

**Request for Grant Applications
HEAL NY- Phase 10**

***Improving Care Coordination and Management Through
a Patient Centered Medical Home Model Supported by an
Interoperable Health Information Infrastructure***

Issued by:
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and
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Section 1: Overview

1.1 The Health Efficiency and Affordability Law for New York (HEAL NY) Capital Grant Program

Pursuant to Section 2818 of the Public Health Law (PHL), the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (the HEAL NY Program) was established in 2004 to invest up to an anticipated \$1 billion over a four year period to affect reform and reconfigure New York's health care delivery system to achieve improvements in patient care and increase efficiency of operation. Section 2818 provides that the HEAL NY Program be jointly administered by the New York State Department of Health (DOH) and the Dormitory Authority of the State of New York (DASNY). The HEAL NY Program is a multi-year, multi-phased, multi-faceted program with two primary objectives:

- To identify and support opportunities for development and investment in health information technology (health IT) initiatives on a regional and state level; and
- To identify and support opportunities for restructuring health care delivery systems on a regional basis in a manner that results in improved quality, efficiency and stability of health care services.

Funding has been made available via state appropriations, beginning with State Fiscal Year 2006 and pursuant to Section 1680-j of the Public Authorities Law (PAL), DASNY bonding authority in the amount of up to \$740 million, as well as through the Federal State Health Reform Partnership (F-SHRP).

The DOH has supported two prior competitive grant rounds for advancing New York's interoperable health information technology infrastructure. The HEAL NY Phase 1 Health IT grant awards were announced on May 24, 2006, to 26 projects totaling \$52.9 million. The HEAL NY Phase 5 Health IT grant awards (HEAL 5) were announced on March 28, 2008, to 19 projects totaling \$105.7 million. A brief description of HEAL 5 awardees' projects, as well as the original Request for Grant Applications, can be accessed: [HEAL 5 Projects](#).

1.2 HEAL NY Phase 10 Health IT Grant Program – Improving Care Coordination and Management through a Patient Centered Medical Home Supported by an Interoperable Health Information Infrastructure.

The HEAL NY Phase 10 Health IT Grant Program (HEAL 10) is funding the continued development and implementation of New York's health information infrastructure while at the same time taking steps to integrate this infrastructure with reimbursement reforms and innovative delivery reforms through the Patient Centered Medical Home (PCMH). This combination and alignment of reforms is essential to transforming health care in New York.

NOTE: A complete list of acronyms is located in Section 7 on page 47.

HEAL 10 seeks applications for projects to improve care coordination and management through a PCMH supported by Interoperable Health Information Infrastructure. This infrastructure includes the technological building blocks, clinical capacity and policy solutions necessary to transition health care from today's largely paper-based system to an electronic, interconnected health care system.

Awards are anticipated to total \$60 million, although if additional funding becomes available, this amount may be increased.

Awards will be administered over a two-year grant period. It is expected that the Grant Disbursement Agreement (GDA) resulting from the Request for Grant Applications (RGA) awards will begin in the fourth quarter of 2009. Specific funding amounts and requirements can be found in Sections 4 and 5.

HEAL 10 is also funding the phase 2 development and implementation of the Statewide Health Information Network for New York (SHIN-NY) through a DOH contract with the New York eHealth Collaborative (NYeC).

1.3 Brief Overview of New York's Health Information Technology Strategy

To deliver safe, effective, high quality and affordable care in the 21st Century, strategic adoption of an interoperable health information infrastructure is needed to transform health care from today's largely paper-based system to an electronic, interconnected health care system.

Evidence shows that when used as intended, health IT saves lives and saves money. A health IT infrastructure can quickly put clinical information in the hands of physicians and patients to guide medical decisions, support the development of health care policies by gathering more precise and timely information about what works in the real world. It also facilitates the seamless exchange of health information for patient care, public health and quality initiatives.

As one of its principal health care reform initiatives, New York has engaged in the development and implementation of a comprehensive health information infrastructure. The infrastructure is comprised of three interrelated components – organizational, clinical and technical – which must evolve together to harness the power of health information to support patient care and population health improvements. The HEAL 5 marked the beginning of laying the foundation of these key organizational, clinical and technical building blocks.

In March 2008, the DOH and the DASNY awarded \$106 million to 19 community based health IT initiatives to advance New York's health information infrastructure. These project awards encompass the HEAL 5 grant program. A year prior, the DOH awarded \$53 million to 26 projects advancing various health IT projects. These 45 projects in total are also contributing more than \$80 million in matching funds to their efforts.

A key principle driving the implementation of New York's health information infrastructure is: *Design Globally, Implement Locally*. This means that the infrastructure is being built upon common statewide information policies, standards and protocols and other technical specifications embodied in the SHIN-NY or "information highway" and electronic health records – collectively referred to as Statewide Policy Guidance. It also means that the infrastructure is based on regional "bottom-up" implementation approaches and care coordination to allow local communities and regions to structure their own efforts based on clinical and patient priorities and market variation. This framework promotes robust public accountability and private sector innovation across the full range of New York's diverse health care delivery settings – from solo-physician offices and community health centers to large academic medical centers and nursing homes, and from Manhattan to rural upstate towns – with vastly different market conditions and health care needs.

The goal of HEAL 5 over the two year grant period from August 2008 – August 2010 is to establish and mature the organizational, clinical and technical building blocks to produce an initial level of health information liquidity or free flow of information among providers considered early health IT adopters and ensure information tools are being used effectively. This could be an interoperable electronic health record (EHR), a web portal or other tools with the ability to share information across settings. Approximately 1,500 physicians, 96 hospitals and 56 long term care facilities should benefit as early health IT adopters from HEAL 5. Specific evaluation and progress based on clinical goals and metrics is being evaluated by the Health Information Technology and Evaluation Collaborative (HITEC).

New York's investment is also being supported by federal funds, including a \$20 million grant in 2008 from the Centers for Disease Control and Prevention (CDC) to improve public health situational surveillance and reporting through health information infrastructure. In addition, the NYeC received a one-year, \$2.8 million contract from the U.S. Department of Health and Human Services (DHHS) to support the Nationwide Health Information Network (NHIN) Trial Implementation Project. The health IT infrastructure components of the American Recovery and Reinvestment Act (ARRA) of 2009 (known as Federal economic stimulus law) also aligns and coordinates well with New York's strategy and will add further support and incentives for health information technology adoption.

The expected opportunities from New York's health IT investment include:

- **Improvements in Efficiency and Effectiveness of Care:** Provide the *right* information to the *right* clinician at the *right* time regardless of the venue where the patient receives care.
- **Improvements in Quality of Care:** Enable access to clinical information to support improvements in care coordination and disease management, help re-orient the delivery of care around the patient and support quality-based reimbursement reform initiatives.
- **Reduction in Costs of Care:** Reduce health care costs over time by reducing the costs associated with medical errors, duplicative tests and therapies, uncoordinated and

fragmented care and preparing and transmitting data for public health and hospital reporting.

- **Improvements in Outcomes of Care:** Evaluate the effectiveness of various interventions and monitor quality outcomes.
- **Engaging New Yorkers in Their Care:** Lay the groundwork for New Yorkers to have greater access to their personal health information and communicate electronically with their providers to improve quality, affordability and outcomes.

As we advance health IT in New York, there are significant opportunities to expand the ways in which we have traditionally thought about consumer rights to access and use of their personal health information. Consumer access to and use of their personal health information is necessary to realize the full potential of the range of technologically enabled care advancements. There are opportunities to create an environment that supports the rights of consumers to control the use of their own personal health information.

New York State (NYS), working in partnership with the NYeC and consumer representatives, has developed a portfolio of consumer-centric materials geared towards educating, engaging and ensuring that consumers understand how health IT can change the ways health care information is accessed, shared and protected, including the benefits and potential risks.

Lastly, New York is at the forefront of clinical excellence and health IT and is well positioned to make effective use of the ARRA funds as well as play a significant leadership role and inform the overall policy and regulatory framework developed by the DHHS.

New York's health IT strategy closely matches the initial key statutory components of the ARRA, including health information exchange infrastructure which is the SHIN-NY, state designated entities to advance HIE infrastructure which is the NYeC and regional extension centers which are conceptual to New York's Community Health Information Technology Adoption Collaborations (CHITAs). There are additional opportunities, all of which New York will be pursuing, regarding a state EHR loan fund program as well as research and development grants to advance interoperability and workforce programs to train professionals in health IT.

Refer to Attachment 6.1 for A Summary of New York's Health IT Strategic Plan.

Section 2: Health IT Investment Framework

2.1 Introduction

The strategic focus of HEAL 10 is to continue to advance New York's health information infrastructure, moving from phase 1 to phase 2 ("infancy to childhood") based on clinical and programmatic priorities and specific goals for improving quality, affordability and outcomes, while at the same time aligning health information infrastructure as an underpinning with new

care delivery and reimbursement models - the PCMH. This policy alignment is essential not only to advance and sustain the technical building blocks of New York's health information infrastructure, but also to ensure that the clinical capacity is established for providers and patients to be prepared and held accountable for new reimbursement models based on quality outcomes and care coordination and management.

The specific goals of HEAL 10 build upon HEAL 5 from a health information infrastructure perspective and go much further align key health reforms included in the PCMH model to improve care. The details are included in Section 3 below.

2.2 Overview of Grant Applications

The DOH is requesting applications from eligible applicants (see Section 3.2) to fund projects that improve the coordination and management of care through a PCMH model supported by the implementation and effective use of interoperable health information infrastructure.

There are many components of a PCMH model. A critical component is the ability to share clinical information across all providers involved in a patient's care to improve the coordination of care. Coordination of care among providers as a patient moves between care settings has been shown to be critically important in decreasing medical errors and their associated costs by reducing the duplication of services and providing information at the point of care. In the PCMH model, the primary care physician coordinates this care, leveraging health IT and new reimbursement models to improve communication and access to critical clinical information. In this model, the primary care clinician is able to access the information needed to communicate with all necessary care givers and coordinate patient care as the patient moves through the health care system. The ability to access accurate and up to date clinical information for managing complex patients requires the implementation of a fully interoperable and functionally complete EHR by the primary care physician and their office team as well as by other care givers and organizations. The model requires EHRs to connect to the SHIN-NY, a health information exchange infrastructure, so that health information is portable or interoperable among providers and patients regardless of where care is delivered while ensuring both privacy and security.

Grants will be awarded based on evaluation criteria described in Section 3.5.

Section 3: Improving Care Coordination and Management through a Patient Centered Medical Home Supported by Interoperable Health Information Infrastructure

3.1 Overview

The DOH is requesting applications from eligible applicants (see Section 3.2) to fund projects that improve the coordination and management of care across the full continuum of care for a target patient population through a PCMH model supported by the implementation and effective use of interoperable health IT.

The proposed projects must identify a target patient population and list in the Stakeholder Template (Attachment 6.3), with a chronic disease or high risk/high cost diagnosis and a PCMH through which the care of the target patient population will be coordinated and managed. The proposed project must also include a plan, using CHITA Services Template (Attachment 6.2), for providing CHITA services for promoting and supporting implementation of interoperable EHRs and other health IT tools and ensuring their effective adoption and use to support the PCMH model. Collectively, the target patient population, PCMH and CHITA, are organized as a Care Coordination Zone (CCZ) to ensure effective organization and management of the project.

The proposed project must also include a partnership with a state-recognized Regional Health Information Organization (RHIO). The role of RHIOs is to support the implementation of the SHIN-NY through participating in the Statewide Collaboration Process (SCP) and implementing and ensuring compliance with Statewide Policy Guidance. The SHIN-NY is a computerized network of networks that utilizes the Internet and includes specialized software and services to mobilize health information and ensure health information systems such as electronic health records are interoperable, to exchange information among providers and with patients to improve care. Key PCMH functions require the ability to exchange information among providers.

Figures 3.0 and 3.1 below show the key organizational building blocks of the CCZ. The CCZ includes the PCMH involved in coordination and management of patient care for the target patient population with the chronic disease or high cost/high risk diagnosis chosen for the project and the CHITA services and support required for successful project implementation.

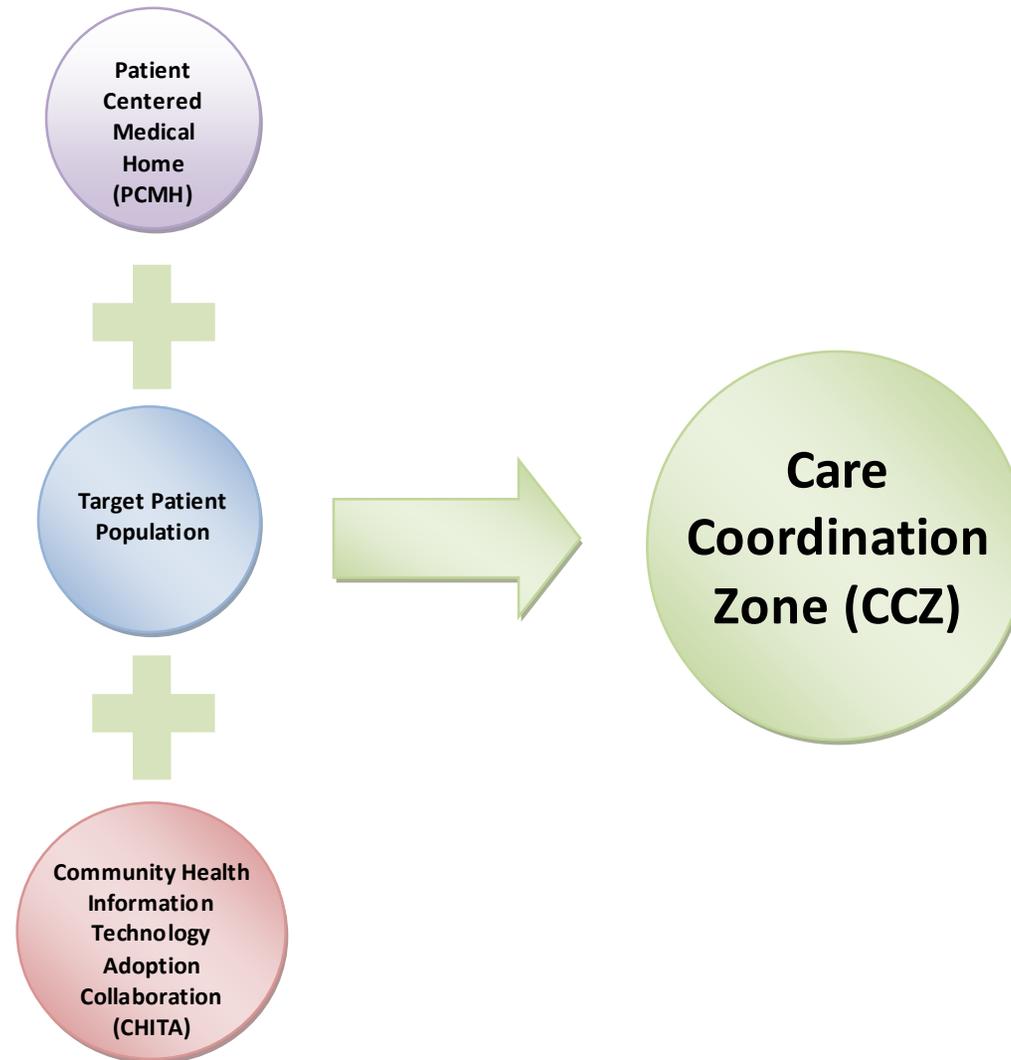


Figure 3.0 – Participants in a Care Coordination Zone (CCZ)

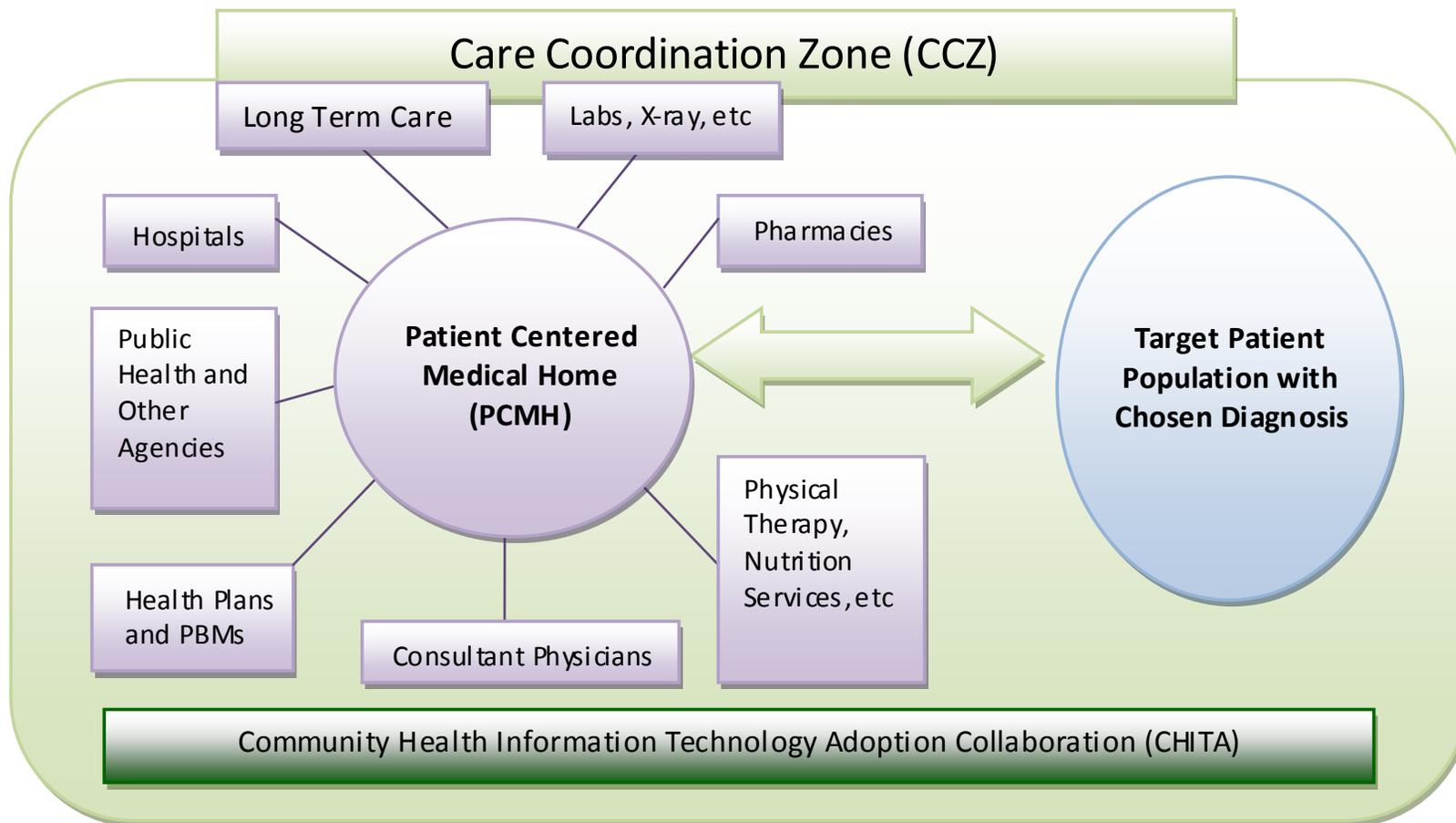


Figure 3.1 – Components of a Care Coordination Zone (CCZ)

(Lines connecting to PCMH represent organizational relationships and not data flow)

Figure 3.2 below shows the relationships of the CHITA with regional and statewide organizational and technical infrastructure services and support. The CHITA is required to work with RHIOs and the NYeC regarding governance and technological coordination of interoperable health IT.

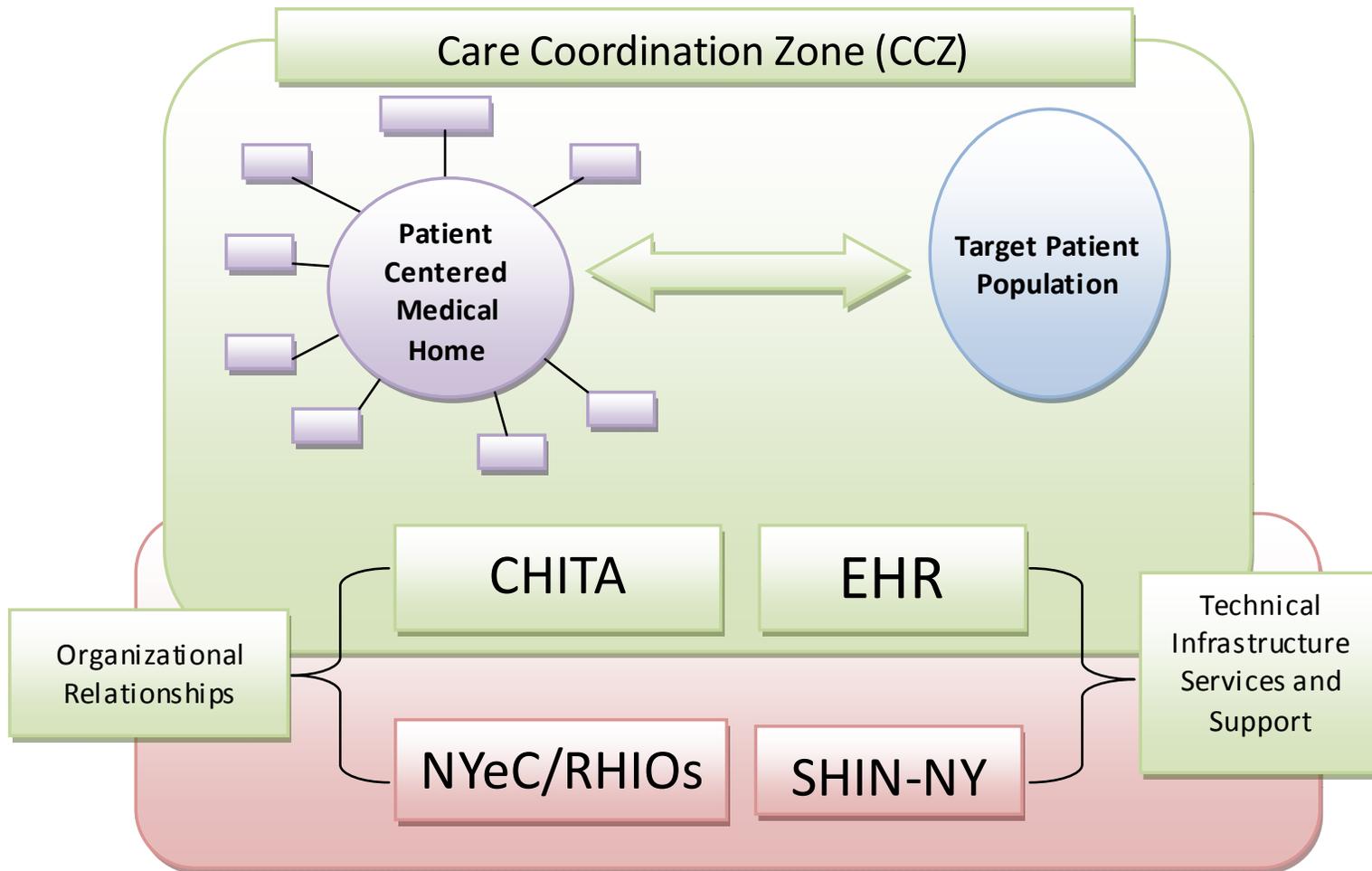


Figure 3.2 – Relationship of the CCZ with regional and statewide organizational and technical infrastructure services and support

Applicants are asked to:

- Define a CCZ around which the proposed project will be organized and managed, including the following components:
 - A target patient population with a chronic disease or high risk/high cost diagnosis in need of improved care coordination (see list of diagnostic choices in Attachment 6.7). Eligible applicants are also encouraged to utilize the DOH's recently released website: https://apps.nyhealth.gov/statistics/prevention/quality_indicators/ to help identify a diagnosis with the highest prevalence specific to their CCZ.
 - A PCMH model, with primary care physicians at the center of coordinating patient care. In this model, primary care physicians and specialists coordinate the care of the target patient population with other providers, payers, clinical organizations and other caregivers, including hospitals, nursing homes, rehabilitation centers, home health care agencies, etc.
 - Awardees will be required to comply with all PCMH requirements as promulgated by the Commissioner of Health.
 - A CHITA to provide health IT adoption and support services to the PCMH to:
 - Ensure proper implementation, configuration and effective use of interoperable health IT;
 - Train providers how to use information to realize the expected quality and efficiency benefits from health IT tools;
 - Support the clinical practice transformation embedded in the PCMH that includes adoption and effective use of EHRs, new reimbursement models (optional) and engagement of patients in their care; and
 - Share best practices and resources through the SCP.
- Implement a PCMH model with adequate representation of primary care physician practices at the center of coordination of patient care and appropriate specialists depending on the target patient population with a chronic disease or high risk/high cost diagnosis.
- Describe a clinical scenario (using the Clinical Scenario Template in Attachment 6.8) that shows how a target patient population, with the chosen diagnosis, can directly benefit from the overall project implementation.
- Implement interoperable health IT for providers participating in the PCMH, ensuring electronic health information exchange among patients' care givers in the PCMH. Emphasis for health IT implementation and support services should be placed on primary care providers and those specialists providing services most directly relevant to the targeted patient population.
- Specify and describe how the project will benefit and improve the quality and efficiency of health care to the target population through the implementation of EHRs or other health IT tools connected to the SHIN-NY technical infrastructure and through active participation as a stakeholder in a RHIO.
- Demonstrate improved coordination and management of patient care for the target population based on clearly defined measures (See Section 3.3.7), including: a

description of the specific clinical data that is shared, documentation of the timing of data transfer, time of patient contact for coordination of care following receipt of patient data and/or other measures previously shown to be effective in evaluation of care coordination or determined to be important through the SCP.

- Explain how information will be routinely shared with patients so they are at the center of their care and a part of making informed choices.
- Explain the method that will be used to share information gained from evaluation of the project with project stakeholders in a timely manner.
- Include payers in the project to implement new reimbursement reform models (Optional).

While there are many costs to implementing a PCMH, eligible project costs only include expenditures for the implementation of interoperable health information infrastructure, including interoperable electronic health records and other health IT tools, clinical informatics services and connecting to the SHIN-NY. Refer to Section 3.3.4: Interoperable Health IT Requirements as well as Attachment 6.1 for an overview of New York's Technical Infrastructure Framework.

Project expenditures may also include CHITA services to promote the implementation of interoperable EHRs and other health IT tools, ensure their successful adoption and effective use to support the PCMH and enable improvements in health care quality, affordability and outcomes.

Total allowable project costs include, but are not limited to, all software, hardware, connectivity, interoperability and technical services costs, as well as health IT adoption and support service costs. Such costs may include organizational development, readiness assessments, change management, workflow redesign, practice transformation including reimbursement reform, project and implementation management, process improvement, quality improvement and other activities necessary for providers to realize expected benefit from health IT and achieve quality and efficiency goals and improve care coordination and management.

Section 3.3.6 includes additional requirements regarding allowable project related costs.

3.2 Eligible Applicants

Eligible applicants that receive grant awards will enter into a GDA with NYS. The eligible applicant will be responsible for ensuring that grant funds are distributed in accordance with the GDA and goals of the HEAL 10. Grant funds may be spent on eligible project related costs that are incurred by the eligible applicant and stakeholder participants actively participating in the PCMH and other required project partners supporting the PCMH and the interoperable health IT requirements.

3.2.1 Lead Applicant

An eligible lead applicant must be either:

- A designated stakeholder participant in a PCMH that has an active role in the care of the target patient population and is an active participant in a state recognized RHIO; or
- A CHITA – a health IT adoption and services organization to promote the adoption and effective use of interoperable EHRs and other health IT tools to support quality improvement - on behalf of one or more PCMHs.

Applicants must be incorporated and able to enter into a GDA with NYS. The following types of stakeholder participants are eligible to serve as the lead applicant of a PCMH to contract with NYS.

PCMH Stakeholder	Examples
Physician practices that include a significant and adequate proportion of primary care physicians and specialists depending on the target patient population, who can lead implementation of the PCMH model	<ul style="list-style-type: none"> - Large multispecialty medical groups. - Smaller medical offices (1-5 physicians) who join together in an organizational structure for the PCMH. - Hospital-based outpatient clinics and hospital owned or affiliated practices. - Community Health Centers/Federally Qualified Health Centers. - Maternal health providers (if appropriate for the target patient population with the chronic disease or high risk/high cost diagnosis chosen for the project). - Faculty practice organizations (medical schools).
Rural Health Network	<ul style="list-style-type: none"> - A rural health network is an affiliation of health care providers serving a rural area, according to a contract, joint or cooperative agreement, or organized under the not-for-profit corporation law. - Participants may include health care providers and organizations, consumers, local businesses and government organizations, who work together to develop comprehensive, cost-effective health care systems serving rural areas. - A network provides or arranges health care and/or administrative services for residents of a rural area according to a Network Plan.
General hospital(s) or medical centers as defined by subdivision 10 of Section 2801 of the PHL with clinical affiliation to PCMH clinicians	<ul style="list-style-type: none"> - Acute care facilities caring for a significant proportion of target patient population with the chronic disease or high risk/high cost diagnosis chosen for the project.
Long term Care Providers	<ul style="list-style-type: none"> - Nursing Home as defined by Section 2801 (2) and (3) of the PHL. - Certified Home Health Agency as defined by Article 36 of PHL. - Licensed Home Care Service Agency as defined by Article 36 of the PHL.
Diagnostic and treatment centers and facilities providing mental health and substance abuse services as defined by Article 31 and 32 of the Mental Hygiene Law	<ul style="list-style-type: none"> - Mental health providers if appropriate for the chosen diagnosis. - Other appropriate providers (depending on the diagnosis chosen for the project).
Agencies	<ul style="list-style-type: none"> - County and municipal public health and social services agencies.

A CHITA organization is also eligible to serve as a lead applicant of a proposed project and contract with NYS on behalf of PCMH participants. A CHITA is a health IT services and support organization (service bureau/extension center) to promote the implementation, adoption, training and effective use of interoperable electronic health records and other health IT tools by providers. CHITAs are also responsible for coordination of the support necessary for practice transformation, reimbursement changes and patient engagement, to vastly improve the availability and use of health information and help ensure that the expected quality and efficiency goals are realized from interoperable health IT.

A CHITA may be a not-for-profit, for-profit corporation or local government agency, dedicated to promoting interoperable electronic health record adoption and effective use, as long as the organization demonstrates the competence and ability to provide directly or through partnerships the following low cost, high value health IT adoption and support services to providers and patients: readiness assessment, organizational development, change management, workflow re-design, practice transformation including the implementation of new reimbursement models, project management, vendor/product selection, implementation and configuration support, interoperability services, user training, ongoing support/help desk services and process and quality improvement services to achieve patient care improvements.

A CHITA should include a Provider Executive Committee (PEC) for each PCMH project or projects it is supporting. The PEC should include all participants in a PCMH, be convened regularly to lead the project and make all key decisions throughout the project.

See Section See Section 3.3.5 for additional information and requirements on CHITAs.

3.2.2 Participants in PCMH

Applicants should include all appropriate types of providers and caregivers within the PCMH who provide care to the target patient population. Ideally, applications will include over 70 percent of the appropriate providers and caregivers. At least 50 percent of the appropriate providers and caregivers that are a part of the PCMH who provide care to the target patient population must be included in the project or the applicant will not be evaluated for a grant award. For the purposes of the RGA, the table below describes the types of providers and caregivers that may be included in the proposed project. Applications including greater than 50 percent of the appropriate providers and caregivers will be scored higher.

Health plan participation is highly encouraged but not required. Applicants that include health plan participation will be evaluated more favorably.

The following stakeholder types are eligible to be included as participants in a PCMH:

Stakeholder	Examples
Primary Care Physicians	<ul style="list-style-type: none"> – Large multispecialty medical groups. – Groups of smaller physician practices (1-5 physicians). – Physicians in hospital-based clinics or hospital owned or affiliated practices. – Physicians in Community Health Centers/Federally Qualified Health Centers. – Maternal health providers if appropriate for the target patient population with the chronic disease or high risk/high cost diagnosis chosen for the project. – Faculty practice organizations (medical schools).
Other Specialty Physician Practices	<ul style="list-style-type: none"> – Specialty physicians who provide care to the target patient population with the chronic disease or high risk/high cost diagnosis chosen for the project.
Rural Health Network	<ul style="list-style-type: none"> – A rural health network is an affiliation of health care providers serving a rural area, according to a contract, joint or cooperative agreement, or organized under the not-for-profit corporation law. – Participants may include health care providers and organizations, consumers, local businesses and government organizations who work together to develop comprehensive, cost-effective health care systems serving rural areas. – A network provides or arranges health care and/or administrative services for residents of a rural area according to a Network Plan.
General hospital(s) as defined by subdivision 10 of Section 2801 of the PHL with clinical affiliation to PCMH clinicians	<ul style="list-style-type: none"> – Acute care facilities caring for target patient population with the chronic disease or high risk/high cost diagnosis chosen for the project.
Long term Care Provider	<ul style="list-style-type: none"> – Nursing homes as defined by Section 2801 (2) and (3) of the PHL. – Certified Home Health Agency as defined by Article 36 of PHL. – Licensed Home Care Service Agency as defined by Article 36 of the PHL. – Other long term care facilities caring for patients with the chronic disease or high risk/high cost diagnosis chosen for the project.
Adult care and assisted living facilities as defined by Article 7 of SSL or Article 46-B of PHL	<ul style="list-style-type: none"> – Supervised residential facilities caring for patients with the chronic disease or high risk/high cost diagnosis chosen for the project.
Diagnostic and treatment centers and facilities providing mental health and substance abuse services as defined by Article 31 and 32 of the	<ul style="list-style-type: none"> – Mental health providers (if appropriate to the specific project chosen diagnosis). – Ambulatory care facilities caring for patients with the chronic disease or high risk/high cost diagnosis chosen for the project.

Mental Hygiene Law	
For profit, and not-for-profit health plan(s) defined by Article 44	<ul style="list-style-type: none"> – Prepaid Health Service Plans (PHSPs) – Other payers involved in payment for the care of the target patient population
Rehabilitation Facilities	<ul style="list-style-type: none"> - Facilities caring for patients with the chronic disease or high risk/high cost diagnosis chosen for the project
Independent physical therapy, occupational therapy, respiratory therapy, nutrition and other services not part of another stakeholder group	<ul style="list-style-type: none"> – Services provided to patients with the chronic disease or high risk/high cost diagnosis chosen for the project
Laboratories, Pharmacies, Imaging Centers	<ul style="list-style-type: none"> – Ancillary serviced provided to patients with the chronic disease or high risk/high cost diagnosis chosen for the project
Hospice as defined in Article 40 of PHL	<ul style="list-style-type: none"> – Services that provide end of life care for patients with the chronic disease or high risk/high cost diagnosis chosen for the project
Schools	<ul style="list-style-type: none"> – Programs that benefit the care of patients with the chronic disease or high risk/high cost diagnosis chosen for the project
Agencies and Organizations	<ul style="list-style-type: none"> – County and municipal public health and social services agencies – Other agencies and organization as appropriate for target patient population chosen for the project ie. Area Agency on Aging, NY Connects, Independent Living Centers

Applicants are required to complete the participant stakeholder template (Attachment 6.3), which requires a description of each stakeholder, their role in the PCMH and specifically how they will contribute to improve coordination and management of care of the target patient population.

A letter of support must also be included from each stakeholder participant included in the template. See Attachment 6.3 for the Letter of Support Requirements.

3.2.3 Other Project Participants

Other participants in the proposed project should include a CHITA providing key health IT adoption and support services (CHITA Services), if the CHITA is not the lead applicant of the project.

A RHIO is also a participant in the project to provide the governance necessary to support interoperable health information exchange among PCMH participants as well as quality and public health reporting to the DOH, both of which are made possible through the SHIN-NY.

Letters of support must also be included from the CHITA and RHIO. See Attachment 6.3 for the Letter of Support Requirements.

3.3 Scope of Work

Applicants should complete the scope of work outlined below according to the application template described in Section 4. The application template has the following sections: organizational, clinical, technical and financial.

Applications will be scored based on evaluation criteria outline in Section 3.5.

3.3.1 Care Coordination Zone

As depicted in figures 3.0 and 3.1 above, a CCZ encompasses a target patient population with a chronic disease or high risk/high cost diagnosis and a PCMH through which the care of the target patient population will be coordinated and managed. The CCZ also includes a CHITA which will be responsible for implementing and ensuring effective adoption and use of interoperable health IT tools to support the PCMH model.

The application must include a detailed description of the CCZ by clearly defining:

- The geography, including a list of counties and/or zip codes. It is within the applicant's discretion regarding the geographic area covered by the CCZ.
- The overall health status, socio economic and cultural factors related to the health in the area.
- The availability and access to health care providers and services in the area.
- A brief summary of the PCMH and the CHITA and their respective roles and responsibilities.
- A brief summary of a RHIO and the RHIO's responsibility in supporting the PCMH.

3.3.2 Target Patient Population With Chronic Disease or High Risk/High Cost Diagnosis

The application should include:

- A description of the target patient population with a specific chronic disease or high risk/high cost diagnosis and specific care improvement goals. A list of diagnoses from which the applicant may choose is included in Attachment 6.7.
- Detailed information with supporting data demonstrating that the target patient population chosen includes a significant portion of the population in the defined CCZ or is a population that is high risk in the CCZ. As an optional resource, the DOH's recently released website (https://apps.nyhealth.gov/statistics/prevention/quality_indicators/) may be helpful to identify high prevalence diagnoses specific to a defined CCZ.
- A patient clinical scenario that clearly demonstrates how the proposed project will improve the coordination of care for the target patient population based on the PCMH model that is supported by interoperable health IT. (An example of a clinical scenario and the clinical scenario template are included in Attachment 6.8.) This scenario should clearly define the role of each stakeholder in patient care and how the proposed project

will be able to demonstrate that the target patient population with the chosen diagnosis will be able to have all the appropriate providers involved in their care and how interoperable health IT will be used to communicate and improve care management through improved coordination of that patient's care between providers.

Eligible applicants can propose other target patient populations not included on the list in Attachment 6.7 as the focus for their proposal but must include sufficient documentation proving that the chronic disease or high risk/high cost diagnosis involves a significant portion of the population or is a particularly high risk population in the CCZ. The chosen diagnosis should also align with the PCMH model and include all appropriate stakeholders.

Applicants must declare the chosen diagnosis in Attachment 6.3 (Stakeholder Template) and where applicable, justify the diagnosis in the event that it is not included in Attachment 6.7, Diagnosis Choices.

3.3.3 PCMH Model

The success of the PCMH approach to coordinate care depends on integrated communication and information exchange among all providers involved in the care of a target patient population. The PCMH model emphasizes the use of systematic, patient-centered, care management processes and care coordination teams, interoperable health IT tools to exchange patient information and new reimbursement models that reward providers for improved coordination and management of care.

An application should include a description of how the PCMH model will support the following functions:

- Access to clinical information, including test ordering and result tracking;
- Referral tracking;
- Communication and exchange of information among providers;
- E-Prescribing and medication management;
- Clinical decision support;
- Care management, patient tracking and registry functions;
- Patient self-management;
- Communication and exchange of information between providers and patients;
- Quality reporting; and
- Reimbursement reform (optional).

An application should include:

- A summary of the PCMH providers and other care givers who provide care to the target patient population. Ideally, applications will include over 70 percent of the appropriate providers and caregivers. At least 50 percent of the providers and other care givers who provide care to the target patient population must be a part of the PCMH. A detailed listing must be completed as part of the participant stakeholder template (Attachment

6.3), as noted in Section 3.2.2. Participants must be listed and documentation included on the percentage of the target patient population with which each clinician and provider cares. NOTE: Applications including greater than 50 percent of the appropriate providers and caregivers will be scored higher.

- A description of the covered geography, using Attachment 6.3.
- A description of how the PCMH participants will use interoperable health IT, including electronic health records, clinical informatics services and the SHIN-NY to perform the functions listed above and support improved coordination of patient care along the continuum of care for the target patient population.
- A description of how participating providers will transform their medical practices by implementing the PCMH and support the coordination of patient care along the full continuum of care. The National Committee on Quality Assurance (NCQA) has proposed a quantitative tool for defining a PCMH. For the purposes of this RGA, however, all awardees are required to comply with DOH PCMH requirements, as promulgated by the Commissioner of Health.
- A description of how the PCMH participants will utilize the Chronic Care Model (CCM) (as appropriate for the target patient population) to support improvements in the coordination and management of care. The CCM incorporates available evidence of system changes that improve care for chronic illness based on a survey of best practices, expert opinion, evidence based interventions and quality improvement work on multiple chronic conditions such as diabetes, depression and cardiovascular disease. The overarching themes of the CCM include a population based approach that is evidence based and patient centered. See Attachment 6.13 for more information on the CCM.
- A description of how the PCMH will ensure the provision of CHITA services supporting proper adoption and effective use of health IT tools and coordinate with a RHIO. The applicant should describe, in detail, its relationship with the RHIO to facilitate connecting EHRs with the SHIN-NY for health information exchange among PCMH providers as well as coordinating quality and population health measurement and reporting.

3.3.4 Interoperable Health IT Requirements

Awardees are required to implement interoperable health information technology infrastructure that support the PCMH model functions outlined above in Section 3.3.3 and are consistent with the NYS health information technology framework. The technical framework includes three main building blocks: (1) the **3Cs**: interoperable EHRs for clinicians, Personal Health Records (PHRs) for consumers, and community information portals; (2) CIS to aggregate, analyze, measure and report data for population health and quality purposes; and (3) the SHIN-NY providing an architecture, common health information exchange protocols and standards to share information among providers and with patients.

The SHIN-NY is viewed as a bedrock infrastructure component that is essential to achieve interoperability and support New York's broader health care goals. Interoperability is essential

to realizing the expected benefit from health IT and vastly improving the availability and use of health information to improve patient care. Perpetuating siloed information systems that do not interconnect will significantly impede the adoption and effective use of health IT tools, including EHRs. Other aspects of the technical infrastructure include electronic PHRs and clinical informatics services which refer to the tools required for the aggregation, analysis, decision support and reporting of data for various quality and public health purposes. Additional information on NYS's technical infrastructure framework is located in Attachment 6.1.

Awardees will be required to comply with current and future versions of the Statewide Policy Guidance which includes common information policies, standards and technical approaches governing the NYS health information infrastructure. Awardees must also require all health IT software and services companies with which they contract utilizing HEAL 10 funds to comply with Statewide Policy Guidance. The current version of the Statewide Policy Guidance is located in Attachment 6.14. Statewide Policy Guidance is developed through the SCP managed by NYeC and approved by DOH.

Refer to Attachment 6.9: Technical Architectural Plan to complete the technical plan.

3.3.4.1 EHRs

Awardees that purchase new EHRs, and/or upgrade existing EHRs adding interoperability and quality reporting functionality must comply with the following requirements:

- All new EHRs must be 2008 or 2009 certified by the Certification Commission for Health Information Technology (CCHIT) or certified per requirements set by the Secretary of DHHS, and must comply with current and future Statewide Policy Guidance for EHR functionality, interoperability, privacy and security, and quality reporting set through the SCP.
- EHRs that are already implemented or are in the process of being implemented by providers within the PCMH, and for which funds will be used for interoperability and quality reporting functionality, must also be 2008 CCHIT certified, and comply with current and future Statewide Policy Guidance for EHR functionality, interoperability, privacy and security, and quality reporting set through the SCP.
- Providers may implement standalone e-prescribing systems, meaning that they are not a part of or integrated within an EHR. Stand-alone e-prescribing systems, however, must be CCHIT certified for the most recent year (starting with 2009) or certified per requirements set by the federal Secretary of DHHS, connect to the e-prescribing network through the SHIN-NY and utilize other clinical data provided through the SHIN-NY as appropriate.

3.3.4.2 Interoperable Health Information Exchange

Applicants must describe and include a technical design, by completing the Technical Architectural and Interoperability Plan (Attachment 6.9), for how EHRs will be connected to the SHIN-NY to enable health information exchange among all providers in a PCMH. One-to-one or proprietary interfaces between an EHR and hospitals, labs, pharmacies, patients, radiology centers, etc., are not permitted. An application will not be eligible for evaluation if a one-to-one or proprietary interface approach is included. In communities where SHIN-NY services may not yet be available, applicants may implement a local hub solution as the interoperability model serving as a bridge to the SHIN-NY. The SHIN-NY interoperability model versus the local hub interoperability model is described in Sections 3.3.4.2.1 and 3.3.4.2.2 below. The SHIN-NY interoperability model is preferred and applicants pursuing this approach compared solely to the local hub approach will be evaluated more favorably.

The technical design – for either the SHIN-NY interoperability model or local hub interoperability model – should include how the applicant will connect EHRs using Common Health Information Exchange Protocols (CHIXP) as specified in the current version of Statewide Policy Guidance to share a minimal set of clinical data among providers involved in the care of the target patient population. The minimum clinical data set includes:

- Active medications (including name, dose, frequency and route) and medication allergies;
- Problem/Diagnosis List;
- Lab results;
- Radiology and imaging reports;
- Discharge summaries, consults and other clinical documents; and
- Other appropriate disease specific diagnostic testing results (ie. echocardiogram reports for congestive heart failure) as appropriate for the target patient population (optional).

Applicants are encouraged to incorporate other clinical data representing accepted DOH and national measures for the target patient population and will be evaluated more favorably if these are included. See Section 3.3.7 below.

3.3.4.2.1 SHIN-NY Interoperability Model

Applicants must include a detailed technical strategy, including architectural design, implementation specifications compliant with the current version of the Statewide Policy Guidance located in Attachment 6.1 and an implementation plan for:

- Interconnecting EHRs to the SHIN-NY, including:
 - Connectivity to the SHIN-NY to deliver labs, radiology, medications and e-prescribing, hospital reports to all stakeholder EHRs; and
 - A summary record exchange and capability to share among stakeholder EHR systems within the PCMH.

- Providing a single point of connectivity via the SHIN-NY for the adoption of other health IT tools, including:
 - Access to information portals;
 - Clinical informatics services; and
 - Patient access to clinical information and communication with providers.
- Providing integration services to support EHR connectivity through the SHIN-NY.

Applicants must also include a RHIO partnership and governance plan describing how the PCMH providers are participating in a RHIO and how they plan on utilizing SHIN-NY services that includes a commitment to share information with all appropriate providers in the PCMH.

3.3.4.2.2 Local Hub Interoperability

Awardees must include a detailed technical strategy for integrating EHRs with local hub architecture to provide an initial interoperability solution, if interconnecting EHRs and other health IT tools to the SHIN-NY is not yet available. A local hub architecture provides a common integration platform to route clinical information such as labs, radiology, hospital reports and medications to EHRs serving as a building block to the SHIN-NY and providing an alternative solution to unacceptable one-to-one or proprietary interfaces. A detailed explanation is required as to why a local hub interoperability solution is needed, how the CHiXP will be complied with and how the local hub solution will develop to full integration with the SHIN-NY and associated timing.

An awardee must include the following in their technical strategy:

- Architectural design and implementation specifications consistent with the current version of the Statewide Policy Guidance located in Attachment 6.1 and an implementation plan. This must include how the local hub solution will connect to the SHIN-NY.
- A plan explaining what technical assistance services will be provided to support EHR connectivity through a local hub solution.

3.3.4.3 Clinical Informatics Services for Quality/Population Health Reporting and Other Health IT Tools

Awardees are required to measure and report quality and population health measures to support the management and coordination of care for the target patient population.

Applicants should include a description of clinical informatics services utilized to facilitate quality and population health measurement and reporting through utilization of EHRs and the SHIN-NY including:

- Extracting de-identified health information from EHRs in accordance with measures specifications, as determined by the SCP.
- Sending extracted health information from EHRs and physician identifiers utilizing the SHIN-NY to approved Performance Assessor(s) quarterly in a standardized electronic

format for performance measurement. Qualified Performance Assessor(s) will be evaluated and determined by the SCP.

- Communicating performance assessment results and opportunities for improvement back to participating physicians utilizing the SHIN-NY.
- Ensuring accurate data intake of physicians' medical record data as required by the SCP.
- Collaborating to develop recommended measures to take in new clinical data sets with the SCP.
- Assisting in the audit process as required by DOH policy.

The quality and population health measures should be consistent with DOH and national measures. A list of possible measures is included in Attachment 6.6. Awardees must comply with all measures determined and required by the DOH.

Information portals and clinical decision support tools may also be included as part of the health IT tools supporting the PCMH model. A detailed description should be included covering any other health IT that will be funded as part of the project to improve care coordination and clinical outcomes and why it is critical to project success.

3.3.5 CHITA Services

HEAL 5 introduced the concept of CHITAs to provide health IT implementation, adoption and support services to providers, ensuring that expected quality and efficiency goals are realized from health IT and vastly improve availability and use of health information. CHITAs promote a "wholesale" rather than "retail" approach to EHR adoption by providing health IT adoption and support services of sufficient scale across a community of providers to realize health IT benefits internally to a group of users at a lower cost and to allow providers to outsource all the services and support they need to successfully adopt and effectively use interoperable health IT. CHITA is synonymous with service bureau or regional extension center. These are terms which have all been used to describe a community based promotion and provision of health IT adoption and support services to providers.

For the purposes of HEAL 10, CHITAs, as lead applicants or project partners, are expected to:

- Be organized to provide low cost and high value services to providers participating in a PCMH and implementing interoperable EHRs and other health IT tools, including but not limited to the following services : readiness assessment, organizational development, change management, workflow re-design, practice transformation including the implementation of new reimbursement models, project management, vendor/product selection, implementation and configuration support, user training and ongoing support, process and quality improvement services and to achieve patient care improvements. CHITA service requirements may include further recommendations as developed through the SCP.

- Be vendor neutral, accommodating different vendors based on provider requirements and product selection.
- Include a PEC for each PCMH project or projects it is supporting. The PEC should convene regularly to guide the project and make all key decisions throughout the project.

A CHITA can partner with, but is not limited to, the following types of organizations to demonstrate the ability to provide all health IT adoption and support services – soup to nuts – to providers: workflow and practice transformation experts, product vendors, quality professionals, informaticians, nurses, consulting and services companies, technology companies, technical service providers, trainers, etc.

Applicants are asked to:

- Describe the composition of the CHITA and how the organization or partnership will perform health IT adoption and support services.
- Describe the business, governance and service plan of the CHITA organization and comply with all future requirements set forth by the Secretary of DHHS regarding Regional Extension Centers. Specifically, how teams of services providers, subject matter experts, trainers, quality experts, etc., will be organized to provide services to PCMH providers. The CHITA organization is not permitted to spend more than 10 percent of grant funds on administrative costs of the organization; 90 percent of costs should be dedicated to the successful implementation, adoption and effective use of health information infrastructure in support of the PCMH to improve care.
- Describe how a CHITA will support a PCMH implementation with health IT adoption services and support, including but not limited to readiness assessment, organizational development, change management, workflow re-design, practice transformation including the implementation of new reimbursement models, project management, vendor/product selection, implementation and configuration support, user training, ongoing support/help desk services and process and quality improvement services to achieve patient care improvements. CHITA service requirements may include further recommendations as developed through the SCP.
- Complete the CHITA Services Template (See Attachment 6.2), outlining the health IT adoption and support services needs and a plan to address those needs. This should include intended results with respect to both patient care and care coordination improvements, and specific actions for achieving the goals during the grant period.

CHITAs are encouraged to support multiple projects. A proposed project has the option of forming a CHITA with whom they will work, or selecting an existing CHITA in the marketplace.

3.3.6 Allowable Project Costs

Applicants must include a detailed description of what health IT products and services will be purchased with HEAL 10 funds, for which PCMH providers in the proposed project and why

these tools are critical for the success of the project (include as part of the Budget Justification see Section 8.2.4). Emphasis should be on providing tools for all primary care providers as part of the PCMH as well as those specialists and providers delivering services most directly relevant to the targeted patient population. Stakeholders who are eligible to receive project funding are listed in 3.2.3. Other stakeholders may be considered with appropriate supporting documentation.

HEAL 10 funds can be used to pay for the following health information infrastructure and services:

- EHRs for primary care providers and appropriate specialty physician practices and other providers participating in the PCMH. A maximum of 25 percent of the costs of inpatient and/or long term care providers EHRs is also permitted;
- Connecting ambulatory and inpatient EHRs to the SHIN-NY or local hub solution as a bridge to the SHIN-NY, including but not limited to results reporting and summary record exchange;
- Information portals (if currently more feasible than EHRs or PHRs, including how such portals will interface with EHRs or PHRs);
- CIS, including clinical decision support software;
- E-Prescribing applications connected to the SHIN-NY with medication reconciliation;
- Integrated medication reconciliation software;
- Implementation, configuration, maintenance and operation, for all of the above;
- Health IT adoption and support services, including quality improvement services (CHITA services);
- Project evaluation, in addition to and/or in cooperation with HITEC, to document improvements in care coordination and outcomes; and
- Project organization and administration of the PCMH.

DOH reserves the right to approve all technology vendors and service providers that will be paid for utilizing HEAL 10 funds.

3.3.7 Measures for Evaluation of Care Coordination and Management

Applicants are asked to propose measures to evaluate how care coordination will be improved for their project. Overall measures to be used by proposed projects will be ultimately recommended by the SCP and approved by DOH. An application will be evaluated more favorably if it includes a detailed description of measures that will be used to monitor coordination of care, that are:

- evidence based;
- previously shown to be effective or are new measures involving the use of EHRs and HIE; and
- able to demonstrate the ability to share information.

Examples of some types of acceptable measures are included in Measures Attachment 6.6. Other measures may also be included in the proposal if they also include documentation and

published references of how these measures have successfully documented care coordination. The DOH may also require further measures as they are developed through the SCP.

3.3.8 Sustainability Plan

Applicants are required to outline a project sustainability plan in their application (per section 4.1.4.3), including all current and potential future funding and reimbursement opportunities. Applicants that include partnerships with health plans to provide incentives and/or new reimbursement methodologies should include a detailed description of the health plan participation and commitment, as well as specifics on the methodologies and potential impact. Applicants should also discuss the impact on their proposed project of the ARRA provisions regarding Medicare and Medicaid incentive payments to qualified providers demonstrating meaningful use of interoperable EHRs.

To achieve a successful sustainability plan, projects are encouraged to participate in other programs' funding which supports health IT to improve patient care and maximize provider participation. Attachment 6.5 gives a list of programs available in NYS as a reference source for methodologies that can be leveraged to provide further funding to supporting HEAL 10 proposed projects. Projects are encouraged to describe how they can integrate these and other opportunities in their sustainability plan.

Although not required, projects will be evaluated more favorably when they include partnerships with one or more health plans to offer new models for reimbursement that support the project plan. The details of the reimbursement model and how each stakeholder is affected should be described, with particular emphasis on support of primary care and the PCMH. Although projects must include only one specific diagnosis for the patient population to be covered in their application, health plans are encouraged to provide enhanced reimbursement to primary care physicians for using the project supported PCMH to care for patients with other chronic and high risk/high cost diagnoses. Multi-diagnosis reimbursement methodologies will be evaluated more favorably.

3.3.9 Participation in SCP

All awardees are required to participate in the SCP. The purpose of the SCP is to ensure all grantees participate in setting information policies, standards and technical approaches, collectively referred to as Statewide Policy Guidance and then implement and ensure adherence to the Statewide Policy Guidance as part of their project. NYeC manages the SCP and develops Statewide Policy Guidance through a statewide transparent governance process. DOH participates in and approves Statewide Policy Guidance. See Attachment 6.1 for the current version of the Statewide Policy Guidance.

Applicants should include resources to participate fully in the SCP in their proposed project budgets. All awardees must designate a representative, or several representatives, to participate in each of the workgroups and sub-workgroups established by the SCP. Current

workgroups include Clinical Priorities, Privacy and Security, Electronic Health Record Collaborative and Protocols and Services. Additional groups will be added as deemed appropriate to move NYS's agenda forward. Workgroup representatives must be staff members with expertise that align with the mission of the specific workgroup (ie. technical liaisons are members of the Protocols and Services workgroup, providers are members of Clinical Priorities, etc.). Stakeholder organizations in awarded projects must contribute participants to the workgroups to work on behalf of the projects. All workgroup representatives cannot be from only the lead organization. Participants are required to budget to allocate at least the following resources to the SCP in their budget:

- Weekly conference calls for each of the workgroups and sub-workgroups;
- 4 in-person meetings per year; and
- Organizational, Clinical and Technical staff hours (includes vendors and stakeholders).

3.3.10 Health IT Evaluation Collaborative

HEAL 10 awardees will undergo an objective, consistent evaluation by HITEC to ensure that expended funding achieves maximal return. The DOH believes that a non-biased, multi-disciplinary team of experts in the areas of informatics, evaluation methodology, health care quality, patient safety, health economics and biostatistics, is critical to a successful evaluation. HITEC is a multi-institutional academic consortium among institutions in NYS including Cornell University, Columbia University, the University of Rochester, the State University of New York at Buffalo and the State University of New York at Albany.

Utilizing a single independent third-party, academically-based evaluation consortium will provide the best available standardized review process to provide valid and generalizable evaluations of health IT interventions made as part of the HEAL NY Phase 10 grant process. With uncoordinated individual evaluations, at the end of the funding period, New York State and its health care community would have mostly single-center studies with a wide variety of outcomes and limited ability to draw generalizable conclusions about what works and what doesn't when large investments are made in HIE.

Applicants are responsible for budgeting staff hours to work with HITEC to successfully conduct project evaluation. If an awardee requires evaluation beyond the scope of HITEC's, appropriate staff hours must also be budgeted for this. At a minimum, all awardees are required to participate in and contribute staff, data and other project information necessary for the project evaluation. Additionally, if required by the awardees HITEC evaluation, the awardee will be responsible for data aggregation and case mix adjustments.

Five percent of all dollars available under HEAL 10 will be provided directly to HITEC to evaluate HEAL 10 projects, incorporating the above described components. Dollars will not be withheld from project awards, as occurred in HEAL 5.

3.4 Project Goals and High Level Project Work Plan and Milestones

Applications must include a list of project goals and a model project work plan that details high level milestones for the project. Applicants will be required to complete Attachment 6.4 to provide this information.

The project work plan should include, but is not limited to, the following elements:

- Project governance and organization, including coordination of all PCMH stakeholders and other project participants, including a CHITA and RHIO as well as participation in the SCP;
- PCMH implementation and a care coordination plan based on target patient population and achieving specified care coordination and management goals;
- Interoperable health information infrastructure plan, including the types of health IT products and services and a technical architecture and implementation plan in support of PCMH;
- CHITA services to promote and support the adoption and effective use of interoperable EHRs and other health IT tools for the PCMH;
- Participation in a RHIO for governance and technical connectivity to the SHIN-NY;
- Project evaluation, in addition to and/or in conjunction with the HITEC, to document improvements in care coordination and outcomes; and
- A sustainability plan including health plan participation (if planned) and an action plan to leverage and participate in other incentive programs supporting health IT.

3.5 Grantee Evaluation Criteria

The applicant's proposal will be evaluated based on the following criteria:

Pass/Fail Criteria

If applications do not meet the pass/fail criteria found in Attachment 6.15, they will not be evaluated for an award.

General Criteria

All applicants will be evaluated based on the criteria in the following table. Each criterion carries the same amount of weight with respect to the application's total score.

Number	Criteria	Description
1	PCMH Care Coordination Goals and Measures	<ul style="list-style-type: none"> - Demonstrate how a primary care physician increases care coordination and improves care based on coordination of care and referral measures and other outcome measures for the target patient population with the chosen diagnosis by implementation of the PCMH model supported by interoperable health IT; - Discuss caliber of measures to demonstrate improved care coordination;
2	PCMH Model	<ul style="list-style-type: none"> - Detail the number and % of primary care physicians implementing the PCMH model;
3	Target Patient Population	<ul style="list-style-type: none"> - Discuss the impact of chosen target patient population showing how the chosen diagnosis represents a significant burden by numbers and/or cost in the CCZ;
	Clinical Scenario	<ul style="list-style-type: none"> - Provide a detailed clinical scenario for the target patient population demonstrating how a target patient population, with the chosen diagnosis, can directly benefit from the overall project implementation;
4	Health IT Functions and Interoperability Plan	<ul style="list-style-type: none"> - Describe all of the health IT functions that the PCMH model will perform; - Define the technical architecture plan ensuring health information exchange among providers and that there is adequate access to clinical information for care management; - Explain interoperability model for EHRs and the implementation of Common Health Information eXchange Protocol (CHIxP) compliant interfaces to the SHIN-NY or local hub model that will bridge to the SHIN-NY. Include description of technology purchased for the project;
5	CHITA Services	<ul style="list-style-type: none"> - Describe what CHITA services will be provided to PCMH, how they will be delivered to PCMH providers and who will deliver them;
6	Communication with Patients including PHRs, Telemedicine and eVisits	<ul style="list-style-type: none"> - Explain infrastructure for communication with patients including plans for PHRs, telemedicine, eVisits or other health IT tools;
7	Medication Reconciliation	<ul style="list-style-type: none"> - Explain medication reconciliation across PCMH providers' EHRs and transitions of care;
8	Participation in a RHIO	<ul style="list-style-type: none"> - Describe participation in a RHIO and role in governance process;
9	Statewide Collaboration Process and Statewide Policy Guidance	<ul style="list-style-type: none"> - Demonstrate project participation in SCP and adherence to the most current version of the Statewide Policy Guidance;
10	Sustainability Plan	<ul style="list-style-type: none"> - Describe sources of other current or potential funding and how the project will leverage those sources and engage in further clinical incentive programs; and
11	Solo and Small Physician Providers	<ul style="list-style-type: none"> - Include ambulatory care providers in solo and small physician offices, including those who have contracts with and serve Medicaid beneficiaries and provide care in long term care facilities, as defined in 3.2.3.

Criteria with Emphasis

The following criteria will more significantly influence an applicant’s total score.

Number	Criteria	Description
1	Payers	Payer stakeholders participating in reimbursement reform to support health IT adoption is optional, but strongly encouraged. Applications with health plan participation will be evaluated more favorably, especially if there is multi-payer involvement in the project. Any proposals for health plan involvement with new projects, compared to those that health plans have previously supported or participated in, are preferred and will be evaluated more favorably. The reimbursement methodology should also be substantially different than previous projects the health plans have supported or participated in. Projects will be evaluated more favorably if payer(s) will incentivize the target diagnosis plus other diagnoses.
2	Medicaid Providers	Includes provider stakeholders serving Medicaid populations.
3	50% or more of stakeholders involved in care of target patient population	All providers that meet this criteria. Ideally, applications will include over 70% of the appropriate providers and caregivers. Applications including greater than 50% of the appropriate providers and caregivers will be scored higher.
4	50% or more of the members of any stakeholder group involved in the care of chosen target patient population	All providers that meet this criteria. Can include patients covered. Applications including greater than 50% of the appropriate providers and caregivers will be scored higher. Ideally, applications will include over 70% of the appropriate providers and caregivers.
5	Technical Architectural and Interoperability Plan	Provide a detailed technical strategy as part of Attachment 6.9 for: <ul style="list-style-type: none">– Integrating EHRs (or other health IT tools) with the SHIN-NY or local hub architecture; and– If applicable, a detailed explanation as to why a local hub interoperability solution is needed, how the CHiP will be complied with and how the local hub solution will develop to full integration with the SHIN-NY and associated timing.

Section 4: Grant Requirements, Evaluation Criteria and Awards Process

4.1 Other Grant Requirements/Minimum Requirements for Evaluation

The evaluation process will include an initial screening to ensure that applications are complete. Applications missing critical elements may be eliminated. Applications will also be screened to confirm that the application meets the minimum requirements for evaluation. If applications do not meet the minimum requirements, they may be eliminated from the evaluation and award process.

The **initial screening** of applications will include the following criteria:

4.1.1 Completeness Review

Each application will be evaluated to ensure that:

- The application includes all required sections, forms and attachments;
- The application was submitted in the required format; and
- The required number of copies is submitted.

4.1.2 Application and Applicant Eligibility

If applications do not meet the Pass/Fail criteria found in Attachment 6.15, they will not be evaluated for an award.

4.1.3 Budget

Initial screening criteria for the budget include:

- Applicants are required to contribute at least 50 percent of the project budget in the form of matching funds. These funds can be in the form of cash or in-kind contributions from project stakeholders. It should be noted that NYS funds may not be considered and/or counted as matching funds. Applicants should specifically identify matching funds and associated source(s) of these funds on the Project Funding / Project Fund Source Worksheet. The total match funds (combined cash and in-kind) should equal the Total Match (N) on the Project Budget Worksheet.
- The awardee is not in fundamental conflict with the Commission mandates and DOH policy.
- Narrative Budget Justification - Each capitalized expense listed on Budget Form must include a detailed explanation as to how the determination was made that the expense is capitalizable.

Scoring of Grant Applications

After the initial screening of grant applications, the next step in the review process is the scoring of grant applications based on the grant requirements outlined throughout the RGA. All grant applications must include two narratives, not to exceed 30 pages each – Program and Financial. Applications will be evaluated based on responsiveness and completeness of all requirements.

The Program Application narrative must be organized and clearly labeled by the five following sections, each of which will be evaluated as part of the review and award process. The sections are:

1. Organizational Plan;
2. Technical Plan;
3. Clinical Plan;
4. Leadership and Personnel Qualifications – Provide detail in Attachment 6.12; and
5. Project Management – Provide detail in Attachment 6.2.

The five sections of the Program Application must include the following major sections and include each of the listed subsections and be labeled as such.

4.1.4 The **Organizational Plan**:

- 4.1.4.1 Mission, vision and overall goals of project
- 4.1.4.2 Project Governance Structure and Process
 - 4.1.4.2.1 Project leaders and project management structure
 - 4.1.4.2.2 Representative steering committee participants
 - 4.1.4.2.3 Roles and responsibilities of the PCMH and CHITA
 - 4.1.4.2.4 PCMH participation in and coordinate with a RHIO for health information exchange
 - 4.1.4.2.5 Participation in SCP
- 4.1.4.3 Sustainability Plan
- 4.1.4.4 References
 - 4.1.4.4.1 Stakeholder Template
 - 4.1.4.4.2 Leadership and Personnel Qualifications

4.1.5 The **Clinical Plan**:

- 4.1.5.1 Definition of a CCZ
 - 4.1.5.1.1 PCMH model
 - 4.1.5.1.1.1 Primary Care physicians implementing the PCMH
 - 4.1.5.1.1.2 Use of interoperable EHRs along care continuum
 - 4.1.5.1.1.3 Use of CCM for target population
 - 4.1.5.1.1.4 CHITA services
 - 4.1.5.1.2 Target population for chosen diagnosis

- 4.1.5.1.3 How project benefits target population and chosen diagnosis
 - 4.1.5.2 Care Coordination and Management
 - 4.1.5.2.1 Propose measures for evaluation
 - 4.1.5.2.2 Use measures to monitor care coordination
 - 4.1.5.2.3 Care improvement goals
 - 4.1.5.3 Reference Attachments:
 - 4.1.5.3.1 Clinical Scenario Attachment
 - 4.1.5.3.2 Stakeholder Template
 - 4.1.5.3.3 CHITA Services Template
- 4.1.6 **The Technical Plan:**
 - 4.1.6.1 How project will benefit from interoperable health information infrastructure (includes a description of what health IT products and services will be purchased, for which providers and why the products and tools are critical to project success)
 - 4.1.6.2 Technical architecture and implementation plan, including compliance with CHIXP and how PCMH will perform:
 - 4.1.6.2.1 Access to clinical information, including test order and result tracking
 - 4.1.6.2.2 Patient referral tracking
 - 4.1.6.2.3 Communication and health information exchange among providers
 - 4.1.6.2.4 E-Prescribing and medication management
 - 4.1.6.2.5 Clinical decision support
 - 4.1.6.2.6 Care management, patient tracking and registry functions
 - 4.1.6.2.7 Patient self-management
 - 4.1.6.2.8 Communication and health information exchange among providers and patients
 - 4.1.6.2.9 Performance reporting and improvement
 - 4.1.6.3 Description of data shared
 - 4.1.6.3.1 Medications and allergies
 - 4.1.6.3.2 Problem/diagnosis list
 - 4.1.6.3.3 Laboratory reports
 - 4.1.6.3.4 Radiology reports
 - 4.1.6.3.5 Discharge summaries, consults and other documents
 - 4.1.6.3.6 Other appropriate specific diagnosis testing results
 - 4.1.6.3.7 Other accepted national measures
 - 4.1.6.4 Reference Attachment:
 - 4.1.6.4.1 Technical Architectural Plan
- 4.1.7 **Leadership and Personnel Qualifications**
 - 4.1.7.1 Describe the roles and responsibilities of all project staff (paid and in-kind) including:

- 4.1.7.1.1 Identify your organization
- 4.1.7.1.2 Primary expertise
- 4.1.7.1.3 Role in the project
- 4.1.7.1.4 Anticipated SCP role
- 4.1.7.1.5 Resumes for all project staff (paid and in-kind)
- 4.1.7.2 Reference Attachment
 - 4.1.7.2.1 Attachment 6.12

The Financial Applications must include the following sections and subsections, and be labeled as such:

4.1.8 The Financial Application:

- 4.1.8.1 Business/Reimbursement Plan
- 4.1.8.2 Reference Attachments:
 - 4.1.8.2.1 Sustainability Programs and Measures
 - 4.1.8.2.2 Budget Forms
 - 4.1.8.2.3 Allowable Project Costs

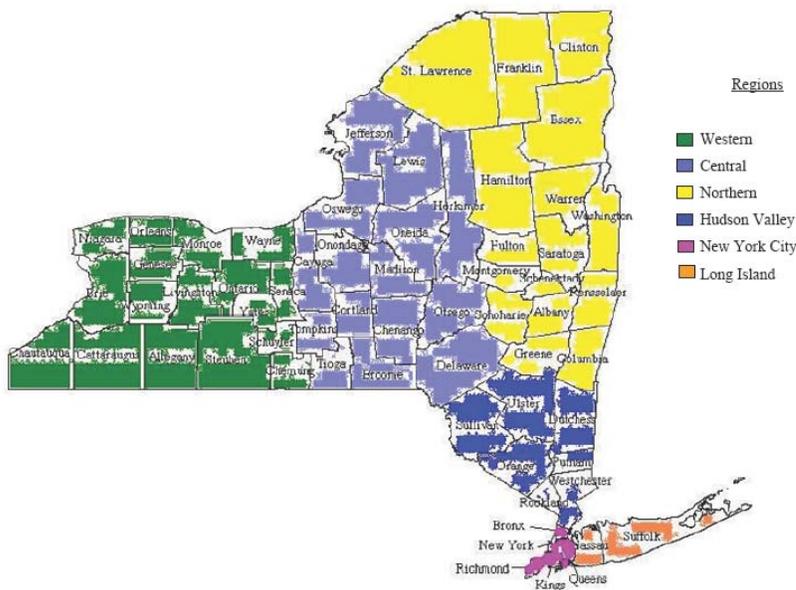
4.2 Award Process

- 4.2.1 DOH reserves the right to make awards in amounts less than requested if budgeted items are determined to be unnecessary or inappropriate for the project. These budget items will be removed and awards will be made based on the adjusted budget.
- 4.2.2 Upon the award of a grant, DOH will issue an award letter to the awardee. The award letter is not a commitment to provide funds, but may assist awardees in obtaining other sources of financing as required to secure the full project cost.
- 4.2.3 For purposes of awarding HEAL 10 grant dollars, awards will be made based upon regions (an aggregation of counties) below.

The regional aggregations are described in the following tables.

Region	Counties Included
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Central	Broome, Cayuga, Chemung, Chenango, Cortland, Delaware, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, Tioga, Tompkins
Northern	Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Warren, Washington

Region	Counties Included
Hudson Valley	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
New York City	Bronx, Kings, New York, Queens, Richmond
Long Island	Nassau, Suffolk



4.2.4 Awards to support the PCMH model and to improve care coordination and management will be made in the amount of \$60 million.

4.2.4.1 Awards

4.2.4.1.1 Applications will be arrayed from high score to low score.

4.2.4.1.2 Awards will be made, based on high scores, with a minimum of one award to each region, and a maximum of two awards to each of the six regions

4.2.4.1.3 Awards will be made for a maximum of \$7M.

4.2.4.1.4 If, after making two awards per region dollars remain, unawarded applications will be considered for funding based on highest scores. This round of awards will be irrespective of regions.

4.2.4.1.5 If funds remain, a determination will be made to either utilize these funds to partially fund the next highest scoring projects or to not award remaining funds.

Section 5: Application Format and Administrative Requirements

5.1 General Application Format

5.1.1 Applications should be concise, single spaced and use a 12 point type, including timeline and budget. The Program Application must not be more than thirty (30) pages in length. The Financial Application must not be more than 30 pages in length. Attachments must be as follows and appear as SEPARATE documents:

- 6.2 CHITA Services Template
- 6.3 Stakeholder Template
- 6.4 Model Project Work Plan
- 6.5 Sustainability Programs and Measures
- 6.6 Reimbursement Model Examples
- 6.7 Diagnosis Choices
- 6.8 Clinical Scenario Template and Examples
- 6.9 Technical Architectural Plan
- 6.10 Allowable Project Costs
- 6.11 Budget Forms
- 6.12 Leadership and Personnel Qualifications
- 6.13 Chronic Care Model
- 6.14 Statewide Policy Guidance
- 6.15 Pass/Fail Review

5.1.2 Applications must be submitted in two separate and distinct parts, following the formats shown in Section 8.

Part I: Program Application

Part II: Financial Application

Include all sections described in all applicable forms in Section 8. Be complete and specific when responding. A panel, convened by DOH and DASNY, will review and score the applications from Eligible Applicants.

No project cost information may be included in the Program Application. Failure to adhere to this requirement may result in disqualification of the application. Each cover page must be signed by an individual authorized to bind the Eligible Applicant to any GDA resulting from the application.

5.2 Question and Answer Phase

5.2.1 All substantive questions must be submitted in writing to:

HEAL NY Phase 10
New York State Department of Health
Office of Health Information Technology Transformation
Corning Tower – ESP Room 2164
Albany, NY 12234

or by e-mail: healthit@health.state.ny.us

- 5.2.2 To the degree possible, each inquiry should cite the RGA section and paragraph to which it refers. Written questions will be accepted through May 11, 2009.
- 5.2.3 Questions regarding the application format or submission process can be addressed in writing or via telephone by calling 518/474-4987.
- 5.2.4 Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the GDA, are to be raised prior to or on May 11, 2009.
- 5.2.5 By May 18, 2009, written answers to all questions raised will be posted on the DOH website <http://www.health.state.ny.us/>. Written answers to subsets of questions may be posted at an earlier date.

5.3 Applicant Conference

An applicant conference will be held on Thursday, April 16, 2009, at the Empire State Plaza, Meeting Room #3, Albany, New York, from 10am to 1pm. To register for this conference send an e-mail to healthit@health.state.ny.us to ensure that adequate accommodations are made for the number of prospective attendees. Please provide a list of individuals expected to attend. A maximum of three (3) representatives from each prospective applicant will be permitted to attend the applicant conference. Failure to attend the applicant conference will not preclude the submission of an application.

Section 166 of the NYS Executive Law requires that conference attendees are required to complete a "Notice of Appearance." This Notice of Appearance will be distributed to applicants upon registration for the conference. Attendees are asked to complete the Notice and bring it to the conference.

5.4 Completing the Application

The Program Application and Financial Application Templates are included in Section 8. Applicants are required to follow these formats to complete the application. Applications must be sent to the mailing address found both above, in Section 5.2.1, and on the cover of this RGA.

5.5 Filing the Application

- 5.5.1 Applications should be concise, single-spaced, and use a 12 point type, including timeline and budget. The application narratives must be not more than 30 pages in

length, excluding required forms and appendices. Each page should be clearly numbered.

- 5.5.2 Applications must be submitted in two separate and distinct parts (each no more than 30 pages of narrative), following the formats shown in Section 4.
 - 5.5.2.1 Part 1: Program Application
 - 5.5.2.2 Part 2: Financial Application
- 5.5.3 Applications must be submitted in electronic form (on a CD or Flash Drive), however all signature pages must accompany the electronic application in original form. These pages will bind the applicant to everything in their electronic submission. One paper copy of each Program and Financial Application should be included. Digital files:
 - 5.5.3.1 Must have a back-up copy (identical folders on the same Flash Drive are acceptable);
 - 5.5.3.2 Be in native format (Excel, Word, etc...) AND also have a Portable Document Format (PDF) copy;
 - 5.5.3.3 ALL PDFs MUST BE SEARCHABLE! Scanned or otherwise generated PDF images of documents will not be accepted;
 - 5.5.3.4 Must have a separate folder for the Program Application and components and the Financial Application and components; and
 - 5.5.3.5 Not adhering to these requirements will result in application disqualification.

NOTE: When preparing electronic files, applicants are requested to comply with the file structure shown below. Additionally, it is request that all PDF files be created using a PDF converter; rather than via a scanner. Free converters are available on the internet. (ie. <http://www.freepdfconvert.com/>)

- 5.5.4 Include all sections described in all applicable forms in Section 8 and attachments. Be complete and specific when responding. A panel, convened by DOH and DASNY, will review and score the applications from Eligible Applicants.
- 5.5.5 No project cost information should be included in the Program Application. Failure to adhere to this requirement may result in disqualification of your application.
- 5.5.6 Each cover page must be signed by an individual authorized to bind the Eligible Applicant to any GDA resulting from the application.
- 5.5.7 Application packages should be clearly labeled with the name and number of the RGA as listed on the cover of this RGA document. Applications WILL NOT be accepted via fax or e-mail.
- 5.5.8 It is the Eligible Applicant's responsibility to see that applications are delivered to the address noted above (Section 5.2.1) prior to the date and time specified. Late applications due to delay by the courier or not received in the DOH mailroom in time for timely transmission to OHITT will not be considered.

5.6 Rights Reserved – New York reserves the right to:

- 5.6.1 Reject any or all applications received in response to this RGA
- 5.6.2 Award more than one GDA resulting from this RGA.
- 5.6.3 Waive or modify minor irregularities in applications received after prior notification to the applicant.
- 5.6.4 Adjust or correct cost figures or minor anomalies, with the concurrence of the applicant if errors exist and can be documented to the satisfaction of DOH and DASNY.
- 5.6.5 Negotiate with awardees within the requirements of HEAL NY Program to serve the best interests of the NYS.
- 5.6.6 Eliminate the detail specifications should an insufficient number of applications be received that meet all these requirements.
- 5.6.7 Reject any application submitted by an eligible applicant not in compliance with all state and federal requirements.
- 5.6.8 Award grants based on geographic or regional considerations to serve the best interests of the state.
- 5.6.9 If NYS is unsuccessful in negotiating a GDA with one or more awardees within an acceptable timeframe, NYS may award the funds to the next most qualified applicant(s) in order to serve and realize the best interests of the state.

5.7 Term of GDA

Any GDA resulting from this RGA will be effective only upon approval by the NYS Office of the Comptroller. It is expected that GDAs resulting from this RGA will begin on or about the fourth quarter of 2009 and will have a duration of two years.

5.8 Payment and Reporting Requirements

Payments under the resulting GDAs will be processed by DOH. The Awardee shall submit information of the type set forth below pursuant to the requirements to be set forth in the GDA.

- 5.8.1 Payment of such invoices by the DOH shall be made in accordance with Article XI-A of the NYS Finance Law. Payment terms will be based on completion of specific milestones to be outlined in the project work plan and must be within the specific GDA budget. Advances will only be authorized in exceptional circumstances to eligible applicants. Not all Applicants may be eligible for payment advances.
- 5.8.2 The Grantee must submit a voucher quarterly to DOH based upon eligible expenses actually incurred by the Grantee. Payment will be made upon presentation to DOH of a Standard Voucher Form (AC-92), together with such supporting documentation as DOH may require, in the forms to be set forth in the GDA or as otherwise determined by DOH.
- 5.8.3 In no event will DOH make any payment which would cause the aggregate disbursements to exceed the Grant amount.

- 5.8.4 All costs for which reimbursement is sought must have been incurred by the Grantee as set forth on the cover page of the GDA or by one of the project stakeholders.
- 5.8.5 Reporting Requirements: During the two year grant period, the grantee is required to submit quarterly reports to DOH, which at a minimum includes:
 - 5.8.5.1 Discussion of milestones achieved and evaluation of project status;
 - 5.8.5.2 Discussion of any delays or other issues encountered;
 - 5.8.5.3 Plan of action for addressing any delays or other issues encountered;
 - 5.8.5.4 Objectives for the next reporting period;
 - 5.8.5.5 Objectives for the remaining Project period;
 - 5.8.5.6 Discussion of any quality control monitoring performed;
 - 5.8.5.7 Financial report of Project expenses and revenues;
 - 5.8.5.8 Description of any collaboration with other grant recipients in their region and with the DOH on the development of statewide standards; and
 - 5.8.5.9 Post implementation reports are also required annually for three years.

5.9 General specifications

- 5.9.1 By signing the Application cover page each signatory attests to its express authority to sign on behalf of the eligible applicant.
- 5.9.2 The eligible applicant, stakeholders and vendors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this GDA will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.
- 5.9.3 Submission of an application indicates the eligible applicant's acceptance of all terms and conditions contained in the RGA. If an eligible applicant does not accept a certain term or condition, this must be clearly noted as described in Sections 4.2.4 and 4.2.5.
- 5.9.4 An eligible applicant may be disqualified from receiving awards if such eligible applicant or any subsidiary, affiliate, partner, officer, agent or principle thereof, or anyone in its employ, as previously failed to perform satisfactorily in connection with public bidding or other State contract, or has failed to meet all regulatory requirements relating to Certificate of Need (CON) and federal and state standards of care.
- 5.9.5 All deadlines are critical, and awardees are expected to meet all timeframes.

5.10 Provisions upon Default

- 5.10.1 The services to be performed by the Applicant shall be at all times subject to the direction and control of the State as to all matters arising in connection with or relating to the GDA resulting from this RGA.
- 5.10.2 In the event that the eligible applicant, through any cause, fails to perform any of the terms, covenants or promises of any GDA resulting from this RGA, DOH and

DASNY, acting for and on behalf of NYS, shall thereupon have the right to terminate the GDA by giving notice in writing of the fact and the date of such termination to the Applicant.

- 5.10.3 If, in the judgment of DOH and DASNY, the applicant acts in such a way which is likely to or does impair or prejudice the interests of NYS, DOH and DASNY, acting on behalf of the state, shall thereupon have the right to terminate any GDA resulting from the RGA by giving notice in writing of the fact and the date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the Office of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the Office of the State Comptroller.

5.11 Appendices

The following will be incorporated as appendices into any GDA(s) resulting from this Request for Grant Application:

- 5.11.1 Appendix A: Standard Clauses for All New York State GDAs
- 5.11.2 Appendix A-1: Agency Specific Clauses
- 5.11.3 Appendix A-2: HEAL Phase 10 Specific Clauses
- 5.11.4 Appendix B: Budget
- 5.11.5 Appendix C: Payment and Reporting Schedule
- 5.11.6 Appendix D: Work Plan
- 5.11.7 Appendix E: Unless the Contractor is a political sub-division of New York State, the Contractor shall provide proof, completed by the Contractor's insurance carrier and/or the Workers' Compensation Board for coverage for:
- 5.11.8 Workers' Compensation for which one of the following is incorporated into this GDA as **Appendix E-1:**
 - 5.11.8.1 **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
 - 5.11.8.2 **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
 - 5.11.8.3 **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance
- 5.11.9 Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2:**
 - 5.11.9.1 **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State

Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR

5.11.9.2 **DB-120.1** -- Certificate of Disability Benefits Insurance OR

5.11.9.3 **DB-155** -- Certificate of Disability Benefits Self-Insurance

NOTE: Do not include the Workers' Compensation and Disability Benefits forms with your application. These documents will be requested as part of the contracting process should you receive an award.

Section 6: Attachments

- 6.1 New York State's Health IT Strategy
- 6.2 CHITA Services Template
- 6.3 Stakeholder Template
- 6.4 Model Project Work Plan
- 6.5 Sustainability Programs and Measures
- 6.6 Reimbursement Model Examples
- 6.7 Diagnosis Choices
- 6.8 Clinical Scenario Template and Examples
- 6.9 Technical Architectural Plan
- 6.10 Allowable Project Costs
- 6.11 Budget Forms
- 6.12 Leadership and Personnel Qualifications
- 6.13 Chronic Care model
- 6.14 Statewide Policy Guidance
- 6.15 Pass/Fail Review

Section 7: References/Contract Appendices

7.1 List of Acronyms

3Cs.....	Electronic Health Records for Clinicians, Personal Health Records for Consumers and Community Portals for public health officials
AHRQ.....	Agency for Healthcare Research and Quality
ARRA.....	American Recovery and Reinvestment Act of 2009
CCM.....	Chronic Care Model
CCZ	Care Coordination Zone
CDC.....	Centers for Disease Control and Prevention
CON	Certificate of Need
CCHIT	Certification Commission for Healthcare IT
CHITA.....	Community Health Information Technology Adoption Collaboration
CHIXP	Common Health Information Exchange Protocol
CIERS	Community-wide interoperable EHRs
CIS.....	Clinical Informatics Services
DASNY	Dormitory Authority of the State of New York
DHHS	U.S. Department of Health and Human Services
DOH.....	NYS Department of Health
EHR.....	Electronic Health Records
ESB.....	Enterprise Service Bus
F-SHRP	Federal State Health Reform Partnership
GDA	Grants Disbursement Agreement

HEAL NY.....Healthcare Efficiency and Affordability Law for New Yorkers

Health ITHealth Information Technology

HIEElectronic Health Information Exchange

HITEC.....Health Information Technology and Evaluation Collaboration

HIPAAHealth Information Portability and Accountability Act

HISPHealth Information Service Providers

HISPC.....Health Information Security and Privacy Collaborative

HITSPHealth Information Technology Standards Panel

HRSA.....Health Resources and Services Administration

IOMInstitute of Medicine

NCQA.....National Committee on Quality Assurance

NHIN.....Nationwide Health Information Network

NYCDOHMH ...NYC Department of Health and Mental Hygiene

NYeC.....New York eHealth Collaborative

NYSNew York State

OASAS.....Office of Alcohol and Substance Abuse Services

OHITTOffice of Health Information Technology Transformation

OMHOffice of Mental Health

ONCOffice of the National Coordinator for Health Information Technology

OSC.....Office of the State Comptroller

PDLBA.....Protocol Driven Late Binding Architecture

PECProvider Executive Committee

PCMHPatient Centered Medical Home
PALPublic Authorities Law
PHLPublic Health Law
PHR.....Personal Health Records
RGA.....Request for Grant Applications
RHIORegional Health Information Organizations
SCPStatewide Collaboration Process
SHIN-NYStatewide Health Information Network for New York

7.2 List of Definitions

7.2.1 Coordination of Care

Providers facilitating care for a patient. This includes following and monitoring a patient's care as they move from provider to provider. Important aspects of this process include, but are not limited to using interoperable electronic health information (such as electronic medical records and electronic prescribing), good communication among providers and between provider and patient and care management. Projects will be responsible for proposing measures that are consistent with this definition and will be scored based on their demonstrated effectiveness.

7.2.2 Care Management

Oversight and educational activities of health care providers related to improving and monitoring patients. Critical elements of care management are described as part of the CCM, which is described in more detail in Attachment 6.13. Examples of such elements are evidence based and patient centered care.

7.2.3 Patient Centered Medical Home (PCMH)

"The patient centered medical home is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship."¹

The primary care physician coordinates this care leveraging health IT and new reimbursement models incentivizing improved communication and access to critical clinical information. In this model, the primary care clinician is able to access the information needed to communicate with all the necessary care givers and coordinate patient care as the patient moves through the health care system and is seen by other clinicians. The ability to access accurate and up-to-date clinical information for managing complex patients requires the implementation of a fully interoperable and functionally complete electronic health record by the primary care physician and their office team, as well as by other care givers and organizations. It also requires interconnection to the SHIN-NY, a health information exchange structure that can provide the needed clinical information while also ensuring both privacy and security.

7.2.4 Interoperable Health Information Technology

The ability to share clinical information across all providers involved in a patient's care to improve the coordination of care. Electronic health records communicate via common

¹ <http://www.ncqa.org/LinkClick.aspx?fileticket=tAzez7UpMo%3d&tabid=631&mid=2435&forcedownload=true>

standards and policies through the SHIN-NY to deliver complete clinical information on patients to providers.

7.2.5 Electronic Health Record (EHR)

An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization.²

7.2.6 Statewide Health Information Network for New York (SHIN-NY)

The SHIN-NY is a network of networks utilizing a common architecture pattern that enables widespread interoperability among disparate health information systems, including electronic health records, while protecting privacy and security. Refer to Attachment 6.1.

7.2.7 Community Health Information Technology Adoption Collaborations (CHITA)

A not-for-profit, for-profit or local government agency, dedicated to the promotion of electronic record adoption and effective use. CHITAs provide adoption and support services to providers and ensure quality and efficiency goals are realized.

7.2.8 Care Coordination Zone (CCZ)

Collectively, the target patient population, PCMH and CHITA are organized as a CCZ to ensure effective organization and management of a project. CCZs comprise both geographic and clinical constructs to describe all providers and entities involved in the care continuum.

7.2.9 Statewide Collaboration Process (SCP)

New York State is developing health information policies, standards and technical approaches governing the health IT infrastructure – collectively referred to as Statewide Policy Guidance. The NYeC, in partnership with the DOH, is leading the development of statewide policy guidance through an open, transparent and consensus-driven process to which all contribute, to ensure a comprehensive policy framework to advance health IT in the public's interest. This process is referred to as the SCP.

To date, the SCP is driven by the efforts of four workgroups which recommend Statewide Policy Guidance to the NYeC Policy and Operations Council, the NYeC Board and the Department DOH. The four workgroups are: (1) Clinical Priorities; (2) Privacy and Security; (3) Technical Protocols and Services; and (4) EHR Collaborative. NYeC is committed to managing the SCP and providing a public-private organizational infrastructure and policy framework evolving to support statewide interoperability.

² http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf

7.2.10 Electronic Health Information Exchange (HIE)

The electronic movement of health-related information among organizations according to nationally recognized standards.³

7.3 Pubic Health Law Section 2818

HEAL NY Legislation (PHL 2818)

§ 2818. Health care efficiency and affordability law of New Yorkers (HEAL NY) capital grant program. 1. The commissioner and the director of the dormitory authority of the state of New York shall enter into an agreement, subject to the approval of the director of the budget, for the purpose of administering the funds available to the health care efficiency and affordability law for New Yorkers (HEAL NY) capital grant program as authorized under section sixteen hundred eighty-j of the public authorities law, in a manner that will encourage improvements in the operation and efficiency of the health care delivery system within the state. A copy of such agreement, and any amendments thereto, shall be provided to the chair of the senate finance committee, the director of the division of budget and the chair of the assembly ways and means committee.

Such agreement shall include criteria, to be developed by the commissioner and the director of the authority, to be considered in their evaluation of applications and determination of awards, including, but not limited to:

(a) determination of eligible applicants, provided that such eligible applicants shall include entities representative of any part of the health care delivery system;

(b) consideration of statewide geographic distribution of funds;

(c) minimum and maximum amounts of funding to be awarded under the program;

(d) the relationship between the project proposed by an applicant and identified community need; and

(e) the extent to which the applicant has access to alternative financing.

Such agreement shall be provided to the chair of the senate finance committee, the director of the division of budget and the chair of the assembly ways and means committee no later than thirty days prior to the scheduled approval of the first bond issuance for the program by the public authorities control board. The authority shall also report quarterly to such chairpersons on the awards made through the program, including the name of the applicant, a description of the project and the amount of the award.

The commissioner and the director of the authority shall award grants to eligible applicants after due public notice of the availability of funds and through a process which ensures to the maximum extent practicable and where appropriate, competition among such applicants, consistent with the following requirements: the commissioner and the director of the authority shall publish the priorities and goals that

³ http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf

are to be achieved through grant funding, and regularly provide public notice of the availability of funding. These priorities and goals shall be consistent with objectives and determinations of the Commission on Health Care facilities in the Twenty-First Century established pursuant to a chapter of the laws of two thousand five, provided, however, that nothing shall prohibit the commissioner and the director for the authority from awarding grants prior to a final report by the commission. For each project that will be recommended for approval, the commissioner and the director of the authority shall report to the chair of the senate finance committee, the director of the division of budget and the chair of the assembly ways and means committee how the project meets the priorities, goals and criteria established pursuant to this section.

Contracts awarded to eligible applicants shall require that work performed thereunder shall be deemed "public work" and subject to and performed in accordance with articles eight, nine and ten of the labor law and the contractors performing such work shall also be deemed a state agency for the purpose of article fifteen-A of the executive law and subject to the provisions of such article.

2. Notwithstanding the provisions of subdivision one of this section, the commissioner and the director of the dormitory authority may award, in an amount not to exceed twenty-five percent of the health care system improvement capital grant program allocation in any given fiscal year, grants to eligible applicants without the process set forth in subdivision one of this section. With respect to the process for the awarding of such funds without the process set forth in subdivision one of this section, the commissioner and the director of the dormitory authority shall determine eligible awardees based solely on an applicant's ability to meet the following criteria:

(i) Have a loss from operations for each of the three consecutive preceding years as evidenced by audited financial statements; and

(ii) Have a negative fund balance or negative equity position in each of the three preceding years as evidenced by audited financial statements; and

(iii) Have a current ratio of less than 1:1 for each of three consecutive preceding years; or

(iv) Be deemed to the satisfaction of the commissioner to be a provider that fulfills an unmet health care need for the community as determined by the department through consideration of the volume of Medicaid and medically indigent patients served; the service volume and mix, including but not limited to maternity, pediatrics, trauma, behavioral and neurobehavioral, ventilator, and emergency room volume; and, the significance of the institution in ensuring health care services access as measured by market share within the region.

(c) Prior to an award being granted to an eligible applicant without a competitive bid or request for proposal process, the commissioner and the director of the dormitory authority shall notify the chair of the senate finance committee, the chair of the assembly ways and means committee and the director of the division of budget of the intent to grant such an award. Such notice shall include information regarding how the eligible applicant meets criteria established pursuant to this section.

3. Notwithstanding subdivisions one and two of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other inconsistent provision of law, of the funds available for expenditure pursuant to this section, thirty million dollars may be allocated and distributed by the commissioner without a competitive bid

or request for proposal process for grants to residential health care facilities for the purpose of restructuring such facilities to achieve a reduction in certified inpatient bed capacity. Consideration relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (a) the existing and projected need for inpatient nursing home beds and community based long-term care services in the area in which a facility applying for such funds is located; (b) the quality of the care being provided by the facility; (c) the ability of the facility to access, in a timely manner, alternative sources of funding, including other sources of government funding; and (d) whether additional funding would permit the facility to achieve greater stability and efficiency in the delivery of needed health care services.

§1680-j. Authorization for the issuance of bonds for the health care efficiency and affordability law for New Yorkers (HEAL NY) capital grant program.

Notwithstanding any other provision of law to the contrary, the dormitory authority of the state of new York is hereby authorized to issue bonds or notes in one or more series in an aggregate principal amount not to exceed seven hundred fifty million dollars excluding bonds issued to fund on or more debt service reserve funds, to pay costs of issuance of such bonds, and bonds or notes issued to refund or otherwise repay such bonds or notes previously issued, for the purposes of financing project costs authorized under section twenty-eight hundred eighteen of the public health law. Of such seven hundred fifty million dollars, ten million dollars shall be made available to the community health centers capital program established pursuant to section twenty-eight hundred seventeen of the public health law.

1. Such bonds and notes of the dormitory authority shall not be a debt of the state and the state shall not be liable thereon, nor shall they be payable out of any funds other than those appropriated by the state to the authority for debt service and related expenses pursuant to any service contract executed pursuant to subdivisions two of this section, and such bonds and notes shall contain on the face thereof a statement to such effect. Except for purposes of complying with the internal revenue code, any interest income earned on bond proceeds shall only be used to pay debt service on such bonds. All of the provisions of the dormitory authority act relating to bonds and notes which are no inconsistent with the provisions of this section shall apply to obligations authorized by this section, including but not limited to the power to establish adequate reserves therefore and to issue renewal notes for refunding bonds thereof. The issuance of any bonds or notes hereunder shall further be subject to the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York State public authorities control board, as required under section fifty-one of this chapter.
2. Notwithstanding any other law, rule or regulation to the contrary, in order to assist the dormitory authority in undertaking the administration and financing of projects authorized under this section, the director of the budget is hereby authorized to enter into one or more service contracts with the dormitory authority, none of which shall exceed more than thirty years in duration, upon such terms and conditions as the director of the budget and the dormitory authority agree, so as to annually provide to the dormitory authority, in the aggregate, a sum not to exceed the annual debt service payments and related expenses required for the bonds and notes issued pursuant to the section. Any service contract entered into pursuant to this subdivisions shall provide that the obligation of the state to pay the amount therein provided shall not constitute a debt of the state within the meaning of any constitutional or statutory provision and shall be deemed executory only to the extent of monies available and that no liability shall be incurred by the state beyond the monies available for such purposes, subject to annual appropriation by the legislature. And such contract or any

3. Payments made or to be made thereunder may be assigned or pledged by the dormitory authority as security for its bonds and notes, as authorized by this section.
4. Notwithstanding any law in the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA) resources fund (061) to the general fund, upon request of the director of the budget, up to \$6,500,000 on or before March 31, 2006, and the comptroller is further hereby authorized and directed to transfer from the health care reform act (HCRA); resources fund (061) to the capital projects fund, upon the request of the director of budget, up to \$139,000,000 for the period April 1, 2006 through March 31, 2007, up to \$170,976,000 for the period April 1, 2007 through March 31, 2008, and up to \$198,408,000 for the period April 1, 2008 through March 31, 2009.

7.5 GDA Appendix A: Standard Clauses for all NYS Contracts

APPENDIX A**STANDARD CLAUSES FOR NYS CONTRACTS**

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licensor, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the

performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor

within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION. (a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law.

(2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's

Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN. In accordance with Section 312 of the Executive Law, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment,

employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State; or (iii) banking services, insurance policies or the sale of securities. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Governor's Office of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and

every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of State Finance Law §165. (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
<http://www.empire.state.ny.us>

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
<http://www.empire.state.ny.us>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

- (a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;
- (b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;
- (c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department

of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

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GDA APPENDIX A-1: AGENCY SPECIFIC CLAUSES

APPENDIX A-1

(REV 10/08)

AGENCY SPECIFIC CLAUSES FOR ALL DEPARTMENT OF HEALTH CONTRACTS

1. If the CONTRACTOR is a charitable organization required to be registered with the New York State Attorney General pursuant to Article 7-A of the New York State Executive Law, the CONTRACTOR shall furnish to the STATE such proof of registration (a copy of Receipt form) at the time of the execution of this AGREEMENT. The annual report form 497 is not required. If the CONTRACTOR is a business corporation or not-for-profit corporation, the CONTRACTOR shall also furnish a copy of its Certificate of Incorporation, as filed with the New York Department of State, to the Department of Health at the time of the execution of this AGREEMENT.
2. The CONTRACTOR certifies that all revenue earned during the budget period as a result of services and related activities performed pursuant to this contract shall be used either to expand those program services funded by this AGREEMENT or to offset expenditures submitted to the STATE for reimbursement.
3. Administrative Rules and Audits:
 - a. If this contract is funded in whole or in part from federal funds, the CONTRACTOR shall comply with the following federal grant requirements regarding administration and allowable costs.
 - i. For a local or Indian tribal government, use the principles in the common rule, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," and Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments".
 - ii. For a nonprofit organization other than
 - ◆ an institution of higher education,
 - ◆ a hospital, or
 - ◆ an organization named in OMB Circular A-122, "Cost Principles for non-profit Organizations", as not subject to that circular, use the principles in OMB Circular A-110, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-profit Organizations," and OMB Circular A-122.
 - iii. For an Educational Institution, use the principles in OMB Circular A-110 and OMB Circular A-21, "Cost Principles for Educational Institutions".
 - iv. For a hospital, use the principles in OMB Circular A-110, Department of Health and Human Services, 45 CFR 74, Appendix E, "Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals" and, if not covered for audit purposes by OMB Circular A-133, "Audits of States Local Governments and Non-profit

Organizations”, then subject to program specific audit requirements following Government Auditing Standards for financial audits.

- b. If this contract is funded entirely from STATE funds, and if there are no specific administration and allowable costs requirements applicable, CONTRACTOR shall adhere to the applicable principles in “a” above.
 - c. The CONTRACTOR shall comply with the following grant requirements regarding audits.
 - i. If the contract is funded from federal funds, and the CONTRACTOR spends more than \$500,000 in federal funds in their fiscal year, an audit report must be submitted in accordance with OMB Circular A-133.
 - ii. If this contract is funded from other than federal funds or if the contract is funded from a combination of STATE and federal funds but federal funds are less than \$500,000, and if the CONTRACTOR receives \$300,000 or more in total annual payments from the STATE, the CONTRACTOR shall submit to the STATE after the end of the CONTRACTOR's fiscal year an audit report. The audit report shall be submitted to the STATE within thirty days after its completion but no later than nine months after the end of the audit period. The audit report shall summarize the business and financial transactions of the CONTRACTOR. The report shall be prepared and certified by an independent accounting firm or other accounting entity, which is demonstrably independent of the administration of the program being audited. Audits performed of the CONTRACTOR's records shall be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States covering financial audits. This audit requirement may be met through entity-wide audits, coincident with the CONTRACTOR's fiscal year, as described in OMB Circular A-133. Reports, disclosures, comments and opinions required under these publications should be so noted in the audit report.
 - d. For audit reports due on or after April 1, 2003, that are not received by the dates due, the following steps shall be taken:
 - i. If the audit report is one or more days late, voucher payments shall be held until a compliant audit report is received.
 - ii. If the audit report is 91 or more days late, the STATE shall recover payments or all STATE funded contracts for periods for which compliant audit reports are not received.
 - iii. If the audit report is 180 days or more late, the STATE shall terminate all active contracts, prohibit renewal of those contracts and prohibit the execution of future contracts until all outstanding compliant audit reports have been submitted.
4. The CONTRACTOR shall accept responsibility for compensating the STATE for any exceptions which are revealed on an audit and sustained after completion of the normal audit procedure.

5. FEDERAL CERTIFICATIONS: This section shall be applicable to this AGREEMENT only if any of the funds made available to the CONTRACTOR under this AGREEMENT are federal funds.

a. LOBBYING CERTIFICATION

- 1) If the CONTRACTOR is a tax-exempt organization under Section 501 (c)(4) of the Internal Revenue Code, the CONTRACTOR certifies that it will not engage in lobbying activities of any kind regardless of how funded.
- 2) The CONTRACTOR acknowledges that as a recipient of federal appropriated funds, it is subject to the limitations on the use of such funds to influence certain Federal contracting and financial transactions, as specified in Public Law 101-121, section 319, and codified in section 1352 of Title 31 of the United States code. In accordance with P.L. 101-121, section 319, 31 U.S.C. 1352 and implementing regulations, the CONTRACTOR affirmatively acknowledges and represents that it is prohibited and shall refrain from using Federal funds received under this AGREEMENT for the purposes of lobbying; provided, however, that such prohibition does not apply in the case of a payment of reasonable compensation made to an officer or employee of the CONTRACTOR to the extent that the payment is for agency and legislative liaison activities not directly related to the awarding of any Federal contract, the making of any Federal grant or loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement. Nor does such prohibition prohibit any reasonable payment to a person in connection with, or any payment of reasonable compensation to an officer or employee of the CONTRACTOR if the payment is for professional or technical services rendered directly in the preparation, submission or negotiation of any bid, proposal, or application for a Federal contract, grant, loan, or cooperative agreement, or an extension, continuation, renewal, amendment, or modification thereof, or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal contract, grant, loan or cooperative agreement.
- 3) This section shall be applicable to this AGREEMENT only if federal funds allotted exceed \$100,000.
 - a) The CONTRACTOR certifies, to the best of his or her knowledge and belief, that:
 - ◆ No federal appropriated funds have been paid or will be paid, by or on behalf of the CONTRACTOR, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal amendment or modification of any federal contract, grant, loan, or cooperative agreement.

- ◆ If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.
- b) The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.
 - c) The CONTRACTOR shall disclose specified information on any agreement with lobbyists whom the CONTRACTOR will pay with other Federal appropriated funds by completion and submission to the STATE of the Federal Standard Form-LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions. This form may be obtained by contacting either the Office of Management and Budget Fax Information Line at (202) 395-9068 or the Bureau of Accounts Management at (518) 474-1208. Completed forms should be submitted to the New York State Department of Health, Bureau of Accounts Management, Empire State Plaza, Corning Tower Building, Room 1315, Albany, 12237-0016.
 - d) The CONTRACTOR shall file quarterly updates on the use of lobbyists if material changes occur, using the same standard disclosure form identified in (c) above to report such updated information.
- 4) The reporting requirements enumerated in subsection (3) of this paragraph shall not apply to the CONTRACTOR with respect to:
- a) Payments of reasonable compensation made to its regularly employed officers or employees;
 - b) A request for or receipt of a contract (other than a contract referred to in clause (c) below), grant, cooperative agreement, subcontract (other than a subcontract referred to in clause (c) below), or subgrant that does not exceed \$100,000; and
 - c) A request for or receipt of a loan, or a commitment providing for the United States to insure or guarantee a loan, that does not exceed \$150,000, including a contract or subcontract to carry out any purpose for which such a loan is made.

b. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE:

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this AGREEMENT, the CONTRACTOR certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The CONTRACTOR agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

c. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for nonprocurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and nonfinancial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other governmentwide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

- 1) APPENDIX B TO 45 CFR PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

- a) By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
- b) The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered and erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
- c) The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
- d) The terms *covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
- e) The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
- f) The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.
- g) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded From Federal Procurement and Non-procurement Programs.
- h) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

- i) Except for transactions authorized under paragraph "e" of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2) *Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions*

- a) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department agency.
 - b) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.
6. The STATE, its employees, representatives and designees, shall have the right at any time during normal business hours to inspect the sites where services are performed and observe the services being performed by the CONTRACTOR. The CONTRACTOR shall render all assistance and cooperation to the STATE in making such inspections. The surveyors shall have the responsibility for determining contract compliance as well as the quality of service being rendered.
 7. The CONTRACTOR will not discriminate in the terms, conditions and privileges of employment, against any employee, or against any applicant for employment because of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status. The CONTRACTOR has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of employment against (including harassment of) any of its employees by any of its other employees, including managerial personnel, based on any of the factors listed above.
 8. The CONTRACTOR shall not discriminate on the basis of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status against any person seeking services for which the CONTRACTOR may receive reimbursement or payment under this AGREEMENT.
 9. The CONTRACTOR shall comply with all applicable federal, State and local civil rights and human rights laws with reference to equal employment opportunities and the provision of services.
 10. The STATE may cancel this AGREEMENT at any time by giving the CONTRACTOR not less than thirty (30) days written notice that on or after a date therein specified, this AGREEMENT shall be deemed terminated and cancelled.
 11. Where the STATE does not provide notice to the NOT-FOR-PROFIT CONTRACTOR of its intent to not renew this contract by the date by which such notice is required by Section 179-

t(1) of the State Finance Law, then this contract shall be deemed continued until the date that the agency provides the notice required by Section 179-t, and the expenses incurred during such extension shall be reimbursable under the terms of this contract.

12. Other Modifications

a. Modifications of this AGREEMENT as specified below may be made within an existing PERIOD by mutual written agreement of both parties:

- ◆ Appendix B - Budget line interchanges; Any proposed modification to the contract which results in a change of greater than 10 percent to any budget category, must be submitted to OSC for approval;
- ◆ Appendix C - Section 11, Progress and Final Reports;
- ◆ Appendix D - Program Workplan will require OSC approval.

b. To make any other modification of this AGREEMENT within an existing PERIOD, the parties shall revise or complete the appropriate appendix form(s), and a Modification Agreement (Appendix X is the blank form to be used), which shall be effective only upon approval by the Office of the State Comptroller.

13. Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for

Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

- CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
- SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

- CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- DB-120.1** -- Certificate of Disability Benefits Insurance OR
- DB-155** -- Certificate of Disability Benefits Self-Insurance

14. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with such breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or subcontractors.
15. All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.
16. Additional clauses as may be required under this AGREEMENT are annexed hereto as appendices and are made a part hereof if so indicated on the face page of this AGREEMENT.

HEAL NY PHASE 10 HEALTH INFORMATION TECHNOLOGY SPECIFIC CLAUSES

1. Performance

A) The Contractor shall maintain detailed information supporting the contract budget and workplan in the format specified by the Department. The detailed information which has been approved by the Department shall be incorporated in the contract by reference, shall be used by the contractor for vouchering contract expenses and reporting workplan progress in the quarterly report format specified by the Department, and shall be used by the State to describe and assess performance under this contract.

B) The Contractor will be required to maintain accounting and other records related to costs incurred by the project and to make the records available to the Department or its representatives upon request during the project and for three years after the project ends.

C) The Contractor accepts all the terms and conditions contained in the Request for Grant Application (RGA) # 0903160302. Non-compliance with standard contract provisions or the RGA may result in the termination of this agreement and the recoupment of grant funds.

D) The Contractor may be disqualified from receiving grant funds if such entity or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or other State contracts.

E) If it becomes necessary for the Contractor to modify the detailed information supporting the contract workplan and/or budget during the contract year, a written request shall be submitted to the State Department of Health which includes:

- 1) The contractor's name and contract number.
- 2) The current workplan and/or budgets and a revised workplan and/or budgets and applicable supporting detailed information reflecting the specific modifications requested.
- 3) A full explanation and justification of the changes requested, including a detailed description of why and how the modification will improve and facilitate the Contractor's ability to achieve the outcomes and goals of the original proposal.

The Contractor will be notified by the Department in writing of approved modifications. Supporting detailed information submitted with subsequent reimbursement requests and quarterly reports shall reflect the approved modification(s).

2. Project Monitoring and Accountability

The Contractor must file quarterly reports and a final report. Quarterly reports are due within 30 days of the end of the quarter. The final report is due within 90 days of the completion of the project. Annual reports are required for three years after completion of the project. Non-

compliance with project monitoring and reporting requirements will result in recoupment of grant funds.

3. Reporting Requirements

A) The Quarterly reporting format will be determined by the Department and will contain at a minimum, the following performance measures:

1. Discussion of milestones achieved and evaluation of project status;
2. Discussion of any delays or other issues encountered;
3. Plan of action for addressing any delays or other issues encountered;
4. Objectives for the next reporting period;
5. Objectives for the remaining project period;
6. Discussion of any quality control monitoring performed;
7. Financial report of project expenses and revenues;
8. Collaborating with other grant recipients in their region and with the Department on the development of statewide standards.

B) The Contractor is required to provide the Department with post-implementation reports annually for three years after completion of the project. The initial post-implementation report is due 90 days after the close of the last project year, as defined by the timeframe of this agreement, and on an annual basis for each of the subsequent three years. Non-compliance with reporting requirements as defined in this agreement shall result in recoupment of grant funds.

4. Intellectual Property Rights

In the event that the Department of Health determines that Contractor is using any HEAL New York funding to develop software or other technology, technical documentation, or products, or to conduct research, the following provisions shall apply.

A) The Contractor hereby grants to the State of New York a worldwide, perpetual, royalty-free, non-exclusive and irrevocable right and license to use, redistribute, sublicense, publish, create derivative works, (and to authorize others to do some or all of the foregoing) any media, documentation, material, device, software (source or object code) or, invention, know-how, trade secrets, technique or methodology or documentation developed or created pursuant to this Agreement.

B) The Contractor shall provide the State of New York with advance written notice of any assignment or transfer of intellectual property rights developed pursuant to this Agreement. Any such assignment or transfer must acknowledge, and be consistent with, the license and other rights granted the State of New York pursuant to the above paragraph.

C) In the event the Contractor distributes, licenses, assigns or transfer any technology (including, but not limited to software and related documentation) or intellectual property rights that are developed or created pursuant to this Agreement in exchange for money or other remuneration, the Contractor agrees to pay to the State of New York a sum equal to five

percent of the gross revenue from such activity. The obligation to make such payments shall terminate the earlier of: when the payments equal the amount of the funding received by the Contractor pursuant to this agreement, or five years from the date of execution of this agreement.

5. Payment Terms

A) Payment of such invoices by the State, via the Department of Health, shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be based on completion of specific milestones to be outlined in the project work plan and must be within the specific approved program budget.

B) Prior to the disbursement of health IT grant funds, the Contractor must provide the Department with documentation evidencing that a segregated account has been established by the Contractor into which grant funds will be deposited. Eligible expenses incurred in connection with the project to be financed with grant funds will be paid out of this account. The funds in such account shall not be used for any other purpose.

C) The Department shall make payment to the Contractor, no more frequently than quarterly, based upon eligible expenses actually incurred by the Contractor, upon presentation to the Department of a Standard Voucher form, together with such supporting documentation using the form(s) and format as required by the Department.

D) The Contractor must provide proof of disbursement of Grant funds, in a form acceptable to the Department, within sixty (60) days of the date that Grant funds are disbursed to the Contractor to pay for such costs. In the event acceptable proof of payment is not provided within that time frame, then DOH will not make any additional disbursements from grant funds until such time as such proof of payment is provided.

E) In no event will the Department make any payment which would cause the aggregate disbursements to exceed the grant amount.

F) All costs for which reimbursement is sought must be incurred by the Contractor of one of the project's stakeholders as set forth in this agreement and the RGA.

6. Project Completion Withhold

The final 10 percent of the grant funds, as defined by the certified budget herewith, shall not be disbursed until and at such time the determination is made that the full project, as described in the project workplan, has been completed.

7. Provisions Upon Default

A) In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department and the dormitory Authority of the State of New York (DASNY), acting for and on behalf of the State, shall thereupon have the right

to terminate this agreement by giving notice in writing of the fact and date of such termination to the Applicant.

B) If, in the judgment of the Department and DASNY, the Contractor act in a way which is likely to or does impair or prejudice the interests of the State, the Department and DASNY, acting on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor. In such case, the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

8. Project Deliverables and Milestones

The Department reserves the right to require the Contractor to include and complete certain project milestones, as deemed relevant and appropriate to the scope of work represented in the RGA.

9. Compliance with all Statewide Collaboration Process Policies and Procedures

A) The Contractor shall participate in the statewide collaboration process facilitated by NYeC, use reasonable efforts to attend all meetings and comply with all work group charters, roles and responsibilities and decision making process.

B) The Contractor shall comply with all principles, policies, standards, technical approaches and services adopted by the statewide collaboration process facilitated by NYeC .

C) The Contractor shall utilize group purchasing contracts negotiated by NYeC regarding all relevant commercially available licensed software products that may be procured through this contract, including but not limited to pricing, licensure/interoperability strategies and other data services

11. Compliance with Health Information Technology Evaluation Collaborative Policies and Procedures

A) The Contractor shall participate in the statewide evaluation process facilitated by HITEC. The Contractor shall establish a mutually agreed to evaluation plan with HITEC and shall reasonably cooperate with HITEC and provide all agreed to data elements to support the evaluation activities as mutually agreed to by the Contractor, HITEC and the Department.

12. Vendor/Subcontractor Approval

The Department reserves the right to review and approve all vendors and/or subcontracts that

Contractor selects to support grant requirements and activities. The Department shall use a reasonable standard of care to maintain the confidentiality of such subcontracts; subject to the requirements of the Freedom of Information Law (FOIL). Contractor shall not subcontract with any software vendor without prior approval of New York State Department of Health. Such approval will not be unreasonably withheld.

Software vendor subcontractors will be expected to incorporate specific vendor subcontract requirements and language, from the Statewide Collaboration Process, which such requirements and language shall be consistent in all respects with the requirements set forth in this Appendix A2, vendor subcontractors will be required to incorporate the then established requirements and language, per the requirements established by the Statewide Collaboration Process, into their vendor subcontracts.

13. Compliance with NYSDOH Policies and Procedures

The Contractor shall comply with all NYS DOH privacy, security, and other fair information practice policies.

GDA Appendix B: Budget

	DOH/DASNY HEAL 10 Reimbursement
Personnel	\$
Hardware	\$
Software	\$
Contractual Services	\$
Other Non Personnel Services	\$
TOTAL	\$

7.8 GDA Appendix C: Payment and Reporting Schedule

APPENDIX C

PAYMENT AND REPORTING SCHEDULE

Payment and Reporting Terms and Conditions

A. The STATE may, at its discretion, make an advance payment to the CONTRACTOR, during the initial or any subsequent PERIOD, in an amount to be determined by the STATE but not to exceed **twenty (20)** percent of the maximum amount indicated in the budget as set forth in the most recently approved Appendix B. If this payment is to be made, it will be due thirty calendar days, excluding legal holidays, after the later of either:

- ❶ the first day of the contract term specified in the Initial Contract Period identified on the face page of the AGREEMENT or if renewed, in the PERIOD identified in the Appendix X, OR
- ❶ if this contract is wholly or partially supported by Federal funds, availability of the federal funds;

provided, however, that a STATE has not determined otherwise in a written notification to the CONTRACTOR suspending a Written Directive associated with this AGREEMENT, and that a proper voucher for such advance has been received in the STATE's designated payment office. If no advance payment is to be made, the initial payment under this AGREEMENT shall be due thirty calendar days, excluding legal holidays, after the later of either:

- ❶ the end of the first quarterly period of this AGREEMENT; or
- ❶ if this contract is wholly or partially supported by federal funds, availability of the federal funds:

provided, however, that the proper voucher for this payment has been received in the STATE's designated payment office.

B. No payment under this AGREEMENT, other than advances as authorized herein, will be made by the STATE to the CONTRACTOR unless proof of performance of required services or accomplishments is provided. If the CONTRACTOR fails to perform the services required under this AGREEMENT the STATE shall, in

addition to any remedies available by law or equity, recoup payments made but not earned, by set-off against any other public funds owed to CONTRACTOR.

- C. Any optional advance payment(s) shall be applied by the STATE to future payments due to the CONTRACTOR for services provided during initial or subsequent PERIODS. Should funds for subsequent PERIODS not be appropriated or budgeted by the STATE for the purpose herein specified, the STATE shall, in accordance with Section 41 of the State Finance Law, have no liability under this AGREEMENT to the CONTRACTOR, and this AGREEMENT shall be considered terminated and cancelled.
- D. The CONTRACTOR will be entitled to receive payments for work, projects, and services rendered as detailed and described in the program workplan, Appendix D. All payments shall be in conformance with the rules and regulations of the Office of the State Comptroller.
- E. The CONTRACTOR will provide the STATE with the reports of progress or other specific work products pursuant to this AGREEMENT as described in this Appendix below. In addition, a final report must be submitted by the CONTRACTOR no later than sixty (60) days after the end of this AGREEMENT. All required reports or other work products developed under this AGREEMENT must be completed as provided by the agreed upon work schedule in a manner satisfactory and acceptable to the STATE in order for the CONTRACTOR to be eligible for payment.
- F. The CONTRACTOR shall submit to the STATE quarterly voucher claims and reports of expenditures on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to the State's designated payment office located in the

Department of Health
Office of Health Information Technology Transformation
Corning Tower, Room 2164
Empire State Plaza
Albany, New York 12237
Attn: HEAL NY Phase V

All vouchers submitted by the CONTRACTOR pursuant to this AGREEMENT shall be submitted to the STATE no later than sixty (60) days after the end date of the period for which reimbursement is being claimed. In no event shall the amount received by the CONTRACTOR exceed the budget amount approved by the STATE, and, if actual expenditures by the CONTRACTOR are less than such sum, the amount payable by the STATE to the CONTRACTOR shall not exceed the amount of actual expenditures. All contract advances in excess of actual

expenditures will be recouped by the STATE prior to the end of the applicable budget period.

- G. If the CONTRACTOR is eligible for an annual cost of living adjustment (COLA), enacted in New York State Law, that is associated with this grant AGREEMENT, payment of such COLA shall be made separate from payments under this AGREEMENT and shall not be applied toward or amend amounts payable under Appendix B of this AGREEMENT.

Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. The CONTRACTOR shall be required to submit a written certification attesting that all COLA funding will be used to promote the recruitment and retention of staff or respond to other critical non-personal service costs during the State fiscal year for which the cost of living adjustment was allocated, or provide any other such certification as may be required in the enacted legislation authorizing the COLA.

Progress and Final Reports

Organization Name: *Project Name* ()

Report Type:

- A. Narrative/Qualitative Report
Project Name will submit, on a quarterly basis, not later than thirty (30) days from the end of the quarter, a report, in narrative form, summarizing the services rendered during the quarter. This report will detail how *Project Name* has progressed toward attaining the qualitative goals enumerated in the Program Workplan (Appendix D).

(Note: This report should address all goals and objectives of the project and include a discussion of problems encountered and steps taken to solve them.)

- B. Statistical/Quantitative Report
Project Name will submit, on a quarterly basis, not later than thirty (30) days from the end of the quarter, a detailed report analyzing the quantitative aspects of the program plan, as appropriate (ie. EHRs installed, interfaces completed, training session conducted, etc.)

- C. Expenditure Report
Project Name will submit, on a quarterly basis, not later than sixty (60) days after the end date for which reimbursement is being claimed, a detailed expenditure

report, by object of expense. This report will accompany the voucher submitted for such period.

D. Final Report

Project Name will submit a final report, as required by the contract, reporting on all aspects of the program, detailing how the use of grant funds were utilized in achieving the goals set forth in the program Workplan.

E. Post-Implementation Reports

Project Name will submit post-implementation reports annually for three years following the completion of this project.

First Quarter Deliverables

A. The Contractor's first quarter deliverables will include:

- i. Detailed Implementation Plan (DIP) – This plan, developed by the Contractor and communicated to the Department via Microsoft Project, which will describe the project milestones that will be used by the Contractor to accomplish the scope of work described in the Contractor's RGA # 0903160302 application. These milestones will be broken down into the corresponding tasks and subtasks required to achieve the milestones.
 - a. The Department reserves the right to determine milestones that need to be included in the Contractor's workplan. These milestone(s), and associated delivery date(s), will be communicated to the Contractor during ongoing communications between the Contractor and the Department and/or will be determined via the Statewide Collaboration Process.
 - b. The Contractor's DIP will be reviewed by DOH during the first three months of the contract period and then must be approved by the Department, after receipt as a first quarter contract deliverable.
- ii. Detailed Budget Plan – The detailed budget plan, developed by the Contractor utilizing the format prescribed by the department, will provide detailed pricing for individual tasks and subtasks that are necessary to accomplish the milestones described in the Detailed Implementation Plan.
 - a. The detailed budget plan is considered a first quarter deliverable for the Contractor.
 - b. The Contractor's detailed budget will be reviewed by DOH during the first three months of the contract period and then must be approved by the Department, after receipt as a first quarter contract deliverable.

HEAL Phase V Vouchering Process.

The Contractor shall submit HEAL Phase V vouchers on a quarterly basis, based on milestones achieved per quarter. The address to send vouchers to is found in Appendix C, Section 1F.

- a. The contractor will submit a single voucher per quarter. This voucher will contain the milestone number and a description of the milestone, corresponding with the description from the detailed implementation plan. Additionally, the contractor will attach;
 - i. A copy of the milestone and tasks/subtasks from the detailed budget plan.
 - ii. Documentation supporting/validating the expenditure. Appropriate supporting documentation will include items such as payroll records (redacted as appropriate), cancelled checks, paid vouchers, or other agreed upon documentation.

APPENDIX D

PROGRAM WORKPLAN
Description for Awardees

A well written, concise workplan is required to ensure that the Department and the Contractor are both clear about what the expectations under the contract are. When a Contractor is selected through an RFP or receives continuing funding based on an application, the proposal submitted by the Contractor may serve as the contractor's work plan if the format is designed appropriately. The following are elements of an RFP or application designed to ensure that the minimum necessary information is obtained. The Department may require additional information if it is deemed necessary.

I. CORPORATE INFORMATION

Include the full corporate or business name of the organization as well as the address, federal employer identification number and the name and telephone number(s) of the person(s) responsible for the plan's development. An indication as to whether the Contractor is a not-for-profit, or governmental organization should also be included. All not-for-profit organizations must include their New York State charity registration number; if the organization is exempt AN EXPLANATION OF THE EXEMPTION MUST BE ATTACHED.

II. SUMMARY STATEMENT

This section should include a narrative summary describing the project which will be funded by the contract. This overview should be concise and to the point. Further details can be included in the section which address specific deliverables.

III. PROGRAM GOALS

This section should include a listing, in an abbreviated format (ie. bullets), of the goals to be accomplished under the contract. Project goals should be as quantifiable as possible, thereby providing a useful measure with which to judge the contractor's performance.

IV. SPECIFIC DELIVERABLES

The project work plan should include the following specific content along with any other added information for your specific project.

a. Strategic Planning / Organization

The project will develop and provide the Department with a specific outline of the value proposition for the project including clinical priorities that are driven by participation in the collaborative. In order to maximize clinical priorities the project will also identify and include physician champions in the organizational planning and design processes as appropriate.

The project will develop and share specific processes and plans for governance as well as planning and implementation of the project. This will include methods to organize and convene stakeholders as well as approaches to education, marketing, communication and finalizing commitments and MOUs.

The project will provide a specific project management plan that is regularly updated in consultation with the Department that will include a defined financing/business model as well as clearly defined project success metrics, working closely with the Department to create and maintain a detailed, up to date, project plan including specifics on scheduling and technical deployment as well as refinement, finalization and implementation of policies.

The project will develop and provide the Department with a specific plan for coordination and interactions with a RHIO identified as being in the project's coverage region and that are appropriate for association with the project through collaborative discussions with the Department.

The project will participate and coordinate with the statewide collaboration process facilitated by NYeC throughout the duration of the grant including participation in workgroups and committees as specified by the Department.

The project will participate and coordinate with the statewide research evaluation function coordinated by HITEC including participation in workgroups, committees, etc as specified by OHITT to help define research questions and support the evaluation process.

The project will share specific plans with the Department that define and describe management of the technical infrastructure and support services that will include, but are not limited to, "Help Desk" functions, back-up / disaster recovery planning, software upgrades, hosting services, network services, hardware / environmental requirements and services as specified by the Department and included in Attachment 6.2 (CHITA Services Template) of the RGA.

The project will share specific plans with the Department that define and describe decisions on vendor selection including definition of core requirements, methods to evaluate options and plans for selection and contracting.

The project will share rationale and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget, for the organizational and management process.

b. Design Process and Activities

The project will develop and provide the Department with a project specific workflow and gap analysis that represents alignment with the statewide collaboration process.

The project will develop and provide the Department with a project specific outline of the requirements gathering process as well as the process and decisions regarding data features, technical architectural design and specifications including evaluation of legacy systems and Interface requirements.

The project will develop and provide the Department with a project specific outline of plans regarding the design model for system and software builds as well as implementation and deployment to include the process for validation of the model, readiness assessment of implementation sites, process for evaluating and selecting sites for implementation and a detailed deployment schedule.

The project will share rational and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget for the design process and activities.

c. Build Process

The project will develop and provide the Department with a specific outline of planned application builds and/or modification of existing and/or vendor software, modifications of software during the build process and validation of the final products.

The project will share rationale and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget, for the build process.

d. Testing Process

The project will develop and provide the Department with a specific outline of the testing process that will be used throughout the build and implementation process including specific plans for testing of initial software builds, software modifications as well as software validation.

The project will share rationale and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget, for the testing process.

e. Pilot Implementation

The project will develop and provide the Department with a specific outline of the process for pilot site training and go – live to include specifics on the evaluation and training process as well as plans for ongoing support and post go-live optimization.

The project will share rational and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget ,for the pilot implementation.

f. Deployment

The project will develop and provide the Department with a specific outline of the process for deployment to include specifics regarding Implementation team training, site scheduling and deployment plans, site training, Go-Live plans and ongoing site support and post go-live optimization.

The project will share rational and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget, for the deployment process.

g. Post Implementation

The project will develop and provide OHITT with a specific outline of the plans for post implementation project optimization assessment, recommendations regarding project modifications and plans for validation of post implementation plans

The project will share rationale and plans to be approved by the Department that define and describe specifics on needs for personnel, hardware, software, contractual services and other necessary but otherwise non-specified services that would be required to meet the strategic planning and organizational category as listed in Appendix B – Budget, for the deployment process.

7.10 GDA Appendix F: Project/Contract Contingencies

Appendix F: Project / Contract Contingencies

This GDA appendix will incorporate any contingencies specific to a project.

Examples might include:

- Contingent upon DOH Certificate of Need approval;
- Contingent upon maintenance of required insurance; and
- Contingent upon meeting relevant NYS Labor Law requirements.

Section 8: Forms and Checklists

8.1 Program Application Forms

8.1.1 Application Checklist

1. Program Application – limit to 30 pages of narrative (excluding attachments)

- _____ Program Application Cover Page
- _____ Eligible Applicant Certification
- _____ Program Application
 - Table of Contents
 - Executive Summary/Project Description (max. 3 pages)
 - Eligible Applicant Description
 - Organization Plan
 - Technical Plan
 - Clinical Plan
 - Leadership/Personnel
 - Project Management/Monitoring Plan
- _____ Vendor Responsibility Information/Attestation

2. Packaging the Application

- _____ Ensure no cost information is included in the Program Application

The package contains:

- _____ One original, signed, Program Application; a full copy of the Program Application

- _____ Two CDs, or 2 clearly labeled USB drives that each contain a full copy of the Program Application
- _____ One original, signed, Financial Applications; a full copy of the Financial Application
- _____ Two CDs, or two clearly labeled USB drives that each contain a full copy of the Financial Application

NOTE: In an instance where there is a discrepancy between hard-copy and soft-copy documentation, the hard-copy documents will prevail

When preparing electronic files, applicants are requested to comply with the file structure shown below. Additionally, it is request that all PDF files be created using a PDF converter; rather than via a scanner. Free converters are available on the internet. (ie. <http://www.freepdfconvert.com/>)

Program Application

- _____ One exact PDF file (copy) of the Program Application that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Program Application in its native application (ie. MS Word / MS Excel)

Program Application Attachments

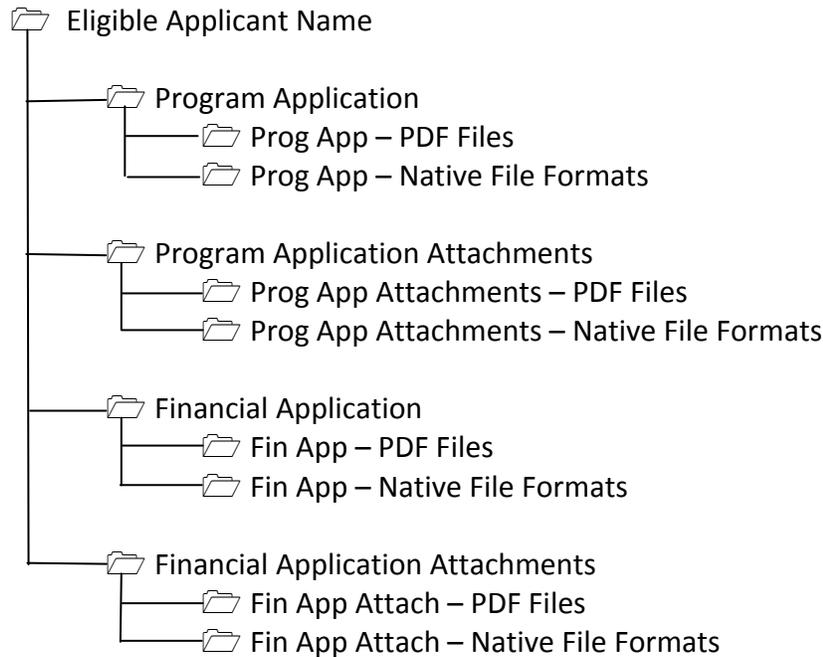
- _____ One exact PDF file (copy) of the Program Application attachments, forms and checklists that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Program Application attachments, forms and checklists in the native application (ie. MS Word / MS Excel)

Financial Application

- _____ One exact PDF file (copy) of the Financial Application that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Financial Application in the native application (ie. MS Word / MS Excel)

Financial Application Attachments

- _____ One exact PDF file (copy) of the Financial Application attachments, forms and checklists that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Financial Application attachments, forms and checklists in the native application (ie. MS Word / MS Excel)



_____ Applications will be accepted only if delivered by 3PM on June 15, 2009

_____ Application package is labeled:

HEAL NY Phase 10: Health Information Technology Grants
RGA # 0903160302

_____ Application must be no more than 30 pages in length; responses should be in the body of the application (not in attachments); attachments should only supplement, not substitute for application content

4. Please double check that

_____ Eligible Application Certification is signed and included in the application

_____ Vendor Responsibility Questionnaire is included or an electronic version has been submitted to the State Comptroller’s website and the certification attesting to submission is signed and included

_____ Cover pages are signed.

HEAL NY Phase 10 Program Application

Eligible Applicant Name _____

Project Name _____

Instructions:

1. Select One Region

- New York City Northern
- Long Island Central
- Hudson Valley Western

Only one region may be selected. If the project encompasses multiple regions, the region with the greatest percentage of the patient population should be selected. Failure to select a region will result in the application being eliminated from review and consideration.

2. Identify Lead Applicant _____

3. Lead Applicant is either a:

- Designated stakeholder in the PCMH
- CHITA

4. _____ Lead Applicant is a legal entity, eligible based on the criteria in Section 3.2.

5. _____ Included clinicians and providers which are clinically affiliated for the purposes of care coordination, but not a part of the same corporate structure.

6. _____ Included a description of active participation in a state recognized RHIO.

IMPORTANT: The Program Application, including this cover page, must NOT contain ANY information regarding the Project cost. Information relative to Project cost is to be included in only the Financial Application. Eligible Applicants failing to comply may be eliminated from further review.

Provide the following contact information

Name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Signature of an individual who will be authorized to bind the Eligible Applicant to any GDA resulting from this application:

Signature _____ Date _____

8.1.3 Eligible Applicant Certification

**CERTIFICATION FOR
HEAL NY GRANTS**

I hereby warrant and represent to the New York State Department of Health (“DOH”) and the Dormitory Authority of the State of New York (“the Authority”) that:

- Applicant will make every effort to ensure that the project described in this application will be consistent with the goals and recommendations of the Commission on Health Care Facilities in the Twenty-First Century, as established pursuant to Section 31 of Part E of Chapter 63 of the Laws of 2005.
- Applicant will make every effort to ensure that the Health IT project described in this application will be interoperable and adhere to the national standards for the type of Project described, and Applicant shall achieve Certification Commission for Healthcare Information Technology (CCHIT) certification in interoperability, privacy and security standards within six months of such standards and certification becoming available.
- All contracts entered into by the Grantee in connection with the Project shall (A) provide that the work covered by such contract that is funded by grant dollars shall be deemed “public work” subject to and in accordance with Articles 8, 9 and 10 of the Labor Law; and (B) shall provide that the contractors performing work under such contract shall be deemed a "state agencies” for the purposes of Article 15A of the Executive Law
- If awarded a HEAL NY grant, the funds will be expended solely for the project purposes described in this RGA and in the GDA and for no other purpose.
- I understand that in the event that the project funded with the proceeds of a HEAL NY grant ceases to meet one or more of the criteria set forth above, then DOH and/or the Dormitory Authority shall be authorized to seek recoupment of all HEAL NY grant funds paid to the Grantee and to withhold any grant funds not yet disbursed.

Applicant Name _____

Project Name _____

Signature _____ Date _____

Name (Please Print) _____

Title (Please Print) _____

Please note that in accordance with Part 86-2.6 of the Commissioner’s Administrative Rules and Regulations, **ONLY** the following individuals may sign the attestation form:

- Proprietary Sponsorship – Operator/Owner
- Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors

Public Sponsorship – Public Official Responsible for Operation of the Facility

8.1.4 Application Format

Eligible Applicant Name: _____

Project Name: _____

A. Cover Page

B. Table of Contents

C. Executive Summary/Project Description

This part of the Program Application should briefly describe:

- The overall project, including brief summary of each section below.
- How the project meets HEAL 10 objectives and requirements.
- Description of eligible applicant and how the eligible applicant and stakeholders meet the minimum requirements (Section 3.2).

D. Eligible Applicant –Description

Describe the PCMH and provide basic information regarding the participants and their role in the project. Characterize the depth and breadth of the CCZ and health IT infrastructure to support the PCMH model and improve coordination and management of patient care.

E. Organizational Plan

See Section 4.1.4

F. Technical Plan

See Section 4.1.6

G. Clinical Plan

See Section 4.1.5

H. Leadership and Personnel Qualifications

See Section 4.1.7

I. Project Management

See Section 4

8.1.5 Vendor Responsibility Information/Attestation

Vendor Responsibility

NYS Procurement Law requires that NYS agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the NYS VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the NYS VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at <https://portal.osc.state.ny.us>. For direct VendRep System user assistance, the Office of the State Comptroller (OSC) Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us.

Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the DOH or the OSC for a copy of the paper form. Awardees must also complete and submit the Vendor Responsibility Attestation (Attachment 9.2.5).

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section IV, Administrative Requirements, H. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

- An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <https://portal.osc.state.ny.us> within the last six months.

- A hard copy Vendor Responsibility Questionnaire is included with this application and is dated within the last six months.

- A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

8.2 Financial Forms

8.2.1 Financial Application Checklist

1. Financial Application

- _____ Financial Application Cover Page
- _____ Project Budget
- _____ Project Fund Sources
- _____ Project Expenses and Justification
- _____ Cost Effectiveness
- _____ Project Financial Viability
- _____ Eligible Applicant Financial Stability

2. Packaging the Application

- _____ Ensure no cost information is included in the Program Application

The package contains:

- _____ One original, signed, Program Application; a full copy of the Program Application
- _____ Two CDs, or 2 clearly labeled USB drives that each contain a full copy of the Program Application

- _____ One original, signed, Financial Applications; a full copy of the Financial Application
- _____ Two CDs, or two clearly labeled USB drives that each contain a full copy of the Financial Application

NOTE: In an instance where there is a discrepancy between hard-copy and soft-copy documentation, the hard-copy documents will prevail.

When preparing electronic files, applicants are requested to comply with the file structure shown below. Additionally, it is request that all PDF files be created using a PDF converter; rather than via a scanner. Free converters are available on the internet. (ie. <http://www.freepdfconvert.com/>)

Program Application

- _____ One exact PDF file (copy) of the Program Application that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Program Application in its native application (ie. MS Word / MS Excel)

Program Application Attachments

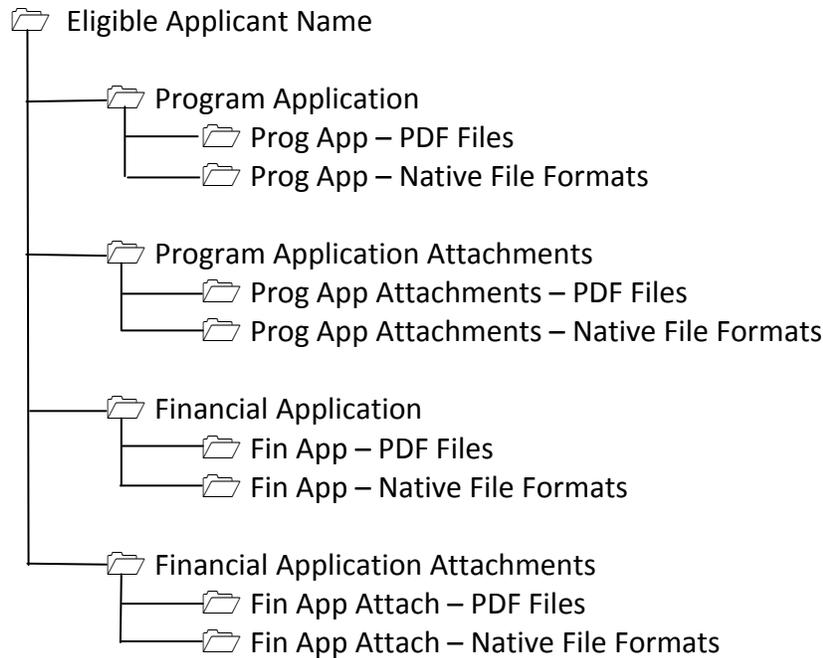
- _____ One exact PDF file (copy) of the Program Application attachments, forms and checklists that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Program Application attachments, forms and checklists in the native application (ie. MS Word / MS Excel)

Financial Application

- _____ One exact PDF file (copy) of the Financial Application that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Financial Application in the native application (ie. MS Word / MS Excel)

Financial Application Attachments

- _____ One exact PDF file (copy) of the Financial Application attachments, forms and checklists that is searchable (on each CD or Flash Drive)
- _____ One exact file (copy) of the Financial Application attachments, forms and checklists in the native application (ie. MS Word / MS Excel).



___ Applications will be accepted if delivered by 3PM on the date shown on the RGA cover page.

___ Application package is labeled:

HEAL NY Phase X: Advancing Interoperable Health Information
Infrastructure to Support the Patient Centered Medical Home (PCMH)
Model and Improve Care Coordination and Management
RGA # 0903160302

___ Application must be no more than 30 pages in length; responses should be in the body of the application (not in attachments); attachments should only supplement, not substitute for application content

3. Please double check that

___ Eligible Application Certification is signed and included

___ The appropriate match has been clearly documented

___ Vendor Responsibility Questionnaire has been submitted (can be submitted electronically), and the certification attesting to submission is signed and included (Section 8.1.5)

___ Cover pages are signed

8.2.2 Financial Cover Page

HEAL NY Phase 10 Financial Application

Eligible Applicant Name _____

Project Name _____

Instructions:

7. Select One Region

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> New York City | <input type="checkbox"/> Northern |
| <input type="checkbox"/> Long Island | <input type="checkbox"/> Central |
| <input type="checkbox"/> Hudson Valley | <input type="checkbox"/> Western |

Only one region may be selected. If the project encompasses multiple regions, the region with the greatest percentage of the patient population should be selected. Failure to select a region will result in the application being eliminated from review and consideration.

8. Identify Lead Applicant _____

9. Lead Applicant is either a:

- Designated stakeholder in the PCMH
 CHITA

10. _____ Included clinicians and providers, which are clinically affiliated for the purposes of care coordination, but not a part of the same corporate structure.

11. Allowable costs attestation:

- I certify that I have read and understand Section 8.2.3 (includes HEAL NY Phase 10 Health IT Allowable Costs) and Attachment 6.10 (Allowable Project Costs), and attest that all project costs for this project are allowable.

Provide the following contact information

Name: _____

Title: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Signature of an individual who will be authorized to bind the Eligible Applicant to any GDA resulting from this application:

Signature _____ Date _____

8.2.3 Financial Application Template

Eligible Applicant Name: _____

Project Name: _____

- A. Table of Contents**
- B. Project Budget, including Forms and Justification**
- C. Cost Effectiveness**
- D. Project Financial Sustainability**
 - See Section 3.3.8
- E. Eligible Applicant and Stakeholders' Financial Stability**

HEAL NY Phase 10 Health IT Allowable Costs Rationale

One of the objectives of this RGA is that the funded project, when completed, will constitute a capital asset that is consistent with interoperable health IT investment priorities state-wide. Applicant costs in developing or obtaining the capital asset may constitute a capitalized cost. Applicants are encouraged to review the American Institute of Certified Public Accountants (AICPA) Statement of Position 98-1: *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use* when determining whether costs are properly attributable to the HEAL NY Health IT grant.

Project costs associated with activities that occur in the regular course of business are considered indirect costs and cannot count as a reimbursable or matching cost. Direct costs only, ie. costs associated with the grant project that would not occur absent a grant contract can be considered as reimbursable or matching costs of the applicant. Examples of indirect costs generally include functional categories such as general maintenance and operation expenses.

This funding is intended to provide support for interoperable health IT rather than brick and mortar capital assets. Within this context, a framework is required to establish the costs which will be eligible for funding under this RGA. In establishing the framework, allowable costs are determined based on the nature of the cost rather than the object of expense of the cost.

HEAL 10 Health IT Allowable Costs

For purposes of this RGA, allowable costs include:

- EHRs for primary care providers and appropriate specialty physician practices and other providers participating in the PCMH. A maximum of 25 percent of the costs of inpatient and/or long term care providers' EHRs is also permitted.
- Connecting ambulatory and inpatient EHRs to the SHIN-NY or local hub solution as a bridge to the SHIN-NY, including but not limited to results reporting and summary record exchange.
- Information portals (if currently more feasible than EHRs or PHRs, including how such portals will interface with EHRs or PHRs).
- Clinical Informatics Services (CIS), including clinical decision support software.
- E-Prescribing applications connected to the SHIN-NY with medication reconciliation
- Integrated medication reconciliation software.
- Implementation, configuration, maintenance and operation, for all of the above.
- Health IT adoption and support services, including quality improvement services (CHITA services).
- Project evaluation, in addition to and/or in cooperation with HITEC, to document improvements in care coordination and outcomes.
- Project organization and administration of the PCMH.

Applicants should include a detailed description of what health IT tools will be purchased, for which PCMH providers in the proposed project and why these tools are critical for the success of the project. Emphasis should be on providing tools for all primary care providers as part of the PCMH as well as those specialists providing services most directly relevant to the targeted patient population. Stakeholders who are eligible for inclusion are listed in 3.2.2 and 3.2.3. Other stakeholders may be considered with appropriate supporting documentation.

All technology that will be paid for with HEAL 10 funds will require final vendor approval by the NYS DOH.

Under this RGA, the reimbursable costs can be both capitalizable and non-capitalizable (see budget form) as well as matching funds.

Matching Funds Cash and In-Kind

For the Purposes of this RGA:

1. Matching funds can be used for milestones associated with project planning, implementation or post-implementation.
2. HEAL 10 Funds can be used for:
 - Milestones associated with the project implementation and post implementation phases of the project
 - Evaluation and collaboration milestones

8.2.4 Overview of Budget Forms and Process

1. There are three budget forms in Excel format included as part of the Financial Application Format and Budget Forms as well as a narrative budget justification template.
2. The budget forms, which are tabs on the Excel file (“HEAL 10 Budget Worksheet”) include:
 - Project Budget
 - Project Funding
 - Revenue & Expense Projections
 - Narrative Budget Justification
3. All budgeted expenses and revenue sources should be accompanied by a written budget justification (maximum of 3 pages).
4. Expenditure amounts should be described in sufficient detail to identify what is being purchased and/or the service being provided. This would be in the form of milestone descriptions entered onto the Project Budget form.
5. Each revenue source amount should be detailed.
6. Each expenditure and revenue source amount should be detailed in a separate timeline for the two-year contract period by quarter of expense (1st Q, 2nd Q, etc.).
7. For the applicant and each stakeholder contributing cash or in-kind services toward the match, attach a corresponding letter of commitment identifying the source and amount of the cash /in-kind services committed, signed by an authorized officer of the corporation/organization. This expressed commitment must be included in the stakeholder commitment letter described in Attachment 6.3.
8. On the Project Budget form, the shaded area containing N/A is restricted to the matching funds only. HEAL 10 funds will not be available for these items of expense. Awardees will be allowed to claim matching funds (cash and in-kind) for the time period of April 1, 2009, until the contract start date. Contracts are anticipated to have a start date late in the fourth quarter of 2009.
9. Reimbursement for non-capitalizable expenses are limited to 40 percent of the total reimbursable expense.

Project Budget Form

Patient Centered Medical Home and Improving Care Coordination and Management

Eligible Applicant: _____

Total Project Costs: \$ -

Milestone	Quarter	Project Cost Categories (HEAL 10 Funding)					(F) TOTAL HEAL 10 FUNDS	Capitalizable / Non Capitalizable			Applicant Match			(O) Total Project Expenses	
		(A) Software	(B) Hardware	(C) Personnel	(D) Contractual Services	(E) Other NPS		(G) Capitalizable Expense	(H) Non Capitalizable Expense	(I) Total Capitalizable / Non Capitalizable	(K) Applicant/ Stakeholder Matching Funds CASH	(L) Applicant/ Stakeholder Matching Funds IN-KIND	(N) Total Match		
1 Develop Organizational Strategy	PreAward	HEAL 10 Funding Not Available for these Functions						Not Applicable						#VALUE!	
2 Develop Technical Strategy	PreAward	HEAL 10 Funding Not Available for these Functions						Not Applicable						\$ -	
3 Develop Clinical Strategy	PreAward	HEAL 10 Funding Not Available for these Functions						Not Applicable						\$ -	
4						\$ -			\$ -			\$ -	\$ -	\$ -	
5						\$ -			\$ -			\$ -	\$ -	\$ -	
6						\$ -			\$ -			\$ -	\$ -	\$ -	
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48						\$ -			\$ -			\$ -	\$ -	\$ -	
Totals		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -			\$ -	\$ -	\$ -	
		Total (K)													
		\$ -													
		Total (J)													
		\$ -													
		Total (M)													
		\$ -													
		Non-Capitalizable as Percentage of Total							#DIV/0!	Match as Percentage of Project Total					
		Must be less than 40%								Must be Greater than or equal to 50%					
		Total (O)													
		\$ -													

Revenue & Expense Projections

Eligible Applicant: _____

Expense & Revenue - Two Year Projected Project Budget

		Revenue		Expense	Net
		HEAL 10	Match		
Year One	Quarter 1	\$ -	\$ -	\$ -	\$ -
	Quarter 2	\$ -	\$ -	\$ -	\$ -
	Quarter 3	\$ -	\$ -	\$ -	\$ -
	Quarter 4	\$ -	\$ -	\$ -	\$ -
	SubTotal	\$ -	\$ -	\$ -	\$ -
Year Two	Quarter 5	\$ -	\$ -	\$ -	\$ -
	Quarter 6	\$ -	\$ -	\$ -	\$ -
	Quarter 7	\$ -	\$ -	\$ -	\$ -
	Quarter 8	\$ -	\$ -	\$ -	\$ -
	SubTotal	\$ -	\$ -	\$ -	\$ -
Project Total		\$ -	\$ -	\$ -	\$ -

Narrative Budget Justification

1. Provide applicant name.
2. The budgeted expenses and revenue sources should be accompanied by a written justification for each item of expense and revenue (total of 3 pages maximum).
3. Expenditure amounts should be described in detail, sufficient to identify what is being purchased the service being provided. This description should be an expanded explanation of each milestone included in the Project Budget.
4. Each revenue source amount should be detailed.
5. Each capitalized expense listed on Budget Form must include a detailed explanation as to how the determination was made that the expense is capitalizable.

Applications must be submitted by June 15, 2009, 3 PM ET to:

HEAL NY Phase 10
 New York State Department of Health
 Office of Health Information Technology Transformation
 Corning Tower – ESP Room 2164
 Albany, NY 12234