchmarks. They also asked what completeness should mean across organizations and the broader ecosystem, who should collect the information, and how CBOs and social services organizations would help shape recommendations.

Members highlighted the need to preserve EHR capacity to collect and exchange relevant information as federal standards evolve. Members also described the effects of missing demographics on disease reporting and population-level analysis. The

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

discussion also addressed legal permissions, ethical expectations, individual choice, and the ability to act on collected information.

Members asked where relevant data already existed across health care, social services, housing, enrollment, and other systems.

Public comment:
A commenter recommended building on existing required assessments, including Dual Eligible Special Needs Plan health risk assessments, and establishing a standardized core aligned with national resources such as United States Core Data for Interoperability and Gravity. Suggestions included direct confirmation with individuals and accessible collection methods. The commenter also supported phased implementation and training.

Another commenter questioned the reliability and use of local housing assessment data and requested access to meeting records.

Agenda Item VII: Individual-Level Demographic Data and HRSN Data Part 2
Katie Heidorn, MPA, Committee Vice Chair
Jacob Parkinson, DxF Program Director
Following the break, Mr. Parkinson introduced the remaining concepts. Privacy, Transparency, and Community Participation addressed consent, appropriate use, safeguards, and patient and community involvement. Targeted Implementation Support addressed technology, staffing, training, funding, and assistance needs, particularly for organizations with limited capacity. HCAI encouraged consideration of existing funding and technical assistance pathways and effective implementation partners.

Questions and comments from the committee:
Members raised concerns about sensitive information, interstate exchange, evolving federal policy, and the need for direct consumer and community involvement. They emphasized clear explanations of how information would be used and shared, meaningful choices, and practical guidance for smaller organizations without in-house legal or technical expertise.

Members highlighted uneven technology and security resources, including among organizations that had not benefited from earlier EHR incentive programs. They requested funded privacy and security education, assessments, integration assistance, and guidance on liability and questions to discuss with counsel.

HCAI Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Social services representatives emphasized program-specific legal requirements, consumer-directed referrals, and collecting the minimum information needed for the service requested. They noted that people may disclose different information in different settings and cautioned against assuming that information provided for one purpose should circulate broadly. Members also raised concerns about access to eligibility information for uses beyond its original purpose.

A member described a collaboration with Project Angel Food illustrating exchange between clinical and nutrition services. The member discussed the potential use of clinical information for assessments and the return of nutrition assessments and care plans to providers, as well as consent, legal costs, FHIR capabilities, and implementation challenges. Members cautioned that social services data may follow different update cycles and that users need to understand its currency and limitations.

Mr. Parkinson said HCAI would refine the concepts based on the discussion and return with more formal recommendations for December consideration, with the goal of publication by January 1, 2027. No formal demographic or HRSN recommendations were adopted at this meeting.

Public comment:
A commenter urged dedicated funding for CBO technology, staffing, training, and ongoing operations. Priority capabilities included consent management; secure collection, storage, updating, and access controls; and interoperability for referrals, service status, and follow-up. The commenter supported shared resources for smaller organizations and phased expectations.

Another commenter requested preservation of the complete meeting recording and raised concerns about open-meeting practices, housing information, and legal preparedness.

Agenda Item VIII: General Public Comment
Katie Heidorn, Committee Vice Chair
A member of the public raised concerns about housing assessments, implementation and training, technological change, and legal accountability. Another commenter thanked the committee for its discussion and requested continued work with HCAI to clarify clinical laboratory requirements for narrowly focused providers and avoid duplicative administrative and reporting burdens. The commenter stated that a letter

Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

would be submitted to HCAI, with the Advisory Committee copied, before the December meeting.

Agenda Item IX: Closing Remarks & Adjournment
Katie Heidorn, Committee Vice Chair
Vice Chair Heidorn thanked committee members, members of the public, HCAI staff, and the facilitation team. The next meeting was scheduled for December 17, 2026, with additional meetings planned for February 18 and April 15, 2027.

The meeting was adjourned at 3:51 p.m.