CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

California Health Information Exchange Onboarding Program (Cal-HOP)

Policies and Procedures

Date	Notes
10/28/20	Revised the following: • Supporting Documentation for Cal-HOP Milestones
11/12/20	Revised the following: • Supporting Documentation for CURES Interface Completion • Sub-Contractor Requirements
12/1/20	Revised the following: • Milestone 2b-CURES link
12/18/20	Revised the following: • Onboarding Plan, • Requirements for Qualified Provider Organizations, • Milestone 2a- Admission/Discharge/Transfer (ADT) Transmission • DHCS Reporting- Qualified HIOs are required to submit bi-monthly reports to DHCS addressing
12/21/20	Revised the following: • Payment Amounts
2/19/21	Revised the following: • Milestone 3- Advanced Interfaces • Milestone Payments • Milestone 1: Initiate Participation in Cal-HOP
3/11/21	Revised the following: • Milestone Payments
6/30/21	Revised the following: • Interface Modernization • Funding Adjustments

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Cal-HOP Policy and Procedures Guidance

The information provided below is intended to clarify program requirements delineated for the California Health Information Exchange Onboarding Program (Cal-HOP). This information will be updated as needed, and each section labeled as “new” or “revised” on a specific date for tracking purposes.

1. Requirements for Qualified HIOs

A. Be a not-for-profit, California-based organization

B. Provide evidence of financial viability and sustainability by demonstrating the following:

- Break-even or better operations each of the past two years, or have sufficient funding commitments from stakeholders to finance operations through the end of the program on September 30, 2021.
- Ability to scale operations to support the projected onboarding and other activities of the Cal-HOP program.

C. Commit to participation by any health care provider organizations that serve Medi-Cal patients in the HIO’s defined service region, regardless of their business affiliations or health IT vendors.

D. Provide evidence of Insurance and liability coverage by demonstrating adequate liability coverage relevant to the exchange of individually identifiable health information (e.g., directors’ and officers’ liability, data theft, data mismanagement, data generation errors, data breach, etc.), in accordance with such standards as may be required by regulation and/or agreed upon policies and procedures.

E. Demonstrate support from Qualified Provider Organizations by providing signed letters of interest for participation in Cal-HOP from at least 10 Qualified Provider organizations. These letters of interest should indicate a willingness on the part of the Qualified Provider organization to connect with the HIE to transmit and receive data.

F. HIO currently has a minimum of two non-affiliated hospitals committed to participating in data exchange with the HIO as demonstrated by a signed letter of interest for participation in Cal-HOP.

G. Technical Capabilities and Other HIE-related Requirements

- HIO is a currently a signatory to the California Data Use and Reciprocal Sharing Agreement (CalDURSA)
- HIO is currently a participant in good standing in the California Trusted Exchange Network (CTEN)

H. Reporting Requirements

- At a minimum, commitment to reporting requirements delineated in item 7 below.

I. Any HIO seeking to participate in the Cal-HOP program must have indicated its intent to seek qualification and submit an application and supporting documentation to DHCS by August 15, 2020 via email at: HIEOnboard@dhcs.ca.gov.

2. Onboarding Plan

A. Qualified HIOs are required by August 30, 2020, or within 30 days of approval as a Qualified HIO, to submit an onboarding plan that:

- Identifies current and planned staff to support projected onboarding.
- Documents the ability of the technology infrastructure to scale up to accommodate the projected onboarding growth.
- Identifies the methodology that will be used in relationships with healthcare provider organizations; including methodology for identifying qualified provider organizations: and for tracking a qualified provider organization's points of contact; end-user access credentials, use of certified electronic health record (EHR) systems, milestone achievement, attestation, and payment tracking.
- Specifies the organizations which has applied to, including organizational NPI; if organization is a hospital or ambulatory practice; if ambulatory practice, whether practice size is less than 10 or 10 and greater providers; projected start and completion date for each milestone to be achieved; a detailed explanation if an exemption is being requested for milestone 2b

(CURES) because the hospital/provider practice is already querying the CURES database through the HIO or has achieved EHR integration with CURES in a manner not involving the HIO; a list of all individual interfaces which will be implemented under milestone 3, including projected interface start and completion dates and the anticipated amount of invoices to be submitted up to $2.6 million.

- The plan for milestone 3 interfaces can be changed before submission of invoices if the list of milestone 3 interfaces is changed in the next report to DHCS and all interfaces are on DHCS's approved list.
- The list of healthcare provider organizations can be changed with prior DHCS approval.
- Clearly detail any planned modernization efforts within the onboarding plan and provide a justification for each modernization project which indicated the interface as substantial and necessary,
- Identify any Qualified Provider Organization which is known to receive services under Cal-HOP through another Qualified HIO and provide a justification as to the geographic need for this organization to onboard to an additional HIO.
- Identify if a Qualified Provider Organization is a standalone laboratory

Revised 12/18/20

B. Authorization for Onboarding to Multiple Qualified HIOs:
   - If a Qualified Provider Organization serves more than 2 counties, it may request permission from DHCS to designate its providers in up to two geographic regions to participate with different QHIOs serving only those geographic regions.
   - In the event more than one Qualified HIO designate the same provider organization in their onboarding plan, and DHCS is unable to approve an exception as defined above, DHCS will contact the provider organization to request a designation of which Qualified HIO will be the recipient of payment for milestones under Cal-HOP. Until this designation is received, DHCS will not accept invoices related to any work performed with this provider organization.
   - If, pursuant to the requirements of this section, a conflict between two onboarding plans arises, a Qualified HIO may voluntarily amend their onboarding plan to exclude the provider organization in dispute, and

surrender the option to receive funding under Cal-HOP for work related to this organization.

3. Requirements for Qualified Provider Organizations

A. Have a valid contract with DHCS, a Medicaid Managed Care Organization or other entity authorized to bill for care for Medi-Cal patients. For the purposes of this section, other entities may include an Independent Physician's Association (IPA) or a Health Center Controlled Network (HCCN).

B. Has executed a letter co-signed by a Qualified HIO that confirms interest to onboard (or if already on-boarded, the intent to implement additional interfaces). The following template letter may be used for this purpose: https://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Cal-HOP-Sample-Letter-of-Interest-Template.pdf.

C. Has sufficient staff or consulting help to coordinate with the Qualified HIO in executing the legal requirements and implement the data interfaces required to meet Cal-HOP milestones.

D. Has health information technology to send/or receive clinical data that assists eligible professionals and eligible hospitals to meet Promoting Interoperability Program measures and achieve the integration requirements for the Cal-HOP basic technical milestones.

E. If a Qualified Provider Organization is a standalone laboratory facility, the provider organization will not be required to utilize a Certified EHR.

Revised 12/18/20

4. Milestones

A. Milestone 1—Initiate participation in Cal-HOP
- Qualified Provider Organization signs a participation agreement, as defined in the Cal-HOP contract, or a letter of interest using the DHCS template which documents the organization's interest to participate in

Cal-HOP with the Qualified HIO, its readiness to achieve Cal-HOP basic technical milestones, and participation in Medi-Cal.

- The Qualified Provider Organization must designate and work with a single Qualified HIO for achieving Cal-HOP milestones, except as designated in the bullet below. It cannot switch to another Qualified HIO for the purposes of achieving Cal-HOP milestones, although the Qualified Provider Organization can participate and connect with multiple HIOs.
- If a Qualified Provider Organization operates outside the geographic service area of a single Qualified HIO, additional Qualified HIOs may seek approval by DHCS to onboard members of that QPO which are not already designated to receive services under Cal-HOP.
- A Qualified HIO may claim payment for Milestone 1 when implementing upgrades or new interfaces for an existing HIO partner. However, a Qualified HIO must provide all required documentation related to the applicable participation agreement, as defined in the Cal-HOP contract, or a letter of interest using the DHCS template.

B. Milestone 2a—Admission/Discharge/Transfer (ADT) Transmission

- For Hospitals—documented live (at least daily) feed of ADT transmission or equivalent content documents meeting HL7 standards delivered to the Qualified HIO within 24 hours of an emergency room visit, hospital admission, or hospital discharge for Medi-Cal patients. Also demonstrated access to and/or use of ADT notifications provided by the qualified HIO via a query/response (pull) mechanism or publish/subscribe (push) mechanism.
- For ambulatory Qualified Provider Organizations—documented (at least daily) feed of continuity of care documents (CCDs) or equivalent content documents meeting HL7 standards delivered to the Qualified HIO within 24 hours of an encounter for Medi-Cal patients. Justification for delivery beyond 24 hours may be provided for consideration in the onboarding plan. Also, demonstrated access to and/or use of CCD-based (or equivalent message) via a query/response (pull) or publish/subscribe (push) mechanism. In the case of standalone laboratories, the ADT equivalent will be reporting COVID-19 results to the HIE within 24 hours.

- Milestone 2a must be achieved within one year after Milestone 1 or by September 30, 2021 (depending on which occurs first).
- If the hospital or ambulatory Qualified Provider Organization provides documentation of prior deployment of a CCD/Event feed it will be deemed to have accomplished this milestone, but will not be eligible for the milestone payment.

Revised 12/18/20

C. Milestone 2b –CURES link

- Documented use of CURES PDMP 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. If the Qualified Provider Organization is already integrated with the CURES database from within their EHR or via a mechanism other than provided by the Qualified HIO (e.g. provided by their EHR vendor or a 3rd party), then the Qualified HIO will be exempt from this milestone and ineligible for payment. However, HIOs may receive milestone 2b payments for providers choosing to access CURES through the HIO interface even though the providers may have access through their EHR. Proof of the ongoing use of the HIO interface must be provided in order to receive the milestone 2b payment. A Qualified Provider Organization which does not prescribe any controlled substances within the scope of their normal business operations may be considered exempt from completion of milestone 2B.
- CURES interfaces to the HIO portal are acceptable for milestone 2b either by direct log on to the HIE portal or by single sign-on from the EHR.

Revised 12/01/20

D. Milestone 3 –Advanced Interfaces

- Hospitals must deploy at least 5 advanced interfaces for this milestone.
- Ambulatory Qualified Provider Organizations must deploy at least 3 advanced interfaces for the Qualified HIO to achieve this milestone. If the ambulatory provider is a standalone laboratory, the QHIO may meet the minimum requirements for this milestone by deploying only 2 advanced interfaces. In order to count as an advanced interface for

labs, the receipt of HL7 messages must be for non-COVID laboratory results.

- See list of approved interfaces at: https://www.dhcs.ca.gov/provgovpart/Documents/OHIT/Cal-HOP-Approved-Interface-Update.pdf.
- Qualified HIOs may request to change the advanced interfaces designated in their plan and for approval of additional types of advanced interfaces.
- The minimum number of required advanced interfaces must be deployed before invoicing for this milestone payment.
- An HIO may select multiple interfaces from the same category of approved advanced interfaces and count these toward the minimum number of required connections. In the case of CCDA documents transmitted via HL7, information included in the CCDA which is identified as a distinct advanced interface under Category A, may be counted multiple times toward the total number of interfaces achieved.

Revised 2/19/21

E. Interface Modernization

- A Qualified HIO may apply the modernization (or upgrade) of existing ADT (or equivalent) transmissions and advanced interfaces toward the completion of Cal-HOP milestones. DHCS must approve these upgrades as substantial and necessary during DHCS' review of the onboarding plan or invoice.
- The number of allowable interface upgrades shall not exceed 50 percent of all achieved interfaces for an individual Qualified HIO. Exemptions for the 2a or 2b milestones do not count toward the total achieved interfaces. Achieved interfaces exceeding the minimum required for Milestone 3 can be counted, but additional payments for Milestone 3 will not be made.
- If an exemption is claimed under Milestone 2A during the invoicing process, a Qualified HIO shall not be eligible to complete an interface upgrade pursuant to this section later in the invoicing process. A Qualified HIO may defer the completion of Milestone 2A while pursuing the completion of other Milestones, however, once an exemption is claimed at attestation this decision may not be reversed.

- Qualified HIOs should submit an Interface Upgrade form to DHCS for this purpose. In general, DHCS will only consider interface upgrades as substantial if the estimated developer and testing times combined equals or exceeds 20 hours for ambulatory provider practices and 40 hours for hospitals.
- Subject to DHCS approval, the addition of new hospital based location or ambulatory locations to an existing ADT connection may be considered for payment as an interface upgrade.

Revised 6/3/21

F. Timeframe for Milestones Eligible for Payment
    - Payment for the completion of milestones 2a and 3 will be issued only for milestones completed after the certification of an entity by DHCS as a Qualified HIO.
    - Qualified HIOs will be eligible for payment for milestone 2b if completed after February 25, 2020

5. Milestone Payments

A. Milestone payments are based on the number of interfaced EHR instances that the Qualified HIO and Qualified Provider Organization connect and NOT the number of facilities that are connected. If the Qualified Provider Organization uses an EHR for both hospitals and ambulatory providers that requires only one interface with the Qualified HIO, milestone payments will be made at the hospital provider level to the Qualified HIO.

B. Upon DHCS review and approval, a skilled nursing facility or an inpatient psychiatric facility may be considered for reimbursement at the hospital provider level. Qualified Provider Organizations which will be considered under this provision must generally perform work which is comparable to a hospital setting and utilize an inpatient EHR system or other health information technology comparable to a hospital specific CEHRT.

C. For the purposes of all Cal-HOP Milestone payments, a standalone laboratory participating in the program shall be considered an ambulatory provider

organization and the Qualified HIO shall receive payments according to the applicable payment schedule for ambulatory provider organizations except as specified in this section.

Revised 3/11/21

D. Milestone payments may only be made to one Qualified HIO for each qualified provider organization, unless otherwise approved by DHCS. DHCS will consider, based on demonstrated need, milestone payments to two or more organizations which serve the same provider organization but operate in separate and distinct geographic service areas. Milestone payments to two Qualified HIOs which share the same service area will not be permitted under this provision except as designated in Section 2 above. Milestone payments may not be issued more than once to the same Qualified HIO for work with the same qualified provider organization.

Revised 2/19/21

E. Payment Amounts
   - Milestone 1--$25,000 per hospital, $5,000 per ambulatory Qualified Provider Organization
   - Milestone 2a--$20,000 per hospital, $7,000 per ambulatory Qualified Provider Organization (10 or more providers), $10,000 per ambulatory Qualified Provider Organization (less than 10 providers).
   - Milestone 2b--$30,000 per hospital, $11,000 per ambulatory Qualified Provider Organization (10 or more providers), $15,000 per ambulatory Qualified Provider Organization (less than 10 providers)
   - Milestone 3--$75,000 per hospital, $25,000 per ambulatory Qualified Provider Organization (regardless of number of providers). If a QHIO meets this milestone for a standalone laboratory provider with only two advanced interfaces the payment shall be reduced to $16,650. If a standalone laboratory is able to demonstrate completion of 3 eligible interfaces under this Milestone, they will remain eligible for the full payment amount.

Revised 12/21/20

F. DHCS will recoup all funding distributed to a Qualified HIO if:
- Milestone 2a and 2b (if needed) is not achieved within one year of achieving Milestone 1 or September 30, 2021 (depending on which occurs first).
- Live connections for Milestone 2a and Milestones 2b (if needed) or Milestone 3 are not maintained for one year or until September 30, 2021 (depending on which occurs first).
- The number of interface upgrades exceeds 50 percent of all interfaces achieved for an individual Qualified HIO as of September 30, 2021. Exemptions for milestones 2a and 2b do not count toward the number of achieved interfaces. Achieved interfaces exceeding the minimum required for Milestone 3 can be counted,
- A letter of interest or participation agreement containing all required elements (as defined in the Qualified HIO contract) is not received by DHCS by September 30, 2021, DHCS will recoup all milestone payments.
- A Qualified HIO fails to successfully onboard at least one hospital and one ambulatory provider under the program contract. Onboarding intended to satisfy this requirement must include completion of at least Milestone 2a or 2b within one year of achieving Milestone 1 or September 30, 2021.
- Recoupments will not occur if:
  - the Qualified Provider Organization ceases health care delivery due to retirement, bankruptcy, closure, acquisition, or some other event not anticipated by the provider, or not communicated to or under control of the Qualified HIO; or
  - the Qualified Provider Organization discontinues use of the EHR or other system to which the interface was made or migrates to another EHR, either by choice or as a result of acquisition or some other event, and did not communicate that intent to the Qualified HIO at the time the milestone payment was invoiced.

G. Acceptable Use of Payments
- Offset Qualified HIO costs, including (but not limited to) costs to connect to a Qualified Provider Organization’s EHR, to develop capabilities to perform the HIE services for milestones, to connect to

statewide databases to achieve milestones, and to achieve meaningful use of Certified EHR Technology (CEHRT)

- Offset Qualified Provider Organization costs including (but not limited to) to EHR connection to the Qualified HIO, and a technology consultant to develop interfaces between their EHR and the Qualified HIO.

H. Unacceptable Use of Payments
   - Ongoing HIE operations
   - Onboarding of providers that do not care for Medi-Cal patients
   - Purchase of CEHRT

6. Funding Adjustments

A. Qualified HIOs may submit requests for additional funding up to $6 million when they have submitted invoices for 70 percent or more of all Milestone 1 activity under their most recently approved contract amendment. The merits of such requests will be assessed by DHCS within 2 weeks of submission. Such adjustments will require amendments of the qualified HIO's contract with DHCS and must be submitted to DHCS no later than July 30, 2021.

B. Requests for additional funding may be granted multiple times to a Qualified HIO which meets all applicable requirements in successive increments of up to $6 million. The maximum funding allotment to a single Qualified HIO shall not exceed $18.6 million.

C. Qualified HIOs that, in the judgement of DHCS, will not be able to invoice for the full amount of their allocation by September 30, 2021 will be subject to having their allocation reduced. DHCS will begin assessing the need for such reductions beginning in December 2020. Any such reductions will be made in consultation with the affected Qualified HIO and result in a contract amendment.

7. Reporting Requirements

A. Public Reporting—Qualified HIOs are required to provide:
   - Up-to-date, public listings of their current and planned services (including a schedule) to assist Qualified Provider organizations in meeting the Cal-HOP milestone requirements.
   - Up-to-date, public descriptions of applicable fees or fee-calculation methods for Qualified Provider's participation with the HIO in the Cal-HOP program.
   - Up-to-date, comprehensive public listing of participating provider organizations.

B. DHCS Reporting—Qualified HIOs are required to submit bi-monthly reports to DHCS addressing:
   - The names and NPIs of Qualified Provider Organizations onboarding for the current quarter.
   - Unless already captured through the submission of a submitted invoice, the specific data interfaces that have been completed for each Qualified Provider Organization onboarding under the Cal-HOP program.
   - The forecasted number of future qualified provider organizations and the milestones that they will be expected to achieve for the two upcoming months. At the midpoint of the contract period, but no later than 05/30/2021, a summary of direct payments made to support activities under Cal-HOP shall be included alongside the bi-monthly report for that period. This summary must include an aggregate sum of all payments made to offset costs to Qualified Provider Organizations, reimburse for technical support services provided by EHR Vendors, or to support costs incurred by Qualified HIO staff and/or subcontractors to support the completion of Cal-HOP milestones.
   - At the close of the contract period, but no later than 11/15/2021, a final summary of all payments made directly to offset costs to Qualified Provider Organizations, reimburse technical support services provided by EHR Vendors, or to support costs incurred by Qualified HIO staff and/or subcontractors to support the completion of Cal-HOP milestones shall be provided to DHCS. This payment

record must include sufficient detail to determine the total amount paid to an individual Qualified Provider Organization, subcontractor, affiliated EHR vendor, or other entity over the course of the program.

Revised 12/18/20

8. Invoicing

A. Preliminary Invoices
- Qualified HIOs must submit preliminary invoices for DHCS review to CalHOPInvoices@dhcs.ca,gov using the Milestone Detail Report (MDR) provided by DHCS.
- Preliminary MDRs must include all supporting documentation that demonstrates how the milestones included in the invoice were met.
  - Supporting documentation must be clearly labeled so that DHCS can easily identify which provider and milestone it relates to.
  - MDRs for Milestone 3 must specify which advanced interfaces were completed and supporting documentation must be provided for each advanced interface.
  - If not previously approved by DHCS, documentation that a upgraded interface is substantial and necessary must be provided.
- After conducting a review of the preliminary invoice, DHCS will contact the Qualified HIO notifying them of an approval or will clearly note any deficiencies with the preliminary invoice and/or the supporting documentation.
  All deficiencies must be remediated and if necessary a revised preliminary invoice may be required. DHCS must approve the preliminary invoice before the Qualified HIO can submit a final invoice.

B. Final Invoices
- Qualified HIOs must submit final invoices for DHCS review to CalHOPInvoices@dhcs.ca.gov or by regular mail to:

  Department of Health Care Services
  Attention: Errin Horstkorta
  1700 K Street
  P.O. Box 997413, Mail Station Code 0004
  Sacramento, CA 95899-7413**

****If submitting an invoice by courier (i.e. UPS, Fed Ex, etc.) please use the following address:**

Department of Health Care Services
Attention: Errin Horstkorta
1501 Capitol Avenue
P.O. Box 997413, Mail Station Code 0004
Sacramento, CA 95899-7413

- Final invoices must match the associated approved preliminary invoice. No additions, deletions, or other changes are permitted.
- Final invoices **must** include the following required information:
    - Date
    - Contract Number
    - The Contractor's name and address as shown in the contract.
    - The billing and/or performance period covered by the invoice.
    - Summary Statement-must include an original signature in blue ink (an electronic signature is **not** acceptable per the State Controller's Office).
    - Approved preliminary MDR

9. Supporting Documentation for Cal-HOP Milestones

A. Qualified HIOs are required to provide supporting documentation as defined in this section to affirm completion of each Cal-HOP milestone. DHCS will retain this documentation for auditing purposes. Supporting documentation provided pursuant to this section shall be accompanied by a table of contents and a narrative explanation, which clearly identifies how the information provided successfully demonstrates the completion of a specific program milestone. A combination of this description and the provided documentation should include at minimum; a description of the specific milestone or milestones the information is intended to demonstrate, identification of the sender and recipient of the transmitted data, and the date of information exchange. For supporting documentation

under Milestone 2b, a Qualified HIO must only provide proof of access to the HIO-maintained CURES interface.

Revised 10/28/20

B. Milestone 1: Initiate Participation in Cal-HOP
   - A signed DHCS-designated attestation form which includes the physical signature or certified digital signature of the Qualified HIO representative.
   - A letter of interest using the DHCS template, or a participation agreement signed by both the Qualified HIO and Qualified Provider Organization containing all of the elements of a participation agreement designated in the Cal-HOP contract. The date of signature by the Qualified Provider Organization and/or Qualified HIO on the letter of intent or participation agreement submitted to DHCS may precede the effective date of the Cal-HOP contract.
   - Until January 15, 2021, DHCS will make a Milestone 1 payment upon receipt of a signed letter of interest or a participation agreement regardless of whether all of the required elements for a participation agreement are present. After January 15, 2021 all milestone payments will be withheld until a letter of interest or participation agreement containing all of the required elements as defined by the Cal-HOP contract is received.
   - Documentation which was signed prior to the date of the Cal-HOP contract, and will be submitted as proof of this Milestone, may exclude an NPI or TIN, provided that the Qualified HIO designates the applicable NPI or TIN in the accompanying MDR.

Revised 2/19/21

C. Milestone 2A: Admission/Discharge/Transfer (ADT) Transmission
   - A signed DHCS-designated attestation form which includes the physical signature or certified digital signature of the Qualified HIO representative and either the electronic signature or upon condition of approval by DHCS, an email which certifies implementation of the relevant interfaces by the Qualified Provider Organization. Invoices for milestones completed after the

beginning of the Cal-HOP contract must be signed by the Qualified Provider Organization.

- A copy of a transaction log or a de-identified HL7 message (or other equivalent documentation) to and from the Qualified HIO and Qualified Provider Organization to demonstrate completion of the milestone.

D. Milestone 2B: CURES link

- A signed DHCS-designated attestation form which includes the physical or certified digital signature of the Qualified HIO representative and either the electronic signature or upon condition of approval by DHCS, an email which certifies implementation of the relevant interfaces through the Qualified Provider Organization.
- Invoices for milestones completed after the beginning of the Cal-HOP contract must be signed by the Qualified Provider Organization.
- Proof of integrated CURES access in the form of screenshots, user access logs, or other relevant documentation to demonstrate the milestone.
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E. Milestone 3: Advanced Interfaces

- A signed attestation form which includes the physical signature or certified digital signature of the Qualified HIO representative and either the electronic signature or upon condition of approval by DHCS, or an email which certifies implementation of the relevant interfaces through the Qualified Provider Organization. Invoices for milestones completed after the beginning of the Cal-HOP contract must be signed by the Qualified Provider Organization.
- A copy of a transaction log, sample continuity of care document, a de-identified example transaction, or other relevant documentation to demonstrate completion of this milestone.

10. Supporting Documentation for CURES Interface Completion

A. Qualified HIO's are required to provide the following documentation at the time of invoicing to demonstrate successful completion of a CURES interface with DOJ and to support all costs incurred as a function of this project:
   - A document of acknowledgement from the DOJ, which follows the DHCS designated template, that the CURES interface was successfully established.
   - A copy of the fully executed MOU between DOJ and the Qualified HIO which established HIO participation in the CURES program.
     A signed Summary Statement, prepared on Contractor letterhead and signed by an authorized official, employee or agent certifying thatthe invoices claimed represent actual allowable costs incurred for service performed under this Contract.
   - An itemized invoice, submitted in excel format with details of expenditures including, but not limited to, fees, employee and contractor costs (including names, classifications and compensation), required system and security upgrade costs necessary to establish interface.

Added 11/12/20

11. Sub-Contractor Requirements

A. DHCS, under its authority in the Cal-HOP contract and CURES Interface Contract, elects to waive the required pre-authorization of subcontracted services and the right to prior review of individual subcontractor agreements. In lieu of these requirements, Qualified HIOs shall provide the information specified below for any subcontractor which engages in duties related to the Cal-HOP program, as defined in each contract's respective Scope of Work:
   - A list of all subcontractors employed on Cal-HOP or CURES projects which includes at minimum the name of the contractor, the business address of the contractor, contact information, and the applicable TIN.
   - For work completed under the Cal-HOP contract and CURES interface agreement, in which subcontractor agreements exceed $50,000, a Qualified HIO must provide a copy of the full subcontractor agreement. This document may be appropriately redacted to exclude sensitive financial information.

B. All documentation required under this section shall be provided to DHCS no later than July 1, 2021. A Qualified HIO will inform DHCS in a timely manner regarding the addition or removal of subcontractors from the subcontractor list, and provide all relevant documentation within 30 days of this change. If a Qualified HIO fails to provide the required documentation by July 1, 2021 or fails to provide DHCS timely notification of a change in subcontractor relationship, DHCS will withhold any milestone payments related to that HIO until the appropriate documentation is submitted.

C. Payments to Qualified Provider Organizations or a Qualified Provider's affiliated EHR vendor will not be considered subcontractor services under this section.

D. Notwithstanding the waiver of specified contract requirements outlined in A, this section makes no changes to subcontractor requirements as outlined in the Cal-HOP Contract or the CURES Interface Contract.

Added 11/12/20