TRANSCRIPTION OF WEBINAR
CALIFORNIA HIE ONBOARDING PROGRAM (Cal-HOP) PROGRAM DESCRIPTION & PROVIDER REQUIREMENTS – MARCH 1, 2019

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Tim	Hello, and welcome to California HIE Onboarding Program Cal-HOP Program Description and Provider Requirements. My name is Tim, and I'll be in the background answering any WebEx technical questions. If you experience technical difficulty at any time during this WebEx event, please submit your technical issue in the Q&A panel, and I will assist you. You may also contact our WebEx technical support at 1-866-779-3239. Please note that as an attendee, you are part of a larger audience today. However, due to privacy concerns, the attendee list is not displayed. All attendees will be in a listen-only mode for the duration of today's call, and as a reminder, this call is being recorded. We will be holding a Q&A session at the conclusion of today's presentation. You may ask a question at any time throughout the event by entering it into the Q&A panel at the lower right of your screen. With that, we invite you to sit back, relax and enjoy today's presentation. I would now like to introduce your speaker for today, Raul Ramirez, Chief of the Office of Health Information Technology. Raul, you now have the floor.
Raul Ramirez	Thank you, Tim. And welcome everybody to the California Medi-Cal HIE Onboarding Program webinar. We can advance the slide, please. Today, the goals are to provide details on California's Medi-Cal HIE Onboarding Program, known as Cal-HOP, and to address questions from provider organizations on the call. Next screen. The agenda for today includes a Cal-HOP overview and timeline, the Cal-HOP structure. We will describe criteria for qualifying provider organizations, Milestone achievements, and at the end of the webinar, answer questions, as time permits. Next. A brief overview of the Cal-HOP program. Next. The vision for Cal-HOP is to expand Medi-Cal providers' access and use of HIE services. We intend to help Medi-Cal providers meet meaningful use measures, improve provider access to information across a medical community, improve care

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	coordination in the quality of care for patients, improve efficiency by reducing unnecessary utilization and waste, and supporting specific Medi-Cal initiatives, including waiver programs such as the Whole Person Care Program.
	Our approach is to establish an incremental progression of achievable Milestones that incentivize the use of HIE services. We hope to expand participation in the community-focused resources of California's HIOs that have the technical capabilities to meet our vision. We will give Medi-Cal providers and HIOs the flexibility to determine how Milestones will be achieved. We hope that we are balancing program accountability and operational efficiency. And we will be rigorously monitoring and evaluating the program and making adjustments as needed with CMS approval. Next.
	There are several goals for the Cal-HOP program. The first is increasing the number of Medi-Cal providers exchanging patient data via a regional HIO. As you know, the value of electronic data exchange for Medi-Cal members and payers increases when the vast majority of Medi-Cal providers within a region participate in an HIO data-exchange network.
	We also hope to expand the exchange capabilities of Medi-Cal providers that are already participating in regional HIOs. As you know, many HIO participants aren't exchanging the full complement of data that will improve the care of their Medi-Cal members. HIO participants also find it difficult to access important HIO data directly from within their EHRs and workflows.
	And, finally, we hope to facilitate Medi-Cal providers' access to the CURES prescription drug monitoring database. The prevailing method of accessing CURES today is via web portal that requires extra workflow steps for providers.
	Integrating CURES directly into the providers EHRs will greatly facilitate compliance with the law and help to reduce over-prescribing of controlled substances, thus addressing the opioid epidemic. Next.
	Some important dates. The Department expects to officially launch the program in June of 2019, once we receive CMS

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	approval of Cal-HOP and supporting contracts. And the Cal-HOP program will sunset on September 30, 2021, along with the sunsetting of the Promoting Interoperability program. Therefore, it's important to note that all Cal-HOP activities much be completed on or before September 30 of 2021. With that said, I'd like to turn the presentation over to Lammot du Pont, with Manatt Health. Thank you.
Lammot du Pont	Thank you, Raul. Next slide, please.
	I'll walk us through the oversight and implementation of Cal-HOP. Next slide, please.
	So, Cal-HOP has three basic features. The first is that there is up to $50 million available for the program through September 30, 2021. $45 million of that $50 million is from federal resources. The remaining $5 million is a match from the state's general fund that's been approved by the California legislature.
	The second important element is that Cal-HOP is a Milestone-based payment program. DHCS will make incentive payments for HIOs and Medi-Cal providers when, working together, meet specific onboarding and HIE connection Milestones.
	And the third important component are the Cal-HOP participants. The participants include DHCS, which will be responsible for overseeing the program and distributing funds. The second participants are regional HIOs, which will apply to become qualified to participate in the program and will receive payments for meeting Milestones with qualified provider organizations. And the third key participant are Medi-Cal provider organizations. These are the hospitals and practices and clinics that will be qualified to participate in the program and receive support from the qualified HIOs. Next slide, please.
	The program will be overseen by two entities, CMS and DHCS. CMS will establish rules for participating and use of funding, they'll review and approve DHCS's program plan, and they'll monitor the program by reviewing contracts and Milestones. In turn, DHCS will establish criteria for qualifying for the program, establish Milestones and payment amounts, and monitor the program and report to CMS. Next slide, please.

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	While DHCS will oversee the program, implementation will be supported by a Management Support Contractor, which will support program implementation, monitor participants' progress against performance Milestones, and submit reports to DHCS, and collect documentation from the Qualified Health Information Organizations. Next slide, please.
	QHIOs, or Qualified HIOs, are California HIOs that meet specific organizational characteristics and technical Milestones. They onboard qualified Provider Organizations, they deliver HIE services to qualified Provider Organizations, and they submit performance reports to the Management Support Contractor. Additional information on Qualified HIO requirements were reviewed in last week's webinar presentation, which will be available soon on the DHCS website. Next slide, please.
	The second type of Cal-HOP participants are the Qualified Provider Organizations. And these are Medi-Cal provider organizations that meet specific characteristics and have certain technical capabilities. They onboard to a qualified HIO, and they meet the technical connectivity Milestones with a qualified HIO. Next slide, please.
	Slide 13 illustrates the key Milestones over the next five months. We divide this five-month period into two phases. The pre Cal-HOP Launch, and the post Cal-HOP Launch, which are delineated by an anticipated official program launch date of June 1st. During the pre Cal-HOP Launch period, providers in HIOs should begin discussions and planning activities. HIOs interested 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. For providers interested in learning more about California's HIOs, we encourage you to review the recently released report on HIOs listed at the bottom of this page. In late March, HIOs will apply to DHCS to become qualified HIOs. DHCS will review those applications and, in early May, DHCS will notify those HIOs that are designated as qualified of their status and post that status on the DHS website. Those not selected to be a qualified HIO, or those that did not submit applications in March, may apply to be designated as a qualified HIO at a later date. DHCS will accept applications to serve as a qualified HIO on a

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	rolling basis. In June, the post Cal-HOP Launch phase will begin. And at that time, any activities that a Qualified HIO and Qualified Provider Organizations undertake will be eligible for Milestone achievement payments. In July, qualified HIOs and their partnering Qualified Provider Organizations will submit their plans for which Milestones they expect to achieve, and when they expect to achieve them. Next slide, please.
	Now, I'll move in to a discussion of the Funds Flow. Next slide, please.
	Cal-HOP Funding has three basic components. The first, as noted earlier, is that there'll be up to $50 million available. Some of that funding will be used to support program implementation and monitoring. The second important component is the Program Deadline. CMS prohibits payments for any activities performed after September 30, 2021. And the third component is the Program Focus. Cal-HOP has limited funds and is not able to reimburse Medi-Cal providers or the HIOs for all the costs that they may incur to connect to HIO services. DHCS recognizes that Cal-HOP's Funding has limitations and is exploring other mechanisms to help cover the costs to implement access and use HIO services. Next slide, please.
	Cal-HOP funding is triggered by achievement of Milestones and the documentation and reporting of that Milestone achievement. Starting from the bottom left-hand side of the slide, the process begins in Step 1, with a Qualified Provider Organization and a Qualified HIO collaborating together to meet specific Milestones. Moving up to Step 2, the Qualified HIO collects Qualified Providers' documentation and then submits an invoice to the Management Support Contractor. Moving up to Step 3, the Management Support Contractor reviews the documentation and forwards a recommendation to DHCS for final review and approval. Please note on the bottom right-hand side that Qualified HIOs will be able to submit documentation for achieving Milestone to the Management Support Contractor as they occur on a rolling basis. Next slide, please.
	The Cal-HOP Payment Process also has three steps. Once Milestone achievement information is reviewed and approved by DHCS, DHCS will make incentive payments to the Management Support Contractor, as illustrated in Step 4. In Step 5, the

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	Management Support Contractor will distribute payments to the Qualified Health Information Organizations. In Step 6, Qualified HIOs will allocate the funds they receive to support the Qualified Provider Organizations' onboarding and interfacing efforts. Please note that DHCS will make payments to the Management Support Contractor within 45 days of receiving a valid request. The Management Support Contractor will then be required to make approved payments to Qualified HIOs within 10 days. Next slide, please.
	With respect to Funding Relationships in Milestones, there's three important considerations. First, Qualified Provider Organizations must designate and work with a single Qualified HIO for achieving the Cal-HOP Milestones. And, once a qualified Provider Organization achieves Milestone 1 with a Qualified HIO, it must continue to work with that Qualified HIO to achieve any further Cal-HOP Milestones. In other words, it may not switch and achieve Milestones 2 or 3 with another Qualified HIO. Finally, please note that Qualified Provider Organizations may participate in and connect to multiple Health Information Organizations. But Cal-HOP payments will only be made for Milestones achieved with one designated Qualified HIO. Next slide, please.
	The amount of payment associated with achieving a Milestone will be based on the number of interfaced EHR instances that the Qualified HIO and the Qualified Provider Organization connect and not on the number of facilities that the Qualified HIO and Qualified Provider Organization connect. To help clarify this payment structure, this slide illustrates three scenarios with the Qualified Provider Organization having differing technology situations. Each scenario has a single hospital system representing a Qualified Provider Organization and three Hospital Sites. In Scenario 1, the Health System is using a single EHR instance across all three sites and will be paid for interfacing one EHR instance. In Scenario 2, the Health System is eligible to be paid for interfacing two EHR instances because it's maintaining separate EHR instances at its three sites. In Scenario 3, the Hospital System has three sites and three separate EHR instances. In this case, the Qualified HIO-Qualified Provider Organization is eligible to be paid for interfacing three EHR instances. Next slide, please.

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	Slide 20 provides examples of some of the allowable and prohibited uses of Cal-HOP funding. CMS rules stipulate that funding must be used to onboard only providers that bill or render services for Medi-Cal. It must be used to help Medi-Cal Eligible Professionals and Hospitals fulfill their meaningful use obligations and measures in the Promoting Interoperability Program. Funding may not be used for ongoing HIE operations. It can only be used for initial onboarding activities. And funding may not be used to purchase Certified EHR Technology or modify and existing EHR to add the functionalist to achieve certification.
	With respect to allowable uses, Qualified HIOs may use incentive payments to offset some of their costs, including the cost to connect to a Qualified Provider organization's HER. The cost to develop capabilities to perform the HIE services specified in the technical Milestones. And finally, use funding to help pay for and offset the costs to connect to statewide databases to achieve the specified Milestones. Qualified HIOs may also use payments to offset certain Qualified Provider Organization costs, including the cost for the EHR to connect to the qualified HIO or the cost for the organization to retain technical consulting support to develop interfaces between their EHR and the Qualified HIO. Next slide, please.
	Now I'll turn to discussing the Qualifying Criteria for Provider Organizations. Next slide, please.
	First, Cal-HOP is open to all providers that have valid contracts with DHCS or a Medicaid Managed Care organization to bill for Medicaid patients. And although the program is focused on supporting Medi-Cal members and help them meet the meaningful use requirements of the Promoting Interoperability Program, Cal-HOP does not exclude any Medi-Cal providers that may have already completed the Promoting Interoperability Program or may be ineligible for the Promoting Interoperability Program. The provider must also demonstrate that it intends to partner with a qualified HIO for the purposes of the program. In order to demonstrate that, it must have an executed letter co-signed by a Qualified HIO that confirms intent to onboard and implement the required interfaces. If the Qualified Provider organization is already onboarded to the Qualified HIO, the letter must document intent to implement additional interfaces to meet

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	the Milestone requirements. With respect to Organizational Capacity, DHS believes that an important ingredient for providers' ability to access health information is having the staff and resources to help make the connections to the Qualified HIOs. Therefore, DHCS expects Qualified Providers to have sufficient staff or consulting help to coordinate with Qualified HIOs in executing the legal agreements and implementing the data interfaces required to meet the Cal-HOP Milestones. DHCS recognizes that it's going to be hard for many providers to get the help that they need. Therefore, DHCS is exploring options to use some of the program funding to make technical assistance directly available to Cal-HOP participants. DHCS expects to have additional details on this technical assistance program later this spring. Next slide, please. There are also important technical requirements for Qualified Provider Organizations depending on the provider's participation in the Promoting Interoperability Program. For those Medi-Cal providers who are currently participating in the Promoting Interoperability Program, they must use a 2015-edition certified EHR or demonstrate that they have plans to upgrade or migrate to a 2015-edition certified EHR by the end of 2019. That electronic health record must also be capable of achieving the integration required to meet the basis HIE technical Milestones of the program. For Medi-Cal provides who are not currently participating in the Promoting Interoperability Program, they must be using health information technology that is able to send and/or receive clinical data that help Eligible Professionals or Eligible Hospitals meet the Promoting Interoperability measures, and achieve the integration required for the Cal-HOP's basic HIE technical Milestones. With that, I'll conclude and pass the microphone over to Walter Sujansky, a principal of Sujansky & Associates, who will lead us through the discussion of the Milestone achievement details.
Walter Sujansky	Thank you, Lammot. Can you hear me?
Lammot du Pont	Yes, I can hear you.
Walter Sujansky	Okay, great. Thank you. Why don't we go to the next slide, then? Introducing the section on Milestone Achievement. Before we jump in to this, I did want to just take a moment and remind everyone that we will be taking questions, addressing your

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	questions in a little while, near the conclusion of the presentation. But, we – those questions must be submitted through the webinar Q&A feature. We'll not be opening up lines for you to submit your questions. So, if you already have questions, or as you formulate questions, please go ahead and submit them to – through the webinar feature. All right. Great. Let's move on to the next – I'm sorry, before we do that, let's back up one slide just to introduce this. As Lammot mentioned, the Cal-HOP funding is triggered by the achievement of certain Milestones, and this part of the presentation will describe what the Milestones specifically are, the various ways they can be achieved, and what the specific incentive program amounts are for each Milestone, depending on the type of provider organization that achieves it. Next, please. So, the focus of the Milestones is to create certain specific types of digital connections between Provider Organizations and HIOs, with the goal of enabling certain high-value use cases. One important point is that the Milestones are generally the same for different kinds of Provider Organizations, Milestones themselves, but the payment amounts may differ between these types of providers, specifically, the type of Provider Organization will, in certain cases, entail a different payment amount. If the provider is a Hospital or is a smaller Ambulatory Organization, defined as with fewer than 10 providers, or larger Ambulatory Organization. The size of the organization will be based on – the count will be based on CMS' definition of eligible professional as the number of providers. And you can look that up elsewhere for a specific definition of eligible profession on that regard. Next, please. So the program consists of three sequential Milestones that roughly consist of first, Milestone 1, initiating participation in the Cal-HOP program to begin with – I'll talk about each of these Milestones in turn in a moment. Milestone 2 entailing implementing certain basic interfaces and it is a requirement of the program to achieve the interfaces of Milestone 2, at least those interfaces. Then Milestone 3 consists of implementing certain advanced interfaces and proceeding to Milestone 3 and implementing those interfaces is an optional component of the program.

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	Before talking about the details of this, a few important timing considerations should be noted. First, Milestone 2 must be completed within one year of Milestone 1 being achieved. Given the short time frame of the overall program, time is of the essence, so the program is incentivizing expedient achievement of the required Milestone 2 at a minimum, that being within one year.
	Also, Milestone 2 and Milestone 3, if it's undertaken, must both be completed before the program ends on September 30, 2021. So in certain cases if Milestone 1, for example, is completed on January 1, 2021, then that would be only nine months to complete Milestone 2 and Milestone 3. So again, best to begin as quickly as possible.
	And then lastly, in certain cases it may occur – in certain situations may occur that will give DHCS the right to rescind funding distributed to the qualified HIOs in this program. For example, if a live connection for Milestone 2 and Milestone 3 are not maintained for one year after implementation, or if Milestone 2 is in fact not achieved within one year of achieving Milestone 1, prior payments, Milestone 1 payments in particular may be rescinded or clawed back by DHCS. Next slide please.
	So turning to the Milestone, the first one is initiating participation in Cal-HOP which consists of four largely administrative components, some of which Lammot already mentioned. The first one is that the provider organization signing and delivering to its designated HIO attestation of its Medi-Cal participation. Secondly, signing and delivering attestation of the provider organization vendor's readiness to achieve the selected Milestone goals to the extent that the vendors will be needed to participate in the program in order to implement some of the interfaces, which will often be the case. The goal there is to encourage provider organizations to begin immediately thinking about the technical aspects of the interfaces that they intend to build in this program and making sure that their vendors are, and their technology is ready to implement those interfaces.
	The third step in this is providing executed documentation of the qualified provider organization's participation with the designated

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qualified HIO. This generally consists of the legal documents, which is a participation agreements and data sharing agreements and so forth. And lastly, as Lammot mentioned that there needs to be a signed agreement with the QHIO documenting the provider's organization's intent to participate in this Cal-HOP program with the particular QHIO and a projection of which specific Milestone it intends to achieve.

Upon completion of these documents and delivery by the QHIO of them to DHCS, the QHIO will qualify for payment of the Milestone amount shown here, and as mentioned, depending on different organizations, hospitals receiving $25,000 and each of the types of ambulatory provider organizations receiving $5,000 for achieving Milestone 1. Next slide please.

The second Milestone consists of two specific components, which we'll call 2A and 2B. 2A entails provider organizations submitting encounter notifications and event notifications to the HIO and being able to access similar notifications submitted by other provider organizations. Specifically, what this entails is for hospitals is that the HIO and the hospital must implement a live feed of ADT or equivalent types of messages delivered to the HIO within 24-hours of an ED visit, a hospital admission or a hospital discharge for all Medi-Cal patients who are eligible to be included in the HIO, that is for all Medi-Cal patients who are not opted out in some way from the HIO.

If the hospital also includes out-patient clinics, those clinics, must submit at least a daily feed of their ADT equivalent messages within 24-hours of an ambulatory encounter, again for those Medi-Cal patients that are eligible to be an HIO.

Lastly, the person at the hospital must have access to and use of an ADT based encounter notifications provided by the qualified HIO. In other words, to receive information about notification that other provider organizations submitted to the HIO. And those must either be available through a query response mechanism to pull them from the HIO or a published subscribed mechanism by which the notifications are sent, pushed to the provider organization.

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	For provider practices, clinics and other ambulatory non-hospital organizations, the requirements are similar to that for the ambulatory clinics at a hospital. They must provide at least a daily feed of ADT equivalent messages to the HIO within 24-hours of an encounter by those same Medi-Cal patients and they must have demonstrated acts as to the notifications provided by other organizations to the HIO through a pull and push mechanism.
	Upon completion of this first part of Milestone 2, you can see the payment amounts that will be made available to the HIO, that's demonstrating completion of this. Note that the payment for smaller ambulatory provider organizations that are provided these types of interfaces are actually a little larger for the larger ones, given the fact that smaller organizations, smaller providers typically have fewer resources in terms of personnel and technology to achieve this type of interface. So, more funding is being made available to that. Next slide please.
	The second part of Milestone 2 consists of integration of the provider organization's EHR with the CURES prescription drug monitoring database. Specifically to support querying of the CURES database for patients drug dispense records at the time of prescribing. As Raul mentioned, the integrated access and streamlined access to the CURES database is one of the key elements of the overall Cal-HOP program. So, CURES integration has been made part of the required Milestone to components.
	In order to meet this Milestone 2B, the provider organization and HIO can do this in one of two ways. First, there can be a CURES data querying and data retrieval function that is provided by the qualified HIO and is integrated into the clinical workflow of the qualified provider organization's EHR, again to enable that streamlined access to the CURES database via the HIO.
	Alternatively, a qualified provider's organization can integrate with the CURES database in different ways, other than through the HIO. For example, through their EHR vendor directly or through a third party. And if this has been done and the provider organization and EHR are essentially exempt from having to meet this requirement to be through the qualified HIO.

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	In these cases, although in some sense they will have met Milestone 2B, because no actual implementation was done, the payment amount will essentially be no payment associated with Milestone 2B, although the HIO provider organization will get credit for completing Milestone 2 in its entirety.
	When Milestone 2B is implemented, however, the payment amount shown at the bottom here will be made to the HIO. Again, the amounts for smaller provider organizations are somewhat larger to accommodate the lesser resources in general of smaller organizations to implement the interfaces for this Milestone. Next slide please.
	Milestone 3 consists of implementing several advanced interfaces. And as mentioned unlike Milestone 2 is optional. Provider organizations don't need to go onto this. But if they do, they must implement a specified number of advanced interfaces selected from our list of 35 designated interface types. Hospitals must need to implement five of these advanced interfaces and ambulatory providers must implement 3 such interfaces.
	Beyond the 35 designated interface types, which we'll show in a moment, qualified provider organizations and HIOs may identify alternative types of interfaces to qualify for Milestone 3 achievement and propose those in addition and instead of the 35 designated ones. And upon approval by DHCS, those can count towards achievement of Milestone 3. Next slide please.
	So this slide shows the 35 allowed interfaces and divided here into several categories for convenience. We're not gonna go through each one of them here, but I'll touch upon the categories briefly. Category A consists of data feeds, essentially from qualified provider organizations, EHR to an HIO to submit relevant clinical data, such as laboratory results, referral request consult notes, etc. to the HIO.
	Category B consists of interfaces through the HIO between provider organizations and certain public health registries, such as the CAIR immunization registry, CalREDIE reportable registry and POLST registries as well.
	Category C consists of delivering interfaces to deliver clinical data from HIOs to provider's EHRs, specifically through web services

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	APIs, for example FHIR APIs. And again, similar set of clinical data types can be transmitted through these allowable interfaces under Milestone 3.
	Category D recognizes that certain provider organizations don't actually submit their data to the HIO en masse, but make it available in local edge servers that are queried by the HIO at the time that information is retrieved. And so, the implementation or extension of one of these types of edge servers is also allowed as a Milestone 3 interface.
	And Category E just recognizes, I mention, that other types of alternative interfaces can be proposed and if accepted allowed to count towards Milestone 3. Next slide please.
	So, this slide just filling new information here is the payment amounts for Milestone 3 as you can see in the bottom right hand corner of the slide. The payment amounts here for hospitals are higher because, again, the hospitals are required to implement five of these interfaces, whereas ambulatory providers are only implementing three. And then the payment amounts for smaller and larger ambulatory providers are the same in this case because we feel that the amount specified should be adequate in both cases to implement just the three interfaces that are required for Milestone 3. Next slide please.
	Now we'll go on just to make this more concrete. A few example scenarios of different ways that provider organizations and HIOs can achieve the Milestones just described.
	The first scenario entails a provider organization meeting Milestone 1 through documentation of CAL-HOP eligibility and so forth. And then going on to implement an ADT submission and event notification interface with the HIO. And, in this case, not implementing the CURES integration because with the HIO because the provider organization has already implemented such an integration, perhaps through its EHR vendor directly to the CURES database. And also then choosing not to go on to the optional Milestone 3. Completion of advanced interfaces. This is generally the minimum Milestone achievement that is required to receive payment under the program.

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	Next slide.
	And again Milestone reminding you that you must be completed within one year of Milestone 1, but Milestone 3 is optional.
	Next
	And in this case you can see the payment amount that will be made to the hospital. In this case, to the hospital. The hospital that achieved these Milestones, corresponding to the completed Milestone event.
	Next
	This is a separate scenario, called a maximum payment scenario where a hospital in this case completes both elements of Milestone 2 and then goes on to complete Milestone 3 all within the allowable timeframes. Here, of course, the full amount of payments for each Milestone is disbursed to the HIO on behalf of these interfaces and HIO supports the provider organization with these funds.
	Next
	This scenario shows the situation where a hospital in this case is already participating in an HIO at the time the Cal-HOP program starts but wishes to use the funding to add additional types of interoperability and interfacing with the HIO. In this case, the hospital by virtue of its prior participation is already sending ADT messages and event notifications to the HIO. So, it is exempted from that component of Milestone 2. But, it must go on and in this case it goes on to complete the CURES integration through the HIO also in 2B and proceeds to implement 5 new advanced interfaces to Milestone 3. In this situation you can see the payments that are disbursed there and the total for this scenario. Next please.
	Scenario 3 is a variation of Scenario 2, again for a hospital that is already participating in an HIO, already sending ADT messages to the HIO. But in this case, the hospital's also already interfacing to the CURES database through its EHR via the EHR vendor, a third party, not the HIO. In this specific situation, this is the only one like this, the provider organization and HIO can go on immediately

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after Milestone 1 to implement the new advance interfaces of Milestone 3 and to receive payment for that upon completion.

As you can see, the organizations receive essentially credit for achieving Milestone 2, the components of Milestone 2, although they don’t receive payment, they are allowed to go onto Milestone 3. Next please.

As I mentioned earlier, there are certain situations in which payments made for Milestone 1 may, in fact, be clawed back, rescinded in situations where, as in this case, a hospital fails to complete or get exemption for any of the Milestones, 2A, 2B or 3, within the required timeframes. This policy of the program underscores the need to truly map out and foresee the level of effort of what will be required to achieve at least Milestone 2 for any provider organization that engages in the program and intends to participate in Milestone 1 payments may not be kept in certain cases if the other elements of the program are not completed. So important to be aware of that before embarking. Next please.

In fact, completion of the Milestones as specified is so important that even in this scenario funds may be rescinded by DHCS. This is a scenario in which a hospital completes Milestone 1, goes on to complete Milestone 2A, the ADT submission, and that notification interface. And, in fact, even goes on to complete five advance interfaces of Milestone 3. But along the way has neglected to either implement the CURES interface through its HIO or to otherwise implement a CURES interface directly to its EHR through its EHR vendor, for example. So, it ends up by the conclusion of the program not having achieved Milestone 2B. In this case, the program DHCS will consider Milestone 2 to not have been completed. So, no Milestone 2 payments will be made. And in fact given that Milestone 2 is a requirement of the program, neither will be the provider organization and HIO be paid for achievement of Milestone 3. Again, this underscores the importance of the program to achieving both of the elements of Milestone 2 as a condition of financial disbursements involved.

With that, that concludes this part of the presentation and the presentation itself and I’ll turn it back over to Lammot to address questions.

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Lammot du Pont	Thanks Walter. And as indicated earlier, if you have questions, please provide them in the chat feature of the WebEx. We've already had a couple of questions come in. And so, we will assign the questions to the corresponding speaker. So, Raul, can I turn the first set of questions assigned to you, over to you?
Raul Ramirez	Sure, thank you Lammot. So, the first question was when was the Cal-HOP plan submitted to CMS? The initial plan was to submit an IAPD update to CMS, which had all of the detailed information on the Cal-HOP program. We have been dialoging with our colleagues at CMS and it was agreed that the best approach in submitting this plan was to submit an informal version to them for review so that they could look at the overall concept and ensure that it aligns with the intent of funding under statement K of the director letter. And once that review was completed, which we are hoping will be done shortly, we could submit the formal IAPD update. By submitting a formal IAPD update that's already had some cursory review by CMS, we hope to avoid delays in the formal process. As you may be aware, when we submit an update, CMS had 60 days to review and so since they have questions that restarts the clock and they get another 60 days once we respond. So, through this process, we hope to mitigate any issues and actually expedite the implementation of the program as was seen on an earlier slide, our goal is to have all approvals and implementation in June. The next question is can PACE organizations qualify as a provider? And the answer is to the extent that Medi-Cal patients are being seen and the PACE program is receiving Medi-Cal reimbursement, then yes they can participate in the Cal-HOP program. The next question was last week a Cal-HOP listserv was mentioned, that list-serve cannot be identified or subscribed. We are in the process of establishing that listserv. We anticipate that it will be up and operational here in the next few days. That information will be posted on the Cal-HOP landing page on DHCS' website. The next question, how will DHCS determine payment if there are more requests than funding? I think it may have been mentioned, this in essence is a first come, first served program.

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	So, as the program is sufficiently approved and we begin to review proposals submitted by qualified HIOs, we will see the feasibility of those HIOs and providers capacity to implement the proposals that have been submitted for funding. And we will go ahead and issue, basically an award letter for authorization to proceed with those efforts. At this time, again, this is a first come, first serve program. I am reviewing some of the other questions, so Lammot if we could proceed.
Lammot du Pont	Sure. So, we had a question with respect to the availability of the presentation that was given last week. And I apologize, we are still in the process of finalizing the modification of the PowerPoint into ADA compliance, but it should be available in the next few days and it will be posted on the DHCS website. And there will be a similar process that, next week, this presentation will be made available. We also had a question is there a way for a hospital provider who's already participating in an HIO to get funds? And the answer is yes. If you are already connected to a health information organization, you may not be currently providing data or have the integration that has been described in the Milestone achievements that Walter talked about. In which case then you would be eligible for the implementation of those EHR integrations that you have yet to achieve. And then we also had a couple of technical related questions. Walter, would you like to answer some of those?
Walter Sujansky	Sure. Yeah, the first one is if a provider organization is already doing ADT, can they do alerting in Milestone 2 and qualify for the payment for the accomplishment of that? So, by doing ADT, I assume that they are submitting the ADT messages as specified for ED visits, submissions, discharges within 24 hours of those events. They are already submitting those two to HIO. And it's not clear what is meant by can they do alerting. If the HIO provides alerting, then they are presumably already receiving – the provider organization is able to receive those alerts. And alternatively, if alerting is not provided by the HIO, but there is some mechanism to – through a portal for example even, to

Presenter	Transcript
	access the submitted events to the HIO, then that has already met Milestone 2 as well.
	So, it is not the intent of the program for hospitals themselves to be doing the alerting. The HIO is doing the alerting. And so the implementation of just the ADT interface to the HIO would meet their requirements of Milestone 2A. And therefore if that already existed, the hospital and HIO would not be, if I'm understanding the question correctly, would not be eligible to receive funding for that interface which already exists.
	And the second question has disappeared from my screen. Could you read it for me please Lammot? I'm not seeing it right now.
Lammot du Pont	Sure. There was a question to re-explain what they heard as a condition to having to implement five or three advanced HIE services. So a provider could not earn some incentive funds towards only one of the advanced interfaces. So, it might be worth –
Walter Sujansky	Okay.
Lammot du Pont	Walking through that again.
Walter Sujansky	Yeah, that's correct. There is a minimum number to – the Milestone 3 payment is a one amount payment, if you will, a bulk payment for the achievement of the minimum number of interfaces. So, it's not prorated by interfaces either. It's an all or nothing kind of proposition. So, indeed, if the hospital would have to implement five interfaces to receive any of that payment, in which case they would have to receive the full payment similarly and the third organizations, three.
Lammot du Pont	Okay, great. And then there was also a question with respect to post-acute care hospitals being eligible if they meet the qualifications listed in the presentation and the answer is yes. As long as they meet the qualifications being billing Medi-Cal and the technology requirements, they can serve as an eligible provider.
	And there are a couple of questions. Raul –
Raul Ramirez	Yeah. So, the next question was please confirm that Milestone payments are made to the HIO, not the provider directly, and are shared with the provider. Several times the speaker seemed to

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	say the payment goes to the hospital. So, that is correct. Payment is made to the HIO. I believe there is an expectation that the HIO and the provider organization work together to see how that funding may support some of the expenses incurred by both the HIO and the practice. Another question was will the technical assistance support function be similar to CTAP for meaningful use? We are still finalizing that, but the expectation is that technical assistance would be provided to qualified provider practices that demonstrated a need for that technical support. And more than likely, that is going to be Milestone based similar to the CTAP program.
Lammot du Pont	Great, thank you Raul. Walter, there's another technical question came in, number 14, can you address that?
Walter Sujansky	Yes. It says I work for an HCCN, health center control network, basically a consortium of community health centers. We have established a connection with many of our member health centers to a local repository we host with the intention to connect to larger HIEs. Would each health center receive the incentive? Yeah, this is a question we got on the last call with the HIOs as well. And I believe we still need to discuss this one. It depends, I would say, on the scope of the health center control network and if it goes beyond a single community health center, member health center, then the network – one option is for the network to receive the incentive funding for each such health center that it is essentially connecting to an HIO. Alternatively, if only a single interface is required to connect all of the community health centers to the HIO, it may be more reasonable to provide – and no additional effort is required for each separate clinical health center, community health center, then it may not make sense to provide payments for each of those health centers given that no additional work was required. This is something I think we need to still think about. If the questioner could reach out to us and we could go over the details of their particular situation, the size of the health center network, how many distinct health centers and the nature of the interface that we'll be implementing. That would give us further information to address that specific point.

Presenter	Transcript
Lammot du Pont	Okay, great. We also received a question asking if there would be a limited number of health information organizations selected to participate in the program. And the answer is no. As long as an organization meets the criteria for serving as a qualified HIO, they will be permitted to participate. There is no maximum number or ceiling for the number of HIOs that can participate. And Raul, there was another question.
Raul Ramirez	Yes, the question was since the program is Milestone based yet contingent upon cost reimbursement like, if the expense of achieving a Milestone is less than a Milestone amount, is it the lesser of the two, i.e., the sole provider office, Milestone 2 cost to $5,000 – the payment $5,000 not $7,000? So, the approach that we took going back to slide four that we talked about efficient and effective administration of the program and balancing the accountability and operational efficiency. While we initially thought that making this a reimbursement based program would be a great idea, I think administratively, it would be just too complicated. Therefore, there was a significant amount of research and analysis done to establish Milestones and Milestone amounts based on the HIE summit feedback and subsequent interviews these Milestones were identified. Therefore, this is no longer a reimbursement program. It is reimbursing cost through Milestones, so the payment would be the Milestone payment and not actual cost. There was another question, who would I reach out to directly? I think at this point the best thing to do is to submit any questions that you might have to our Cal-HOP web email and we will provide that at the end of this webinar.
Lammot du Pont	Great, thank you Raul. And it looks like we have exhausted the list of incoming questions. So, we'll do one more quick call and call for questions through the chat feature – and sorry the Q&A. So give folks a couple more seconds to see if they have any final questions. Okay, I see a couple more questions coming in. Thank you. Raul, can you address question number 18?

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Raul Ramirez	Yes. The question is what should HIOs do with the excess funds? Again, I think as I mentioned earlier, we recognize that there may be some efficiencies with certain provider practices, hospitals and HIOs. This is not a reimbursement program, it's Milestone based. Therefore, there's an expectation at least from the department's perspective that the HIOs and provider practices would be looking to distribute that funding according to costs and level of effort between themselves. So, there is no returning of funds since this is not a reimbursement, this is Milestone based. And with that, I would like to say thank you. The slides and questions from this webinar will be posted on the Cal-HOP website, which is a part of DHCS' website. So, if you go to DHCS' site and under search type in Cal-HOP, it will take you to that page and you will be able to find copies of the slides and information – responses to the questions that have been asked here in the very near future. Thank you very much for your participation. Thank you to all of the presenters and we hope to be in further communication providing updates on our progress in establishing this program. Thank you.
[Announcer]	Ladies and gentlemen, thank you for attending today's webinar. This concludes today's event. You may now disconnect your lines.