California Medi-Cal HIE Onboarding Program (Cal-HOP): HIO Webinar
February 22, 2019

Raul

(Slide 4) So for the overview, I'll cover our vision and approach first. Our vision is to expand Medi-Cal provider access to and use of HIE services in order to support providers' achievement of meaningful use measures, improving provider access to information across medical communities, improving care coordination and the quality of care of their patients. Also improving efficiencies by reducing unnecessary utilization and waste. And supporting specific Medi-Cal initiatives, which include waiver programs such as whole person care. Our approach is to establish an incremental progression of achievable milestones, that incentivize the use of HIE services, expanding the participation in community focused resources of California's HIOs that have the technical capabilities to meet our visions. Providing Medi-Cal providers and HIOs flexibility to determine how milestones are achieved. Balancing program accountability and operational efficiencies. And, as the program progresses, rigorously monitoring and evaluating the program and to the extent necessary, making adjustments as needed with CMS approval.

(Slide 5) We have a number of goals. The first is to increase the number of Medi-Cal providers which are exchanging patient data via regional HIOs. As you are aware, the value of electronic data exchange for Medi-Cal members and payors increase when the vast majority of Medi-Cal providers within a region participate in an HIO data exchange network. We also want to expand the exchange capabilities of Medi-Cal providers that are already participating in regional HIOs. As many of you know, many HIO participants aren't exchanging the full complement of data that will improve the care of their members. HIO participants are also finding it difficult to access important HIO data directly from the EHRs and workflows.

Finally, we are hoping to facilitate Medi-Cal providers accesses to the CURES prescription drug monitoring database. Today, the prevailing method of accessing CURES is via web portal, that often requires extra workflow steps for the providers. By integrating CURES directly into the providers EHRs, we are greatly facilitating compliance with the law and helping to reduce opioid overprescribing, and overprescribing many controlled substances.

(Slide 6) Some important dates that I'm sure you all are interested in. The department expects to officially launch the Cal-HOP program in June of 2019. And that is dependent on CMS final approval of our APD and supporting contract. The program will close on September 30, 2021 with the sunset of the Promoting Interoperability Program. So it will be important that all Cal-HOP activities be completed on are before September 30, 2021.

(Slide 7) With that said, what I'd like to do is turn the webinar presentation over to Lammot du Pont with Manatt Health, who will provide overview and implementation of the program. Lammot.

Lammot du Pont

Great. Thank you Raul, can you hear me okay?

(Slide 8) Fantastic. So I'm going to walk through the oversight and implementation of Cal-HOP. Cal-HOP has three basic features. The first is that there's up to fifty million dollars available. And that funding is available through September 30, 2021. Forty-five million dollars of that fifty million is available from federal resources. The remaining five million dollars is a match from the state's general fund that's been approved by the California legislature. The second important component is that this is a milestone-based program. DHCS will make incentive payments for health information organizations and Medi-Cal providers when, working together, they meet specific onboarding and HIE connection milestones that we'll both discuss later in the presentation. The third component is the Cal-HOP participants. Key participants include the department, DHCS, which will oversee the program and distribute funds, regional health information organizations that will apply to be qualified to participate in the program, and who will receive payments from meeting milestones with the qualified provider organizations, and that represents the third important key participant, the Medi-Cal provide organizations. These are the hospitals, clinics and practices that will also be qualified to participate in the program and receive support from the qualified HIOs. Next slide, please.

(Slide 9) So, this slide illustrates the entities with oversight roles. And that is CMS and DHCS. CMS establishes the rules for participating, and the uses and prohibitions for the use of funds. CMS also reviews and approves all of DHCS' program related plan. They will monitor the programs and review contracts and milestones on a periodic and ongoing basis. The second oversight function is accomplished by DHCS which will establish the criteria for the entities that will qualify for the program. They're also establishing the milestones and the payment amount, and they'll monitor the program and provide evaluation reports directly to CMS. Next slide please.

(Slide 10) The oversight function will be supported by a management support contractor. And the implementation support from this management support contractor will occur in two ways. First is, the management support contractor will monitor participants' progress against data performance milestones, and they'll submit reports to DHCS. Secondly, they will collect the documentation from qualified HIOs, review them, and then make the recommendations and subsequent reports up to DHCS. Next slide please.

(Slide 11) In terms of participants, there are two categories of entities that will participate in Cal-HOP. The first is what we're calling "qualified health information organizations," or HIOs. Qualified HIOs are California HIOs that meets specific organizational characteristics and have specific technical capabilities. They will onboard qualified provider organizations. They will deliver HIE services to those organizations. And they will support performance reports to the management support contractor. Next slide, please.

(Slide 12) The second category of Cal-HOP participants are the qualified provider organizations. They are Medi-Cal providers that meet specific characteristics and also have certain technical and staffing capabilities and features. They will onboard with qualified health information organizations, and they will also be expected to meet technical connectivity milestones and report that achievement to the qualified HIOs. Next slide.

(Slide 13) There will be a lot of activity and important milestones over the next six months. So we wanted to lay those out to you. And what we're describing is two phases. The first phase is the pre Cal-HOP launch, and that period run from now until June 1 when we expect Cal-HOP to launch. And then there will be the post-Cal-HOP launch.

During the pre –Cal-HOP launch period, HIOs and providers should begin discussions in their planning activities. Health information organizations interesting in participating in the program should begin the process of preparing to serve as qualified HIOs, and reach out to their current and prospective participants to engage them in the planning process. In late March, DHCS expects to release a solicitation with additional criteria and application procedures for entities to serve as qualified HIOs. Upon receiving the applications to serves as qualified HIOs, in early May, DHCS will notify those health information organizations that have been designated as qualified of their status, and they'll post that status on the DHCS website.

Those entities that have not been selected as qualified HIOs or those HIOs that decided not to submit an application in March, may apply to be designated as qualified HIOs at a later date. DHCS will accept applications to serve as a qualified HIO on a rolling basis. On June 1, the program is expected to begin in earnest and launch with an announcement from DHCS. It is after that that the post Cal-HOP begins. And any activities that a qualified HIO and a qualified provider organization undertake will be eligible to be considered for milestone achievements and payments. Beginning in June, after the launch, qualified HIOs and their partnering qualified provider organizations can formally submit their onboarding plans, the pace of their onboarding activities to the management support contractor for review and approval.

Please note that an anticipated timeline that is represented here, and the final dates will depend on CMS approval of the Cal-HOP plan. Next slide, please.

(Slide 14) So now we're going to move in to the section that discusses the funds flow. Next slide.

(Slide 15) The funds flow has three basic components. First, as noted earlier, there'll be up to 50 million dollars available. Some of that funding will be used to support program implementation and monitoring. The second important element is that the program deadline in September 2021, and CMS prohibits payments for any activities performed after September 30, 2021. So program activities must be completed prior to that date in order to be eligible to receive funding. The third important element of funding is to note

that the program's focus is that it is an incentive program and not a reimbursement program.

Cal-HOP has limited funds, is not able to reimburse Medi-Cal providers or HIOs for all the costs they could incur to connect to and use HIE services. DHCS recognizes that Cal-HOP's funding has limitations. And is exploring other mechanisms to help cover the cost to implement, access, and use HIE services. Next slide, please.

(Slide 16) So now we're going to trace the flow of reporting and funds. So we'll start with the flow of documentation of the achievement. Cal-HOP funding is triggered by achievement of milestones, and the documentation and recording of milestone achievement. Starting at the bottom left hand of the slide, you can see that the first step is for the qualified provider and qualified HIO to collaborate together to meet the milestones. Moving up to step two, the qualified HIO collects Qualified Providers documentation and then submits that with an invoice to the management support contractor. And finally in step three, the management support contractor reviews the documentation and invoices from the qualified HIO, and forwards recommendations to DHCS for review and final approval. Next slide, please.

(Slide 17) With respect to funding, the Cal-HOP payment process also has multiple steps. On the top right hand side in step four, once a milestone is achieved and information is reviewed and approved by DHCS, they make incentive payments to the management support contractor. In step five, the management support contractor distributes the incentive payments directly to the qualified health information organizations. In step four, the qualified HIOs allocate funds to support the qualified provider organization's activities and other activities associated with that meeting milestone.

Of note with respect to payments, DHCS will make payments to the management support contractor within 45 days of receiving a valid request. The management support contractor will then make approved payments to the qualified HIOs within 10 days. Next slide please.

(Slide 18) There are important relational requirements and characteristics for Cal-HOP to note. First, qualified provider organizations must designate and work with a single qualified HIO for achieving Cal-Hop milestones. And once a qualified provider organization achieves milestone one with a qualified HIO, it must continue to work with that qualified HIO to achieve any further Cal-HOP milestones. In other words, that qualified provider organization may not switch and achieve milestones two or three with another qualified HIO in order to meet milestone achievement payments. Qualified provider organizations, may participate in and connect to multiple health information organizations. But, it's important to note that Cal-HOP payments can only be made from milestones achieved with one qualified HIO. Next slide please.

(Slide 19) Another important consideration in the payments amounts. They will be based on a number of interface EHR instances that the qualified HIO and qualified provider organization connect. To help clarify the payment structure, this slide

illustrates three scenarios with a single qualified provider organization represented as the health system with three hospital sites. The difference between the scenarios is the technology situation for each of the systems. In scenario one, the qualified provider organization is a health system with three sites. And they're all using the same instance of an EHR, in this case, EPIC. In this case, the HIO qualified provider organization is eligible to be paid for interfacing two EHR instances. And, in the third and final scenario, we have a health system that has three hospital sites. And three EHR instances. And in this situation the qualified HIO and the qualified provider organization would be eligible to be paid for interfacing each of those three EHR instances. Next slide please.

(Slide 20) There are some restrictions and prohibitions for the use of the Cal-HOP funds. In terms of restrictions for CMS regulations, the funds must be used to onboard only providers that bill or render services for Medi-Cal. The funding must be used to help Medi-Cal eligible professionals and hospitals fulfill their meaningful use objectives and measures in the promoting interoperability program. The funds may not be used for ongoing HIE operations. In other words, they can only be used for the initial onboarding activities, or the integration of new interfaces. And they may not be used to purchase or otherwise modify certified EHR technology, or to amplify existing EHR technology such that it would be functionally able to achieve certification. In terms of eligible uses for the funding, qualified HIOs may use the incentive payments to offset some of their internal costs. Including the HIOs cost to connect to a qualified provider organization's EHR, in terms of the cost of that qualified HIO to develop capabilities to perform the HIE services specified in the milestones, and also the cost to connect to statewide databases to achieve the specified milestones. The qualified HIOs may also use incentive payments to offset certain costs incurred by the qualified provider organization.

For example, costs associated with the qualified provider organization for their EHR to integrate with the qualified HIO's technology. In addition, a qualified provider organization's cost to retain a technology consultant to help develop the interfaces to connect between their EHR and the qualified HIO's technical system. Next slide please.

(Slide 21) Now we're going to walk through the criteria for HIOs to become qualified. Please note that there is also criteria for Medi-Cal providers to serves as qualifying provider organizations. And we'll discuss those during next week's March 1st webinar. Next slide please.

(Slide 22) The first bucket of characteristics and criteria are the organizational characteristics. First, the HIO must be a California-based non-profit organization or government entity.

Second, they must have a publicly declared mission to support the exchange of information with organizations in a defined region.

Third, it must be a multi-stakeholder organization that is not a health care provider organization or payor, not majority owned by a provider organization or payor, and not a majority governed by a provider organization or payor.

Number four, they must be open to participation by any healthcare enterprises that serve Medi-Cal patients regardless of their business affiliations or their health IT vendors

They must be financially viable and sustainable. Demonstrate sufficient insurance and liability coverage. Have the ability to scale operations to accommodate the projected onboarding they forecast. And they must also demonstrate commitment from at least 25 Qualified Provider Organizations with the HIO to participate in Cal-HOP. Next page please.

(Slide 23) There are also a number of expected technical capabilities. As identified in number nine, they must receive patient-specific clinical data on a regular basis from at least two, non-affiliated hospitals and make those data electronically available to other provider organizations. They must be a signatory to CalDURSA, and they must also be a participant in good standing with CTEN.

With respect to publication and reporting requirements, the qualified HIO will be expected to provide up-to-date, public listings of three items:

The current and planned capabilities that they have to assist Qualified Provider organizations. An applicable fees or fee-calculation methods for Qualified Provider organizations to participate. And number three, the names, organization type, and exchange services of the provider organizations currently participating in the Qualified HIO.

And finally, there's the expectation that the Qualified HIO must submit quarterly reports on an ongoing basis to DHCS regarding Cal-HOP onboarding activities within 15 days after the end of each quarter.

At this point, I'm going to turn the presentation over to Walter Sujansky, a principal of Sujansky and Associates, who is going to walk through the milestone issue.

Walter Sujansky

(Slide 24) Thank you, Lammot. Can you hear me? Great. Before I start this section, I just wanted to remind everyone that at the end of this section, we'll be taking questions on the contents of the entire presentation, and we'll be doing that just through the WebEx Q & A mechanism. So if you have questions, please enter them there, and you can already go ahead and feel free to begin entering them and we'll tee them up for the last part, the last 15 minutes or so of the presentation.

(Slide 25) Okay, so we've talked about, Lammot has mentioned that there are several milestones, it's a milestone based program, so now we'll turn to what the specific milestones are, the ways that can be achieved, and the incentive payment amounts

associated with each milestone. Depending on the type of provider organization involved.

So first, the focus of the milestones is to create specific types of digital connections between provider organizations and HIOs, with the goal of enabling certain high-value use case. And one important point is that although the milestones are generally the same across different types of provider organizations, the definitions of those milestones, the payment amounts may differ among them. Specifically between organizations that are hospitals, organizations that are smaller ambulatory providers, and organizations that are larger ambulatory providers, and we'll go over those specific numbers as we talk about the milestones. Next please.

(Slide 26) So the program consists generally of three sequential milestones that roughly consist of first initiating participation in Cal-HOP. A provider organization and an HIO initiating such participation in a peer-wise fashion. Then secondly, implement basic interfaces, which we'll define momentarily. And thirdly, implementing certain advanced interfaces. Again, which we'll talk about shortly. And notably, the advanced interfaces, unlike the basic interfaces of milestone two are optional, so organizations and HIOs don't necessarily need to go on to milestone three.

There are also some important timing considerations in achieving the milestones. Very important to note these. First, milestone two must be complete within one year of milestone one being achieved. The purpose for this is to move things along briskly, given the relatively short timeframe of the overall program. Secondly, of course, as mentioned, Milestones 2 and Milestone 3, although the work to implement those must be completed before Sept 30, 2021. So obviously, if Milestone 1 is completed on January 1, 2021, then that leaves only nine months to achieve Milestone 2 and Milestone 3, rather than the one year mentioned a moment ago.

And lastly, there are certain situations in which payments may be made for Milestone 1, but those payments are later rescinded, clawed back by DHCS if, for example, live connections implemented for Milestone 2 or Milestone 3 are not maintained for at least one year after they go live, or if Milestone 2 is mentioned as not achieved within one year of achieving Milestone 1. Next.

(Slide 27) So, let's go through the milestones now. The first one, initiating participation in Cal-HOP consists of four. The first is the Qualified Provider organization attesting that it is in fact a Medi-Cal participant, which is requirement of CMS, as we discussed.

Secondly, the provider organization signing attestation that its vendors, EHR vendor or other health IT vendors, are in fact ready to achieve the selected milestones for them, to the extent that the vendor's participation is needed. The goal here is to make sure that the provider organization and their vendors discuss this up front during this first milestone step, so that there are no surprises or failures to account for the vendor's needed participation down the road.

Thirdly, the Qualified HIO simply needs to be a member of and a participant in a … I'm sorry, the Qualified Provider organization needs to be a member of and a participant in a Qualified HIO, and the relevant documentations, participation agreement and so forth need to be provided for that.

And lastly, the provider organization also needs to sign, in addition to that, an agreement with the QHIO that essentially formalizes the provider's intent to participate in the Cal-HOP program and indicates which specific milestones it intends to achieve. At the conclusion of submitting, essentially the documentation for these four components, the first milestone payment will be made to the Qualified HIO for that particular provider organization. Or more specifically, for each EHR instance of that provider organization that is scheduled to be onboarded. So you can see the payment amounts that will be disbursed when Milestone 1 is completed.

And, importantly, note that the payments will be disbursed at the conclusion of each milestone and sequentially made available. Next please.

(Slide 28) Milestone 2 actually consists of two specific components, which we'll refer to as 2a and 2b here. 2a entails provider organizations submitting encounter notifications, and event notifications to the HIO and also being able to access similar notifications when submitted by other provider organizations. So specifically for hospitals, that means there needs to be implemented at least daily feed of ADT messages or messages or documents with similar content that are delivered to the Qualified HIO within 24 hours of either an ED visit, hospital admission, or hospital discharge for all Medi-Cal patients who are eligible to be included in the Qualified HIO. Who have, who are opted in, or not opted out, depending on the opt-in model.

If, secondly, if he hospital includes outpatient clinics, those clinics also must submit ADT or equivalent messages within 24 hours of an encounter, patient encounter, for those same Medi-Cal patients.

And lastly, hospitals have to demonstrate access to, and/or use of encounter notifications that have been submitted to the HIO and provided by the HIO, and that must, those must either be available through a pull mechanism, query/response type mechanism or a push mechanism, publish/subscribe. We recognize that the push mechanism is generally more useful, but are allowing the pull mechanism given the short timeframe of the program, and the need for implementing Milestone 2 within a year of Milestone 1.

For outpatient provider organizations, clinics, IPAs, small practices and other types of non-hospital organizations, similarly to the outpatient clinics of the hospital, they are required to submit encounter notifications within 24 hours of encounters for Medi-Cal patients and also to demonstrate similar accessibility to access through push or pull mechanisms, for similar notifications provided by others.

As you see below, Milestone payments, three different Milestone payment amounts will be dispersed, depending on the type of organization. The logic here, specifically for …

excuse me, specifically for the smaller and larger provider organizations is that smaller organizations in fact will receive more funding, given that they typically have fewer resources to implement these types of interfaces with HIOs. Next please.

(Slide 29) The second part of Milestone 2 consists of integrating provider organizations' EHRs with the CURES PDMP database to support queries for CURES records. Again, this is, as mentioned earlier, this is a very important part of the overall Cal-HOP program, and therefore is included as a required element of Milestone 2. So specifically, there are two ways of achieving this particular milestone component. The first is that there's a documented data querying and data retrieval function as provided by the qualified HIO, and is integrated into the clinical workflow of the provider organization's EHR, specifically through a mechanism that allows providers to access the CURES database without leaving their EHR, and without logging into a separate system using the HIOs capabilities as well as the CURES database API.

The second way this milestone can be achieved essentially is that the provider organization HIO can be exempted from the milestone if the provider organization already has an integration with the CURES database through some other mechanism than the HIO. For example, provided by the provider organization's EHR vendor directly or a third party. In these case, there will not be a milestone payment made for the 2b component, but the provider organization can achieve Milestone 2 and receive the incentive payment for Milestone 2a, nevertheless.

You can see below, again, the respective dollar amounts associated with incentive payments for Milestone 2b for hospitals and provider organizations. Again, outpatient, smaller outpatient provider organizations are provided more funding for the reasons that I mentioned earlier, their more limited resources for implementing these types of interfaces. Next please.

(Slide 30) The third milestone, which is again, optional, unlike Milestone 2 consist of implementing advanced interfaces between provider organizations and HIOs. The interfaces must specifically be selected from a list of 35 designated interface types. That we'll talk about in a moment. And for hospitals to achieve Milestone 3, five of these interfaces must be implemented. Ambulatory providers need only implement 3 such interfaces. Beyond the 35 designated interfaces, provider organizations and HIOs can also identify alternative types of interfaces that they feel constitute advanced interfaces and those may also be counted towards achieving Milestone 3, contingent on DHCS's approval. Next please.

(Slide 31) So more specifically, the 35 allowable interfaces are divided for convenience into five different categories. I won't go through all the interface types of course, but the categories essentially, Category A consists of data feeds from Qualified Providers to Qualified HIOs. Typically via HL7, including things like laboratory results, discharge summaries, consult notes, etc.

Category B consists of interfaces to submit or retrieve information, patient information from Public Health Registries, including the immunization registry, the CalREDIE

reportable event registry and POLST registries. Note that a bi-directional interface with such registry will account for two such advanced interfaces.

Category C entails the delivery of data from HIOs to provider's EHRs, directly via some type of web-services API, between the EHR and HIO, such as FHIR. Again, depending on the type of information retrieved via this interface, each type of information counts as a separate advanced interface that can be achieved.

Category D is related to provider organizations that share data with HIOs via edge interfaces. And we recognize that there are a number of HIOs that provide this mechanism and a number of provider organizations that prefer to share their data in this way rather than submitting it directly to the HIO. And, so again, different types of edge interface data types that are made available through such interfaces also count towards the advanced interfaces. Or the implementation of an edge interface, edge server to begin with.

And lastly, Category E of course is the "Other" category where, subject to DHCS approval, other than these 35 specific interface types can count toward achievement of Milestone 3. Next please.

(Slide 32) So the only new information on this slide is down at the bottom, the payment amounts for Milestone 3 achievement. Obviously, hospitals are having to implement five of these interfaces, rather than just three. So the dollar amounts are substantially higher for hospitals. But for small and large organizations, they are the same in this case, because we feel that the amount of the payment is substantial to begin with and should certainly be adequate to cover three of these advanced interfaces. Next please.

(Slide 33) So to conclude this part of the presentation, we just wanted to go through several sample scenarios of different ways that milestones may be achieved. Kind of drive home the point of a certain amount of flexibility in that regard, but also some restrictions on what the provider organizations and HIOs specifically need to do. Next please.

(Slide 34) So the first scenario entails a provider organization HIO first achieving Milestone 1 through the documentation, then going on to implement the ADT submission and event notification interface. But in this case, being exempted from CURES integration because the provider organization already has a interface between its EHR and the CURES database through the CURES API, so that's not required, and the provider organization HIO in this case choosing not to go on and implement any of the advanced interfaces for Milestone 3. Next Please.

(Slide 35) So, just a reminder that the Milestone 2 components that are completed need to be done so within one year of completing Milestone 1, and again, it's okay not to go on to complete Milestone 3. Next.

(Slide 36) So, in this specific example, the payment amounts would consist of the Milestone 1, initiation payment, the payment for 2a. No payment for 2b because no interface was implemented there, but the overall Milestone 2 was completed by virtue of

the exemption for Milestone 2b. So, in this case, using a hospital as an example, the overall payment would be $45,000. Next.

(Slide 37) Another example for a hospital, again, is sort of the maximum payment scenario where the hospital needs to and does implement along with the HIO both 2a and 2b milestones, as well as going on to implement 3 new advanced interfaces. In this case the maximum total payment would be dispersed to the hospital and the HIO— to the HIO, which would consist of $150,000. Next please.

(Slide 38) This next scenario involves a provider organization that is already a member of an HIO, participating with that HIO, and in fact already sending ADT or equivalent messages to the HIO, but now is choosing to participate in Cal-HOP in order to implement CURES integration as well as to implement additional new advanced interfaces. This is absolutely allowed, and in this case when there is an exemption from the 2a component of Milestone 2, but upon completion of each of Components 1, 2b and 3, the relevant milestone payments are made—in this case totaling $130,000. Next please.

(Slide 39) This is a twist on the same scenario where, again, a provider organization that's an existing member of an HIO also chooses to participate in Cal-HOP, and in this case not only has the provider organization already implemented an ADT interface with the HIO, but they have also already implemented outside of the HIO an integration between their EHR and the CURES database. So, they're essentially exempted from both components of Milestone 2, and this is the single case where provider organization and HIO can immediately go on to implement the interfaces to achieve Milestone 3. And when that is done, again, the payment for Milestone 1 is made, of course, and the payment for Milestone 3 is made, but no payments for Milestone 2 are made given that no interfaces were developed and the total payment in this case would be $100,000. Next please.

(Slide 40) So, as I mentioned earlier, there are a couple of scenarios to be aware of where although a Milestone 1 payment may be made upon documentation of those four elements of initiating Cal-HOP program, failure to go on to complete Milestone 2 within the one year timeframe or Milestone 3 before the program ends will actually result in even the initial dispersed payment for Milestone 1 being rescinded by DHCS. So, in this type of scenario there will be no payments ultimately received by the HIO for that particular provider organization's onboarding. So it's very important to be aware of that and HIO should very much focus on engaging with provider organizations that can go on to achieve at least the required elements of Milestone 2 in order to receive any funding from the program whatsoever. Next please.

(Slide 41) A similar scenario to be aware of involves failure to achieve all of Milestone 2. In this case, after achieving Milestone 1, and even implementing an ADT interface, failure to achieve Milestone 2b or be exempted from Milestone 2b will similarly trigger this clawback provision, even if, in this case the HIO and provider go on to complete Milestone 3. So, this underscores the importance to DHCS and this program of fully implementing both elements of Milestone 2 or being exempt from Milestone 2, certainly

before going on to Milestone 3 or before being really eligible to receive payments for Milestone 2, Milestone 3 interfaces as well as even the initial payment for achieving Milestone 1. With that that concludes this section of the presentation on the scenarios as well as the entire presentation, and so I'll turn it back over to Lammot for Q and A.

Lammot du Pont

(Questions Slide) Thank you Walter. And so we've been receiving some questions those the chat feature, so if people have additional questions that they'd like to submit at this time we'll start to work through them.

So, starting out, there's the question of "Will the slides for this presentation be made available?" And yes, they will. A copy of today's slides are going to be posted on DHCS' website. We will do that early next week, and also there will be a companion presentation directed at providers next Friday, and we'll also post not only the slides but also the recording of this presentation.

Another question we received was with respect to eligible entity. And the question is, there are certain circumstances where an organization may be both a health information organization and also providing clinical services. And in those situations where an organization is doing such, where they're both eligible to be a qualified health information organization and they're eligible to be a qualified provider organization, that entity must decide which type of organization that it intends to be. It can serve as either a qualified HIO or a qualified provider organization, but it cannot serve as both.

We also received a question with respect to the criteria for serving as a qualified HIO. And the question was on Slide 22 was, "Is there a difference between non-profit and not-for-profit." And then the answer is that non-profit includes not-for-profit organizations and public sector entities. So, we're not using the strict legal definition. We're making sure that the non-profit sector is adequately represented as being able to serve as qualified health information organizations.

We also received a question about where is the money flowing through. So, the question was, "Is the money going to go to the health information organization that enrolls the hospital or to the hospital to pay the health information organization?" And it is in fact the former. If you look at the Slide 17, the funding is going to be made available from the DHCS to the management support contractor. The management support contractor will disperse funding to the qualified health information organization.

We also received a question about onboarding for an organization with respect to Milestone 1 if they are already onboarding. And that, I think, lends to the question of the distinction between onboarding to a health information organization for health information exchange purposes versus onboarding to the Cal-HOP. And the idea is that, as Walter described, you may already be an entity that is technically connected to or starting to connect to the health information organization. In order to qualify for Milestone 1, you must be a qualified provider organization and you must satisfy the

onboarding for the Cal-HOP requirement. It could be different from, but inclusive of, onboarding through the health information exchange.

And now I'm going to turn it over—Raul, I believe there are also some questions that you'd like to address?

Raul

Sure. I think one of the questions that we received was, "What if a Medi-Cal eligible professional had maxed meaningful use and has completed six years?" And that was in reference to Slide 20 which identified some restrictions on funding by CMS. I think the message that we were trying to convey is that State Medicaid Director Letter 16-003 made available funding to support exchange of information between eligible professionals participating in the promoting inoperability program and other Medicaid professionals. So in this program it's not necessary that you be a eligible professional participating in the Medicaid program. It's simply intended to also support Medicaid providers who are exchanging information with those eligible professionals and helping them achieve meaningful use.

Another question that we received was regarding the management support contractor. The questions was, "When will the management support contractor be onboarded and how will we know that procurement opportunity to be published?" So, one of the things that we are doing as we seek CMS approval for the Cal-HOP program is simultaneously working on a procurement document for the management support contractor. Once that document is completed and we are authorized by CMS to release that procurement document, we will publish it on the Cal-HOP website. We're also establishing a listserv which will share this type of information out. And State of California also has other mechanisms to advise the public procurement efforts.

Let's see. I believe those are the questions that I'm aware of right now Lammot. I believe that there were also some questions regarding CURES that perhaps our colleagues at the Department of Justice wanted.

Lammot Du Pont

Sure. Tina and Baskar, are you on the line?

Okay, well we check if they get off of mute. I believe there are some other technical questions, Walter, that we've keyed up for you to address. Do you want to handle those?

Walter Sujansky

Sure. Sure. One question is—I'll just read the question—"Is the CURES integration intended to go through the HIO versus directly between the provider's organization's EHR and the CURES API?" So, to qualify as a integration that is performed as part of the Cal-HOP program and for which the incentive payments are made, it must go through the HIO. However, as mentioned, it can go through directly between the

provider organization's EHR and the CURES API, but that would fall outside of the Cal-HOP program. So, the organization could be exempted from completing that integration via the HIO, but it would not receive any funding from the Cal-HOP program for that particular integration.

The second question was, and again I'll read it, "What happens if one EPIC instance, for example hosted by OCHIN, is shared by several qualified provider organizations and an HIO wants to onboard many such qualified provider organizations?" That's an interesting question. I would say that the provider organization—I'll defer to Raul on the final verdict on this. In my opinion, for each distinct provider organization, they would essentially be treated as if they had one EHR instance, the one hosted by OCHIN, and they would then onboard and complete the milestones with a particular HIO, and that would count as one onboarding. If another provider organization used the exact same instance of EPIC, and this is kind of a unique situation with OCHIN where multiple distinct provider organizations are using the same instance—and those organizations may even be drastically different geographic areas—I would say that that second provider organization that happened to also be using the same instance of OCHIN would qualify as a separate onboarding instance, if you will, and be eligible for separate onboarding payments. But I think we need to discuss that a little bit more. An alternative would be to for each HIO that OCHIN built an interface for its EPIC instance, that would only count as one onboarding. This specific edge case is an open issue. Raul, did you want to add anything to that?

Raul

No, other than—well I'll try. I concur. I think there's a little more discussion that we need in regard to this scenario.

Walter Sujansky

Okay, thank you. I think those were the only ones. Maybe we can go on to the DOJ folks, if they're available now.

Tina and Baskar

Hi, we're here.

Lammot du Pont

Great. So Tina there was a question with respect to CURES. Do you mind addressing that?

Tina and Baskar

Um, sure. Let me see if I can locate which one we're looking at.

Lammot du Pont

Would it help for me to read it to you?

Tina and Baskar

Yeah it would be. Thank you.

Lammot du Pont

Sure, yeah. And it's, "Have you confirmed that CURES is able to implement APIs with any organization during the timeframe?"

Baskar

Yes, um. So you want to understand the volume of the HIOs that will be participating in the program so that we can plan and give it information. It also depends on the volume of transactions that each HIO has. So, we need to consider those aspects before we can answer that question.

Tina

Yeah. And I'll just, like, add to that. There is like some expectation of readiness on the HIOs part technologically to run through the battery of test scripts that we require before they get put into production. So there's a little bit of—you know, there's a couple of things going, you know. Yes, we have to execute the MOU and we can do that fairly timely. And then there's also the testing process that is not just entirely on the DOJ end; it's also on the HIO's part. So there's definitely engagement from two sides to make that happen, and so there's going to be dependencies on both sides to help facilitate the full onboarding process. So, I just wanted to make sure everybody was aware of that.

Baskar

And they need to be aware of the technology as well. We had [an integrating?] solution. We use a standard called MTPTP version part 10.7. So the HIOs need to be familiar with that to be able to connect with that.

Tina

We have a fairly detailed website on the CURES web service and the onboarding process and the CURES web service implementation guide, which is a technical document. So that's something, you know. For those who aren't already aware of it, they should review that information, because those are our requirements for getting signed up to the web service.

Okay, was there another CURES question?

Lammot du Pont

No Tina. Not at this time. There are a couple of questions related to what constitutes and counts towards demonstrated support for an HIO interested in being a qualified HIO. One of the questions was, “Can organizations that are already participating with an HIO be counted towards the 25 needed to qualify as a qualified HIO?” And the answer is yes. Then they may be existing participants. They do not need to be new participants.

There’s another question to, with respect to that, is “What does ‘demonstrated commitment’ mean in regards to the 25 organizations? Would a letter of support be enough?” And yes it would. The intent is that it’s a demonstrated letter of commitment to abide by the requirements of Cal-HOP so that there will be some standard language with respect to the type of letter that would demonstrate support to participate in the program.

Okay. And with that we have come to 11 o’clock. There’s some additional questions that have rolled in while we were answering these, and we will reply and post responses to these in the methods that Raul described. So Raul, I will turn it over to you for any closing comments or thoughts.

Raul

Ah, thank you Lammot. I just want to say thank you all for participating in this webinar. Again, a reminder that there is a second webinar that will be held March 1st with an emphasis on onboarding provider practices. We intend to review the numerous questions, and I think there were over 40 questions that were received during the webinar, answer those and post those to the Cal-HOP web page. And to the extent that we could get our listserv established here in the next couple of days, communicate that information out. So, thank you all for your interest and participation and we look to hearing back from CMS on their approval and commencement of this program, which I think is going to provide an invaluable service to our Medi-Cal provider population and result in improved health outcomes of our Medi-Cal members. Thank you.

Tim

Ladies and gentlemen, that concludes today’s event. You may now disconnect your lines, and have a great day.