Request for Grant Applications

HEAL NY-- Phase 5
Health Information Technology Grants

Advancing Interoperability and Community-wide EHR Adoption

Issued by:
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and
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SECTION 1: OVERVIEW

1.1 The HEAL NY 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 effectively reform and reconfigure New York's health care delivery system to achieve improvements in patient care and increased efficiency of operation. Section 2818 provides that the HEAL NY Program shall 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 program with two primary objectives:

- To identify and support opportunities for development and investment in health information technology (IT) initiatives on a regional 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 the 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).

Multiple Requests for Grant Applications (RGAs) have been issued and to date more than $300 million in awards have been made.

The $52.9M in funding originally designated for HEAL NY Phase 3 is now a part of the HEAL NY Phase 5 Health IT Grant Program totaling $105.75M.

1.2 HEAL NY Phase 5 – Health IT

New York State (NYS) envisions a health care system supported by health IT where:

- Clinical information is in the hands of clinicians so that it guides medical decisions and care coordination;
- Medical information follows the consumer so they are at the center of their care;
- Quality initiatives requiring health IT tools result in robust accountability based on the information needed to assess outcomes/performance;
- Clinical information is accurately collected in a timely manner for population health reporting, clinical trials and for other research purposes; and,
- Clinical research and care delivery are linked together to measure and monitor longitudinal outcomes.

The HEAL NY Phase 5 Health IT grant program seeks applications for health IT projects which lay a foundation for realizing this vision and build on the HEAL NY Phase 1 Health IT grant projects.

The strategic focus of the HEAL NY Phase 5 Health IT RGA is to advance interoperability through the funding of a health information infrastructure based on a community driven model open to all providers, payers and patients. Interoperability is the ability to exchange patient health information among disparate clinicians, other authorized entities and patients in real time while ensuring security and privacy protections. Interoperability is essential to realizing the expected value of health IT to support patient care improvements.

The HEAL NY Phase 5 Health IT grant awards are anticipated to total $105,750,000 ($105.75 million) although if additional funding becomes available, this amount may be increased. The awards are expected to range from a minimum of $1 million up to a maximum of $10 million over a two-year grant period with an option to renew the contract for up to two additional one year periods to ensure completion of the project. It is expected that the GDAs resulting from this RGA will begin on or about the first quarter of 2008.

1.3 National Health IT Movement

Our health care system does not consistently deliver safe, effective and affordable care for New Yorkers despite enormous expenditures and groundbreaking advances in biomedical research and technology. According to the Institute of Medicine (IOM) reports "To Err is Human" and "Crossing the Quality Chasm," the U.S. health care system does not reliably deliver the best care when and where it is needed, and millions of Americans are routinely subjected to errors and other systems failures that cause unnecessary harm and deaths. In response, the IOM described six aims to guide health care system reform and improvement efforts. The aims of a reformed health care system are: safe, effective, patient-centered, timely, efficient and equitable. Coordination across all stakeholders is needed to advance these aims, and one of many strategies identified by IOM is widespread adoption of health IT. The IOM is quoted as follows:

> *In the 20th century, brick and mortar constituted the basic infrastructure of the health care delivery system. To deliver care in the 21st century, the system must have a health information and communications technology infrastructure that is accessible to all patients and providers.*[i]

Nationally and across the states, interoperable health IT adoption among multiple stakeholders has become a cornerstone in the overall strategy to obtain greater value in health care. According to the Commonwealth Fund's study "Achieving a High Performance Health System":

> *It is not enough for individual organizations to perform well; each institution, whether a small physician practice, a large hospitals system, a health plan, or a nursing home, must be tied together into a coordinated system of care. Significant changes are required to foster improvement and innovation within the health care system. Each component of change will require commitment from*

> *multiple players. Organizing health care information around the patient requires expanded use of health information technology, among other changes, which similarly entail involvement from physicians, health care delivery organizations, insurers, purchasers, and patients, as well as commitment from the government.*[ii]

While the federal government has a long history of health IT policy leadership through organizations such as the National Committee for Vital and Health Statistics, these policy efforts were significantly expanded in April 2004 when the President called for interoperable electronic health records (EHRs) for every American by 2014 and established the Office of the National Coordinator for Health Information Technology (ONC) to spearhead national efforts to achieve this goal. ONC is managing multi-year landmark health IT initiatives that together provide a foundation for the development of a nationwide health information network (NHIN).

Multiple federal agencies also are undertaking initiatives to support health information exchange and health IT adoption. Together, the Agency for Health Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) are funding community-based health IT projects in 43 states, where at least half of the recipients are located in rural or underserved areas. Furthermore, many observers expect the government to propose changes to Medicare payments to provide incentives for interoperable EHR adoption and quality improvements.[iii]

The federal executive branch agencies' interest in health IT is matched by a strong and growing interest in Congress. While the Congress has yet to unite around a specific proposal, in 2006 and 2007, 23 and 20 health IT bills respectively were introduced, including proposals to develop and set interoperability standards, enhance privacy and security of health information, authorize the ONC, and appropriate federal funds for interoperable EHR adoption.

Increasingly, states are leading the development of health IT policy, coordinating multi-stakeholder approaches to health information exchange and quality tools, addressing patient privacy and confidentiality, and funding and promoting the adoption and effective use of interoperable EHRs. At least 35 states have issued health IT gubernatorial executive orders, proposed budget appropriations, commissioned planning efforts, established executive-level offices and/or introduced legislation.

Communities across the country are also shaping the emerging health IT landscape through Regional Health Information Organizations (RHIOs) to enable interoperability, quality measurement and reporting and population health improvement initiatives. RHIOs are providing real-world laboratories for analyzing the technology, governance, clinical, business and legal issues raised by interoperable health information exchange and health IT adoption. There are also well over 100 financial incentive and pay-for-performance programs under way in the private sector developing health IT quality tools and designing incentive payments to clinicians along a spectrum of prevention, process and quality-based outcomes. While still in early development stages, health information exchange projects and quality improvement tools supporting pay-for-performance

initiatives are providing early lessons regarding the importance of the organizational, technical and clinical aspects of health IT to realize the value from health information.

1.4 New York's Health IT Agenda

Health IT is an element of New York's health care reform agenda, along with hospital and long-term care restructuring, reimbursement reform, universal coverage, and disease prevention and wellness initiatives. These initiatives and others will drive improvements in health care quality, affordability and outcomes for New Yorkers.

There is mounting evidence that strategic investment in interoperable health IT – investment that will allow the health care field to transform from today's largely paper-based system to an electronic, interconnected system – can lead to improvements in health care quality, affordability and outcomes. Increasingly, this interest has focused on interoperable health information exchange – (the secure flow of personal health information to follow the patient) – and quality measurement and reporting tools – (the valid collection of clinical data to measure results or outcomes to improve quality and population health). As a health information infrastructure in New York is developed, we must ensure that health IT tools are open to all providers and payers through a community-based, multi-stakeholder model so the systems used by clinicians, providers and New Yorkers are able to communicate seamlessly with one another to achieve interoperability.

On August 8, 2007, the New York State Department of Health launched a comprehensive health IT program, part of Governor Eliot Spitzer's agenda to advance patient-centered care and enable improvements in health care quality, affordability and outcomes for each person, family and business in New York. The new Office of Health Information Technology Transformation (OHITT) is charged with coordinating health IT programs and policies across the public and private health-care sectors. These programs and policies will establish the health IT infrastructure and capacity to support clinicians in quality and population health improvement, quality-based reimbursement programs, and new models of care delivery. In addition, significant reductions in health care costs are expected over time by reducing costs associated with medical errors, duplicative tests and therapies, and uncoordinated and fragmented care.

As part of the Spitzer Administration's commitment, an initial $105.75 million will be invested in New York's health care community to support the implementation of health IT tools to allow portability of patients' medical records and new tools to assess and target improvements in health care quality. A key objective driving New York's investment is ensuring the privacy and security of patients' individually identifiable health information and supporting the right of New Yorkers to have greater control over and access to their personal health information.

The expected opportunities or benefits that New York's health IT investment is supporting are:

- **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:** Harness the power of clinical information to support improvement 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 physicians to improve quality, affordability and outcomes.

The delivery of health care in New York occurs in settings from solo physician offices and community health centers to large academic medical centers, nursing homes and multi-specialty physician practices, from Manhattan to rural upstate towns with vastly differing market conditions and health care needs. There is a critical need for a coordinated statewide health IT framework which supports common policies, technical standards and protocols as well as regional “bottom-up” implementation approaches and care coordination to allow local communities and regions to structure their efforts based on clinical and patient priorities.

SECTION 2: HEALTH IT INVESTMENT FRAMEWORK

The strategic focus of the HEAL NY Phase 5 Health IT grant program is to advance interoperability through the funding of a health information infrastructure based on a community driven model open to all providers, payers and patients.

Interoperability is the ability to exchange patient health information among disparate clinicians, other authorized entities and patients in real time while ensuring security, privacy and other protections. Interoperability is necessary for compiling the complete experience of a patient's care and ensuring it is accessible to clinicians as the patient moves through various healthcare settings. This will support clinicians in making fact-based decisions so medical errors and redundant tests can be reduced and care coordination improved. Interoperability is critical to cost-effective, timely and standardized data aggregation and reporting for quality measurement, population health improvement, biosurveillance, and clinical research. Interoperability is also needed for patients to have access to their personal health information that is portable, not tethered to a particular payer or provider.

In summary, interoperability is essential to realizing the expected value of health IT to improve the quality and efficiency of care in New York. Advancing this goal requires the funding and implementation of three interrelated components of New York's health information infrastructure – organizational, clinical and technical – to harness the power of health information to support patient care improvements.

NYS is now requesting applications from Eligible Applicants (as defined in Section 3) for grants to support the development and implementation of New York's health information infrastructure, which must be driven by clinical priorities, patient care improvements and include ongoing process improvement and quality improvement services.

For the purposes of this RGA, grants are expected to be made to fund projects which support a health IT investment approach based on a technical framework and clinical investment priorities and which are in one of three categories of grant applications.

2.1 Technical Framework

The high-level technical framework for New York's health information infrastructure is comprised of three main layers or building blocks.

2.1.1 A Statewide Health Information Network for New York (SHIN-NY) is a network of networks to interconnect clinicians to exchange patient information regardless of the venue where the patient receives care in order to deliver the right care at the right time in a coordinated, patient-centered manner. The SHIN-NY will utilize the Internet and include specialized software protocols and services, including security tools, and

will be a part of the emerging Nationwide Health Information Network (NHIN).

2.1.2 **Clinical Informatics Services (CIS)** are community-based health IT tools which aggregate, analyze, measure and report data in a standardized and valid manner for various uses, including quality and population health initiatives, available to all payers, providers and public health officials.

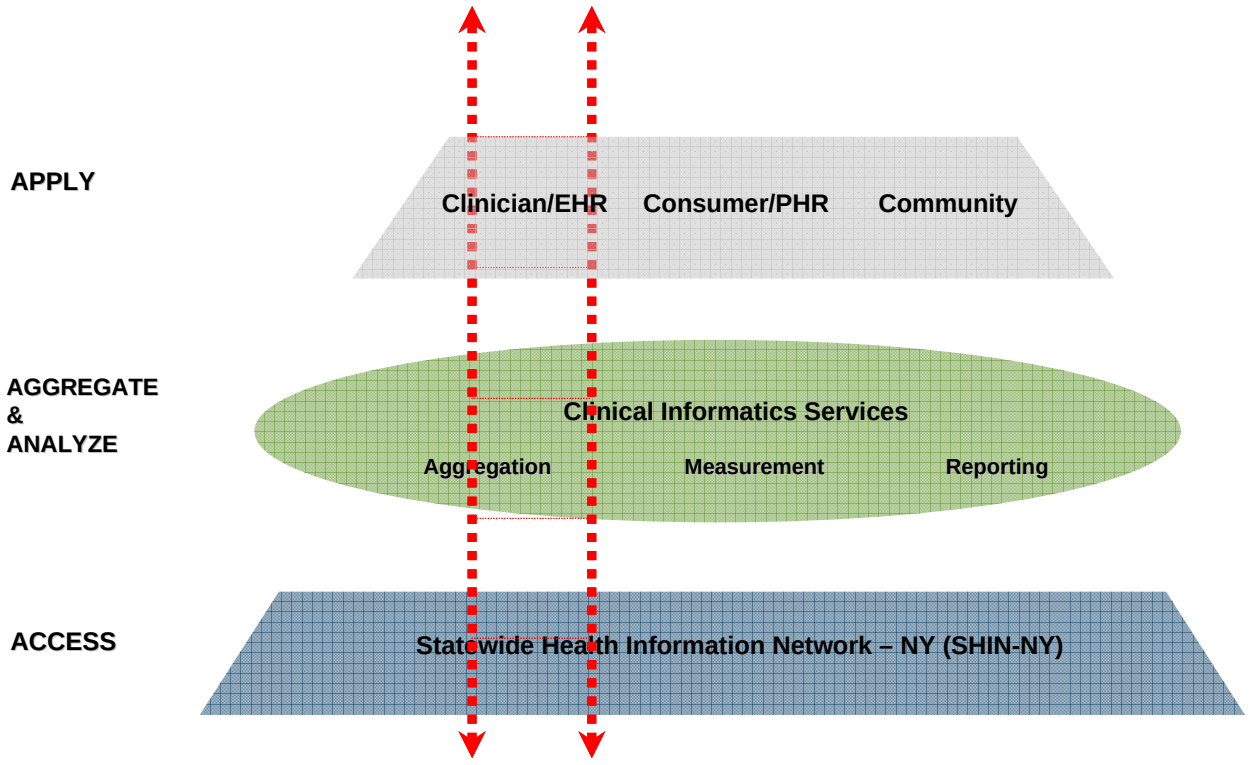
2.1.3 **Information Tools (3Cs)** are Electronic Health Records for **Clinicians**, Personal Health Tools for **Consumers** and **Community** Portals for clinicians and public health officials, collectively the **3Cs,** providing: (i) clinicians with information tools when and where they need them to guide medical decisions, (ii) New Yorkers with greater control over and access to their health information and (iii) Public Health Officials with the ability to survey, report and respond to population health events.

NYS is requesting grant applications which collectively advance a cross-section of the building blocks or "cross-sectional" interoperability, as depicted in Figure 1 below.

Figure 1

Framework for New York's
Health Information Infrastructure

"Cross-Sectional" Interoperability – People, Data, Systems



Cross-sectional interoperability, which advances each of the building blocks in a coordinated manner, is a key objective of the RGA. This approach is expected to yield

value each step of the way in implementing and evaluating New York's health information infrastructure to improve health care quality, safety and efficiency, as well as to reduce costs.

2.2 Clinical Investment Priorities

Another key objective of the RGA is ensuring that clinical priorities drive technology implementation. Accordingly, NYS is providing a set of clinical investment priorities from which applicants are required to choose as the goals of their application to advance New York's health information infrastructure. Each clinical investment priority has a corresponding use case that reflects the high-level clinical and business requirements to guide software functionality and technical implementation.

For the purposes of this RGA, the clinical investment priorities and corresponding use cases are as follows:

- **2.2.1 Connecting New Yorkers and Clinicians**: Providing the capacity to connect New Yorkers to their clinicians and providers in a health information exchange environment sharing clinical results, emergency contact information, and reminder programs. The goal is to engage New Yorkers in their health care and prepare for health care emergencies. The use case incorporates components of federal Medication Management, Emergency Responder and Consumer Access use cases.
- **2.2.2 Health Information Exchange for Public Health**: Improving situational awareness and reporting for public health purposes in a health information exchange environment and reducing administrative costs of preparing and transmitting data among providers and public health officials. The use case incorporates the NYSDOH/NYCDOHMH and federal biosurveillance use cases.
- **2.2.3 Interoperable EHRs for Medicaid**: Sharing Medicaid information, including medication and visit histories with community clinicians in a health information exchange environment, including electronic prescribing to support clinical decision making and improve care coordination. The use case is NY Medicaid's HIE use case.
- **2.2.4 Quality Reporting for Outcomes**: Reporting quality-based outcomes based on clinical information in a health information exchange environment open to all payers and providers to improve quality and support new payment models. The use case incorporates the Federal Quality use case and NY's priorities and requirements for quality measures and approaches.
- **2.2.5 Clinical Decision Support in a HIE Environment**: Providing analytic software to guide medical decisions and facilitate quality interventions. A Clinical Decision Support use case must be submitted by each applicant for consideration in the evaluation process.
- **2.2.6 Immunization Reporting via EHRs**: Interfacing EHRs with the NYSDOH and NYCDOHMH Immunization Registries to enhance their use and

improve safety and efficiency. The use case is NY's Immunization Registry use case and incorporates criteria set forth by the Centers for Disease Control and Prevention (CDC) and the Certification Commission for Healthcare Information Technology (CCHIT).

2.2.7 Quality Reporting for Prevention via EHRs: Implementing EHRs with embedded quality metrics for reporting prevention and process measures to support quality reporting. The use case incorporates the Federal Quality and Lab-EHR use cases and NY's priorities and requirements for quality measures and approaches.

The use cases are described in Section 7.1: HEAL NY Phase 5 Health IT Candidate Use Cases. The use cases attached herein are high level and applicants are expected to use them as a guide in completing the HEAL NY Phase 5 Health IT grant application. Grant awardess will be expected to build upon them and complete detailed use cases are part of the grant project.

2.3 Three Categories of Grant Applications

Based on the technical building blocks and the clinical investment priorities, NYS is requesting three categories of grant applications to advance New York's health information infrastructure. Each grant category includes a subset of the clinical investment priorities listed in Section 2.2, from which applicants are required to choose as the goals of their applications. Grants will be awarded per category, as further described in Section 5. If an applicant is applying for a grant in more than one category, an application for each category must be submitted. An applicant can apply only once per project category.

The grant categories are:

2.3.1 CATEGORY I: Reference Architecture & Pilot Implementations of the Statewide Health Information Network for New York (SHIN-NY).

NYS is requesting applications from RHIOs (as defined is Section 3 – Eligible Applicant) to enable the development and implementation of the SHIN-NY. RHIOs applying for grants in this category are required to demonstrate how their project will implement at least two out of the following four clinical investment priorities and corresponding use cases:

- Connecting New Yorkers and Clinicians
- HIE for Public Health
- Interoperable EHRs for Medicaid
- Quality Reporting for Outcomes

The SHIN-NY will be a network of networks implemented at the regional level based on common HIE software protocols, core services and a suite of standards which work together to support health information exchange between and among multiple stakeholders using widely divergent systems. The SHIN-NY will be a part of the

emerging NHIN and may influence its development. Four key concepts related to the architectural vision for the SHIN-NY are briefly defined below and further explained in Section 7.2: Technical Discussion Document – Architectural Framework for New York's Health Information Infrastructure.

1. Network of Networks: The SHIN-NY will be a standardized network of networks, which will result from the implementation and interoperability of HIE networks at the regional level across NY.

2. Common HIE Protocols: The common HIE protocols will be the linchpin of the SHIN-NY providing a common basis for interoperability. The protocols will provide a common language for every component or core service to talk to every other component or core service it requires to fulfill its function, with an optional adapter layer for external/legacy environments. The simpler or thinner the protocols are, the better chance of success on a widespread basis. The common HIE protocols also need to be 'open' to avoid ceding control of a linchpin element to a particular vendor or institution. The common HIE protocols will be addressed through a collaborative process among all SHIN-NY awardees, which will take place through the HEAL NY Health IT Collaboration process described in Section 4.

3. Core HIE Services: The SHIN-NY will be comprised of core HIE services, which include the network software and services necessary to support secure connectivity, patient identification, health information location, reliable authentication, authorization and access policies and a suite of standards that work together to support health information exchange between and among multiple stakeholders using widely divergent systems. There are 22 core HIE services that have been identified in The Gartner Group's "Summary of the NHIN Prototype Architecture Contracts." The scope of the core HIE services will be addressed through a collaboration process among all SHIN-NY awardees, which will take place through the HEAL NY Health IT Collaboration process described in Section 4.

4. Standards: The SHIN-NY will be comprised of a suite of common standards based on national standards development and harmonization, including the efforts by the Health Information Technology Standards Panel recognized by the Secretary of HHS. The selection and adoption of standards for the SHIN-NY will be determined in a coordinated manner among grant projects through the HEAL NY Health IT Collaboration process noted in Section 4.

The scope of work for this grant category is achieving the organizational and technical capacity to achieve interoperability via the SHIN-NY through the development and implementation of common HIE protocols, core HIE services and a suite of standards. The technical capacity will be guided through demonstration of the clinical investment priorities and corresponding use cases, as indicated above.

Based on the current health information exchange landscape in NY and in order to address the architectural principles outlined in Section 7.2: Technical Discussion Document – Architectural Framework for New York's Health Information Infrastructure, RHIOs are encouraged to partner with each other and co-apply for grants to develop and implement the SHIN-NY. This means two or more RHIOs can co-lead an application, but must designate one lead RHIO to enter into a Grant Disbursement Agreement (GDA) with NYS. Individual RHIOs, however, that are partnering on an application may maintain their respective organizational structures, as discussed in Section 3.1.

The award amounts and process is outlined in Section 5.3.

2.3.2 Category II: Pilot Implementations of Clinical Informatics Services (CIS).

NYS is requesting applications from RHIOs and Community Health Information Technology Adoption Collaborations (CHITAs) (as defined in Section 3 – Eligible Applicants) to implement CIS. RHIO and CHITA applicants applying for grants in this category are required to demonstrate how their project will implement at least one of the following two use cases:

- Quality Reporting for Outcomes
- Clinical Decision Support in an HIE Environment

The Quality Reporting for Outcomes use case is included in Section 7.1: HEAL NY Phase 5 Health IT Candidate Use Cases and is based on NYS' priorities and requirements for quality measures and the Federal Quality use case developed by the ONC. In contrast, NYS has not provided a defined use case for the Clinical Decision Support in an HIE Environment. Applicants interested in implementing a Clinical Decision Support in an HIE Environment use case are required to submit a proposed use case as part of their application, which will be considered in the evaluation process.

The CIS are community-based health IT tools which aggregate, analyze, measure and report data in a valid fashion for various uses, including quality and population health reporting. CIS are implemented in a health information exchange environment and thereby open to all payers and providers.

Applicants in this category are required to use clinical information as the primary source of information to measure and report on physician quality. Applicants may also use claims and administrative information sources, but CIS projects based solely on claims information will not be accepted.

The award amounts and process is outlined in Section 5.3.

2.3.3 CATEGORY III: Pilot Implementations of Community-wide Interoperable EHRs (EHR).

NYS is requesting applications from RHIOs and CHITAs (as defined in Section 3 – Eligible Applicant) to implement community-wide interoperable EHRs to ensure effective use and improve patient care. The EHRs are required to be certified by the Certification Commission for Healthcare Information Technology (CCHIT). RHIO and CHITA applicants applying for grants in this category need to demonstrate how their project will implement at least one of the following three use cases:

- Immunization Reporting with EHRs
- Quality Reporting for Prevention
- Interoperable EHRs for Medicaid

These use cases specify that certified, interoperable EHRs must include interfaces to the NYS and NYC Immunization registries and/or embedded quality metrics and reporting capability. See Section 7.1 – HEAL NY Phase 5 Health IT Candidate Use Cases.

For the purposes of this RGA, “community” is defined geographically as a care coordination zone, which includes a community of ambulatory care clinicians and clinically affiliated providers demonstrating the adoption and effective use of ambulatory physician office-based EHRs, which are certified and interoperable.

The scope of work for this grant category is implementing and achieving significant adoption of certified, interoperable EHRs for ambulatory care clinicians in a defined care coordination zone. In order to drive successful adoption and effective use of EHRs, the delivery of clinical results *to* ambulatory clinician office-based EHRs *from* clinically affiliated provider systems (e.g., hospitals, labs, pharmacies, long-term care/home care) is required as well as the development of a standard and publishable interface between the EHR results delivery capability and the SHIN-NY to demonstrate interoperable EHRs. The EHR results delivery that may be needed from national laboratories and pharmacies, depending on the region, should be coordinated statewide across multiple projects.

Applicants define a care coordination zone as part their grant application. Care coordination zones may vary by overall population size represented, the number of ambulatory care clinicians and clinically affiliated providers, such as acute care hospitals, long term care providers, labs and pharmacies. There are no restrictions on the definition/size of a care coordination zone other than the project requirements to involve specific types of participants, as defined in Section 3.2. In defining the make-up and size of the care coordination zone, however, applicants should keep in mind that fostering communities of adopters of sufficient scale is necessary to realize EHR benefits internally within the community. Applicants will be evaluated more favorably based on sufficient scale within a care coordination zone to ensure effective use and hence expected patient care improvements.

The majority of grant funds are required to be spent on ambulatory physician office-based EHR implementations in solo and small physician practices, including those practices which have a contract with and serve Medicaid beneficiaries. Grant funds are not permitted to be spent on EHR implementation in a hospital practice setting.

The award amount process is outlined in Section 5.3.

SECTION 3: ELIGIBLE APPLICANTS

NYS is inviting two types of eligible applicants to submit applications. They are:

- Regional Health Information Organizations (RHIOs) and
- Community Health Information Technology Adoption Collaborations (CHITAs)

For the purposes of this RGA, RHIOs are primarily responsible for enabling interoperability for health information exchange and quality/population health tools. RHIOs are eligible to apply for funding for the SHIN-NY, CIS and EHR grant categories. CHITAs are primarily responsible for achieving adoption and effective use of health IT tools, especially EHRs, by clinicians at the point of care. CHITAs are eligible to apply for funding for the CIS and EHR grant categories.

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 NY Program. Grant funds may be spent on eligible project-related costs that are incurred by the eligible applicant and its stakeholders. Eligible project-related costs are described in Section 9.3.4.

3.1 Regional Health Information Organization (RHIO)

3.1.1 Definition

To qualify as an eligible applicant, a RHIO is required to be a non-governmental organization that exists as a New York State not-for-profit corporation with an overall mission to advance interoperable health IT to improve health care quality and safety and reduce costs. To fulfill this mission, RHIOs require commitment from multiple health care stakeholders in a geographic region, including physicians, hospitals, long-term care and home care providers, patients, insurers, purchasers and government.

RHIOs are responsible for *enabling* interoperability through which individual stakeholders are linked together – both organizationally and technically – in a coordinated manner for health information exchange and quality and population health reporting. On behalf of their stakeholders, RHIOs are responsible for providing key services to advance interoperability, including governance; clinical priorities and effectiveness; technical policies; business model; patient privacy, confidentiality and security policies; and other patient engagement services.

RHIOs are not technology organizations, do not develop software or provide technical integration services, and are not proprietary physical health information exchange networks. Rather, RHIOs partner with, and for the purposes of this RGA contract with, qualified health information service providers (HISP) or vendors competing in the marketplace for these services; ensuring clinical goals drive technical implementation and that open health information exchange protocols and services are developed and implemented and available to all providers and payers.

3.1.2 Requirements

RHIO applicants are required to develop and submit an application comprised of organization, technical, clinical and financial plans as well as leadership and personnel qualifications and project management activities. The evaluation criteria are outlined in Section 5.

With respect to the organizational plan, RHIO applicants will be evaluated based on stakeholder involvement, the service area represented by the RHIO and the scope of services provided by the RHIO for the benefit of its stakeholders, as defined below.

3.1.2.1 Stakeholder Involvement

RHIOs are characterized by multi-stakeholder involvement and commitment. For the purposes of the RGA, at least six different types of stakeholder of the following types are required to participate in a RHIO and benefit from its governance and services.

- **a.** Physician groups such as a limited liability corporation, professional corporation or independent practice associations
- **b.** Solo practitioners and small ambulatory physician offices (between 1-5 physicians), including those which have a contract with and serve Medicaid beneficiaries
- **c.** Diagnostic and treatment centers and licensed clinicians providing mental health and substance abuse services as defined by Article 31 and 32 of the Mental Hygiene Law
- **d.** Community Health Centers/Federally Qualified Health Centers
- **e.** A county or municipal Public Health Department
- **f.** General hospitals as defined by subdivision 10 of Section 2801 of the PHL
- **g.** Long-term care providers, including Long Term Home Health Care Providers, Certified Home Health Agencies or a Licensed Home Care Service Agency as defined by Article 36 of the PHL, Nursing Homes as defined by Section 2801 (2) and (3)
- **h.** Data suppliers, including pharmacies, laboratories and imaging centers
- **i.** Insurers and Purchasers
- **j.** Rural Health Networks, as defined by Health Care Reform Act
- **k.** New Yorkers as patient/consumer representatives

RHIOs should include in their application a method for growth and inclusion of all stakeholders. This should include a matrix of existing stakeholders and targeted new stakeholders defining specifically how and over what timeframe each stakeholder will participate in and benefit from the RHIO governance and services. The matrix should also clearly identify each of their stakeholders by specifying their corporate name and identify which type of stakeholder they are.

Applications for projects submitted by RHIOs will be evaluated more favorably based on how the following stakeholders benefit from participation, including long-term care providers, rural health networks, solo practitioners and small physician offices, including those that have a contract with and serve Medicaid beneficiaries. RHIO are also encouraged to include competing organizations which provide similar services, e.g., multiple hospitals, and will be evaluated based on how inclusive they are. Evaluation will also include how well RHIO governance structures promote broad participation among stakeholders and transparency.

3.1.2.2 Service Area

An analysis of the RHIO service or market area within the region or across regions will be evaluated based on breadth and depth of coverage, as defined in Section 5, including:

- **a.** The number of hospitals participating out of the total number of hospitals in the region, including the percentage of all admissions in the region
- **b.** The number and type of insurers participating out of total number of insurers in the region, including the percentage of covered lives in the region
- **c.** The percentage of the population served by the health care providers in the region
- **d.** The number of physicians and physician offices participating out of total number of physicians and physician offices in the region, including the percentage of the population covered
- **e.** The number of physicians and physician offices participating out of the total number of physicians and physician offices in the region that contract with and provide services to Medicaid beneficiaries
- **f.** The number of long-term care providers participating out of the total number in the region.
- **g.** The number of labs, pharmacies and imaging centers participating out of the total number utilized in the region.

3.1.2.3 Scope of Services

A description of the services provided by RHIOs will be evaluated, including:

- **a. Clinical Requirements and Effectiveness:** Processes and activities ensuring that clinical and patient care priorities lead technical decision making; physician relations, health IT adoption and quality improvement priorities.
- **b. Technical Policies:** Processes and activities ensuring adherence to statewide architectural principles and other key technical policy level decisions.

c. Governance Model: Participatory governance models demonstrating transparent processes.
d. Business and Value Model: Business practices and financial model that address the long-term sustainability of health information exchange and health IT adoption.
e. Privacy and Security Policies: Privacy and confidentiality, patient consent and security policies consistent with emerging state and federal policies.
f. Patient Engagement: Patient engagement activities that educate and support New Yorkers' rights to have greater control over and access to their personal health information.

The scope of services will be evaluated based on additional criteria included in Section 5.2.1.

RHIO applicants, regardless of the category or categories for which they are applying, should submit a matrix outlining, for each service area, the current status and accomplishments as well as the future goals and specific actions for achieving the goals during the grant period.

3.1.2.4 Other Criteria

The organizational plan will be further evaluated based on criteria included in Section 5 of the RGA as well as the following:

a. RHIO applicants that apply for the EHR grant category are required also to address the health IT adoption and support services outlined in section 3.2.2.

3.2 Community Health Information Technology Adoption Collaboration (CHITA)

3.2.1 Definition

A CHITA is a community collaboration of ambulatory care clinicians and clinically affiliated providers with a mission to advance adoption and effective use of health IT tools, especially EHRs, for clinicians at the point of care. A CHITA's goal is to ensure that effective adoption and use of health IT results in patient care improvements by facilitating the provision of adoption and support services, such as workflow re-design and process and quality interventions and improvement. In contrast to RHIOs, CHITAs do not have to be separate not-for-profit organizations, but rather smaller and looser collaborations of clinician and provider participants required for effective EHR use and to improve care coordination. One of the CHITA's participants is required to be identified as the entity that will serve as the lead applicant to contract with New York State.

3.2.1.1 Lead Applicant

The following types of CHITA participants are eligible to serve as the lead applicant to contract with New York State:

- **a.** A physician group, such as an independent practice association, limited liability corporation or professional corporation
- **b.** A legally constituted network or consortium of community health centers
- **c.** A county or municipal public health department
- **d.** A diagnostic and treatment center
- **e.** A general hospital as defined by subdivision 10 of Section 2801 of the PHL
- **f.** Long-term care providers, including Long Term Home Health Care Providers, Certified Home Health Agencies or a Licensed Home Care Service Agency as defined by Article 36 of the PHL, Nursing Homes as defined by Section 2801 (2) and (3)
- **g.** A Rural Health Networks, as defined by Health Care Reform Act

3.2.2 Requirements

CHITA applicants are required to develop and submit an application comprised of organization, technical, clinical and financial plans as well as leadership and personnel qualifications and project management activities. The evaluation criteria are outlined in Section 5.

With respect to the organizational plan, CHITA applicants will be evaluated based on the types of participants, a defined care coordination zone and the provision of health IT adoption and support services.

3.2.2.1 Participants

For the purposes of this RGA, the following types of clinicians and providers, which are clinically affiliated for the purposes of care coordination, but not a part of the same corporate structure, are eligible to be a participant in a CHITA:

- **a.** Physician practices with an emphasis on ambulatory care clinicians in solo and small physician offices (1-5), including those that have contracts with and serve Medicaid beneficiaries and serve long term care facilities including nursing homes as defined by Section 2801 (2) and (3) of the PHL or a Certified Home Health Agency or a Licensed Home Care Service Agency as defined by Article 36 of the PHL
- **b.** Community Health Centers/Federally Qualified Health Centers

c. General hospital(s) as defined by subdivision 10 of Section 2801 of the PHL with clinical affiliation to CHITA clinicians
d. Long term care facilities including nursing homes as defined by Section 2801 (2) and (3) of the PHL or a Certified Home Health Agency or a Licensed Home Care Service Agency as defined by Article 36 of the PHL with clinical affiliation to a CHITA hospital(s)
e. 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
f. For profit, and not-for-profit health plan(s) defined by Article 44, including the Prepaid Health Service Plans (PHSPs).
g. Laboratories, Pharmacies, Imaging Centers
h. Rural Health Network

CHITAs are required to include ambulatory care clinicians in solo and small physician offices, including those that have contracts with and serve Medicaid beneficiaries and provide care in long term care facilities, as defined in section 3.2.2.2.

A description of the governance process and activities provided by a CHITA is required, including a designated project leader, representative steering committee of participants, and how the CHITA will coordinate with a local RHIO.

3.2.2.2 Care Coordination Zone

Each application submitted on behalf of a CHITA is required to include a summary and analysis of the CHITA care coordination zone comprised of clinicians and clinically affiliated providers within a community demonstrating sufficient scale to realize health IT benefits internally within the community, including:

a. The number and scale of clinicians practicing in solo and small physician offices
b. The number of clinicians in “a” above that contract with and provide services to Medicaid beneficiaries
c. The number of community health centers/federally qualified health centers
d. The number of referrals/discharges among clinicians and hospitals, clinicians and long-term care providers, and hospitals and long term care providers.
e. The number of insurers and the percentage of covered lives

3.2.2.3 Health IT Adoption & Support Services

A description of the services provided by CHITAs for health IT adoption and support is required, including, but is not limited to: readiness assessments,

workflow re-design, project management, vendor selection, user support and process, and quality improvement interventions and services to achieve patient care improvements.

CHITA applicants are required to submit a matrix outlining the health IT adoption and support service goals, including intended results with respect to both patient care and care coordination improvements, and specific actions for achieving the goals during the grant period.

3.2.2.4 Other Criteria

The organizational plan will be further evaluated based on criteria included in Section 5 of the RGA as well as the following:

a. Signed letters of commitment from all CHITA participants.
b. CHITA participation in a local RHIO.
c. The participation of multiple insurers, to support health IT adoption and effective use through letters of commitment.

SECTION 4: HEAL NY HEALTH IT COLLABORATION

4.1 Statewide Collaboration Process

NY is implementing a statewide collaboration process to advance health information technology initiatives across the state. The purpose of the statewide collaboration process is to support improvements in health care quality, affordability, and outcomes for New Yorkers by:

- Providing a convening vehicle for the State and the health care community to collaborate on key areas of New York's health information technology agenda, starting with HEAL NY Health IT projects
- Providing a forum to discuss and collaborate on health IT policy priorities
- Coordinating and harmonizing the implementation of regional HIE and quality and population health IT tools.

The New York eHealth Collaborative (NYeC), a NYS not-for-profit corporation is facilitating the state level collaboration process and providing technical assistance to the grantees. The NYSDOH is participating in the collaboration process as a public-private partnership. NYeC's mission is to improve health care quality and efficiency through health IT and is comprised of health care leaders across the State, including physicians, hospitals, health plans, public health officials, safety net providers, employers, consumer and health care advocates, quality and regional health information organizations, and includes participation by health information service providers (vendors) and health care associations.

4.2 Requirements

RHIO and CHITA awardees and their health information service provider partners will be required to participate in the statewide collaboration process over the course of the grant period. A kick off meeting will be conducted by NYeC shortly after grant awards are made to discuss and finalize the convening process and meeting schedule with the grant awardees. Applicants should anticipate regular meetings and factor this into their overall plans and budgets as part of the application. Accordingly, applicants are required to provide five percent of reimbursable funds or matching funds to NYeC to support the collaboration process.

CHITA applicants for the CIS and/or EHR grant category will be expected to partner with a RHIO to coordinate the components of the project requiring shared HIE functionalities via the SHIN-NY to ensure interoperability. Teaming arrangement will be discussed and determined at the collaboration process kick-off meeting and official letters of commitment required as an early deliverable of the project.

SECTION 5: OTHER GRANT REQUIREMENTS, EVALUATION CRITERIA & AWARD PROCESS.

5.1 Other Grant Requirements

5.1.1 All Phase 5 funds are required to be utilized for capital costs and other reimbursable costs through grant funds, as defined by State law and incurred after the start date of the GDA (see **Section 9.3.4: HEAL NY Phase 5 Health IT Allowable Costs** for further information). Costs incurred after October, 2007, which are clearly related to the Project, including planning costs, may count as matching funds.

5.1.2 Eligible applicants are required to confirm that the Project is fully funded prior to the execution of the GDA.

5.1.3 Matching Funds

5.1.4.1 Grant awards will be considered for up to 75 percent of the cost of a project. Eligible applicants are required to demonstrate at least a 25 percent match. Applicants are encouraged to demonstrate a 10 percent cash contribution match and those that do will be evaluated more favorably. The remaining 15 percent match can be in-kind. This match criterion applies to RHIO and CHITA applicants.

5.1.4.2 Matching funds will be required from a combination of the eligible applicant and stakeholder resources, as well as from other funding sources, including but not limited to other non-State grants or commercial loans. The following criteria will be utilized to determine whether particular costs may be considered matching funds:

- **a.** Only direct costs will be counted toward the match. No indirect costs, such as administrative costs, will be counted. In-kind contributions are allowable as long as they are direct costs.
- **b.** Costs financed by project income from October 2008 through the term of the GDA may count toward satisfying a match.
- **c.** Costs and third party in-kind contributions must be verifiable from the records of grantees and sub-grantees.
- **d.** Only the non-State share of matching funds and/or services may be counted toward the match requirement.
- **e.** Donated services provided to a grantee will be valued at a rate consistent with those ordinarily paid for similar work.
- **f.** Supplies equipment and space donated by or loaned by third parties will be valued at the fair market value or rental rate for such supplies, equipment and space.

5.1.4 Project Evaluation

5.1.4.1 All applicants are required to allocate five percent of reimbursable funds or matching funds to an independent project evaluation process. The evaluation will be conducted statewide by a third

party evaluation consortium in a consistent and objective manner across all funded projects. At the time of grant award, the projects will be convened to discuss the evaluation process.

5.1.4.2 All applicants are required to identify appropriate staff to support the evaluation process as part of the organization plan.

5.1.5 Grant Disbursement Agreements (GDAs) in connection with the Eligible Applicants shall, (a) provide that the work covered by such contract shall be deemed "public work" subject to and in accordance with Articles 8, 9 and 10 of the Labor Law, if applicable; and shall (b) provide that the contractors performing work under all such contracts shall be deemed to be "state agencies" for the purposes of Article 15-A of the Executive Law.

5.1.6 Eligible applicants are required to meet all applicable regulatory requirements relating to Certificate of Need (CON) and federal and state standards of care.

5.2 Evaluation Criteria

The evaluation process will include an initial screening to ensure that applications are complete. Any applications missing critical elements may be eliminated. Applications will also be screened to confirm that the applicant and its participants or stakeholders meet the minimum requirements as outlined in **Section 7.4: Minimum Requirements for Evaluation Process.** If applications do not meet the minimum requirements, they may be eliminated from the evaluation and award process.

All applications will be evaluated based on responsiveness and completeness, including the following six criteria, each of which will be evaluated as part of the award process. The first five criteria comprise the Technical Application. The sixth criterion is the Financial Application. If elements of a criterion are not already in place, the applicant should describe how the requirement will be met and the associated timing.

The criteria are:

1. Organizational plan
2. Technical plan
3. Clinical plan
4. Leadership and personnel qualifications
5. Project management
6. Financial plan

5.2.1 The **Organizational Plan** will be evaluated based on a detailed discussion of how the proposed project will:

5.2.1.1 Meet the priorities and goals of the HEAL NY Program overall, as outlined in Section 1, and the strategic focus of Phase 5, as outlined in Section 2.

5.2.1.2 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.

5.2.1.3 Participate in the statewide collaboration process as described in Section 4

5.2.1.4 Participate in the statewide evaluation process as described in Section 4

5.2.1.5 Meet the expected opportunities and benefits from the proposed project(s), as outlined in Section 1.4, with respect to:

- **a.** Improvements in efficiency and effectiveness of care
- **b.** Improvements in quality of care
- **c.** Reduction in costs of care
- **d.** Improvements in outcomes of care

5.2.1.6 Achieve clearly measurable goals, work plan and timeline for the organization plan, including the requirements and activities listed in section 3.1.2 for RHIOs and Section 3.2.2 for CHITAs.

5.2.1.7 Governance for RHIO applicants: Describe the governance model, including the processes which clearly demonstrate the buy-in, trust and participation of its stakeholders, including:

- **a.** An open and trusted governance process where stakeholders have participation in organizational and policy decisions.
- **b.** Formal voting procedures, rights and quorum needed for decision making, and transparency in its meetings and other processes.
- **c.** Rights and responsibilities of each stakeholder.
- **d.** Conflict of interest and anti-trust policies applicable to members of the governing board, officers, employees and member of any committee with governing body delegated powers.
- **e.** Information sharing agreements to support pilot implementation projects.
- **f.** Signed letters of commitment from each RHIO member or stakeholder, including commitment to participation in the governance process and implement agreed-upon data sharing agreements, and consistent privacy and consent policies.
- **g.** Legal incorporation papers documenting not-for-profit status and an intent to submit NYS charities registration.
- **h.** A committed executive director or a plan to hire an executive director to lead RHIO scope of services and overall grant project.
- **i.** Support local CHITA applicants, as necessary and determine upon grant awards.

5.2.1.8 Governance for CHITA applicants: See “a, b, c and e” in section 5.2.1.7 above.

5.2.1.9 Business and Value Model for RHIO applicants: Develop and implement a business and value model, including:

a. The manner in which the eligible applicant will ensure that the grant proceeds are appropriately spent.

b. Description of the business model, including the viability and the sustainability of the business model and the role of financial incentives and reimbursement reform in this regard.
c. An explicit discussion of the organizational growth plan and impact on the business model.

5.2.1.10 Business Considerations for CHITA applicants: See "a" in section 5.2.1.9 above as well as the role of financial incentives and payment reform in sustaining EHR adoption.

5.2.1.11 Privacy & Security for RHIO applicants: Develop and implement privacy & security policies, including:
a. Solutions for authentication, authorization, access and auditing (4As) in a health information exchange environment
b. Privacy and security breach response plan
c. Compliance with HIPAA privacy rules and State privacy laws
d. Implementation of patient consent solution, which is required to be consistent across all grant awards and DOH policy. All awardees will be expected to comply with DOH's patient consent policy guidance based on the findings and recommendations from the New York Health Information Security and Privacy Collaborative (NYHISPC) Patient Consent Initiative.

5.2.1.12 Privacy & Security for CHITA applicants: See "c and b" above in section 5.2.1.11.

5.2.1.13 Patient Engagement Service for RHIO applicants: Provide patient engagement services, including:
a. A description of the process and activities regarding patient education and engagement, including supporting the right of New Yorkers to have greater control over and access to their health information.
b. A description of the process to involve New Yorkers in project activities.
c. A plan for open, transparent marketing and promotion of a patient consent solution referenced above in section 5.2.1.11.
d. A plan for providing incentives for participation by New Yorkers and supporting electronic communication with clinicians.

5.2.1.14 Patient Engagement Service for CHITA applicants: see "b" above in section 5.2.1.13, including services to support patient compliance to improve care.

5.2.2 The **Technical Plan** will be evaluated based on the following:

5.2.2.1 Refined use cases reflecting additional and/or honed clinical/business requirements and proposed technical requirements and architectural design.

5.2.2.2 A technical approach based on the project scope of work described in Section 2, candidate use cases described in Section

7.1 and technical discussion document and architectural framework in Section 7.2.

5.2.2.3 Specific discussion of roles and responsibilities among RHIOs and CHITAs for projects involving the CIS and EHR, if applicable, as per use cases and requirements in Section 2.

5.2.2.4 The technical task list outlined in Section 7.3 to which applicants should respond.

5.2.2.5 Standards compliance with current and emerging federal and state health IT standards, including the CCHIT, HITSP and HISPC initiatives.

5.2.3 The **Clinical Plan** will be evaluated based on the following:

5.2.3.1 The process and activities to ensure that clinical priorities drive technical implementation.

5.2.3.2 Clinician relations and adoption and support services as discussed in section 3, including expected outcomes and results with respect to patient care improvements and care coordination.

5.2.3.3 Process improvement and quality improvement interventions and services particularly those supporting medically complicated patients.

5.2.4 Leadership and Personnel Qualifications will be evaluated based on the following:

5.2.4.1 Demonstration of the qualifications, competence and ability of the RHIO or CHITA and participating stakeholders, vendors and others involved in the Project to achieve Project goals.

5.2.4.2 The grant application should include the names of all key personnel that will be contributing to the project, including credentials, roles, relevant qualifications and expected level of participation (expressed in hours per week). Specific attention should be given to the role of the executive director for RHIOs and project leader for CHITAs (or comparable position); if not yet hired, include qualifications that will be utilized in the selection process. Attention should also be given to executive leadership participation, e.g., chief executive, chief medical officer, chief information officer in the governance process for both RHIOs and CHITAs.

5.2.5 Project Management will be evaluated based on the following:

5.2.5.1 Describe specific experience with project management and the credentials/certifications held by team members overseeing the project management aspect of the project.

5.2.5.2 Describe project management tools/techniques that will be utilized to ensure the delivery of an on-time and on-budget project, including quality assurance and risk mitigation

5.2.5.3 Describe methodology/process utilized to develop work plans and associated key milestones.

5.2.5.4 Present an implementation plan with specific timeframes, based on incremental phases clearly delineating which stakeholders are participating in the pilot implementation (including their respective roles and responsibilities) and how the project will be rolled out across the region.

5.2.6 Financial Application will be evaluated based on the following:

5.2.6.1 Demonstrate the ability of the RHIO applicant and CHITA lead applicant to fund the proposed project from multiple funding sources, including the HEAL NY Program.

5.2.6.2 Show the extent to which each stakeholder and subcontractor will utilize HEAL NY Program Grant funds.

5.2.6.3 Describe the manner in which the eligible applicant will ensure that the grant proceeds are appropriately spent.

5.2.6.4 Provide the financial obligation of each stakeholder and demonstrate financial commitment among stakeholders beyond the scope of awarded funds from the State.

5.2.6.5 Describe the business model, including the viability and the sustainability of the business model, revenue commitments from stakeholders and the role of financial incentives and payment reform in this regard.

5.2.6.6 Demonstrate expected costs savings and quality improvement to the health care community.

5.2.6.7 Describe relationship between the savings or improved quality and the amount of the grant request.

5.3 Award Process

Eligible applicants may submit a grant application for one, two or all three of the grant categories. Applicants may submit only one application per grant category. Separate applications are required for each grant category. If an applicant submits grant applications in more than one category, the respective applications should each describe the interrelationship with each other. The applicant should identify the grant category for which they are applying and for each grant category the use cases and requested funding amounts between $1million - $10 million both as part of the Technical Application (Section 9.2) and as part of the Financial Application (Section 9.3). If an applicant is applying for grants in more than one grant category, then the total requested funding amount must not be higher than $15M.

5.3.1 NYS 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.

5.3.2 Upon the award of a grant, NYS 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.

5.3.5 For purposes of awarding HEAL-NY Phase 5 grant dollars, the six geographic regions described by the Commission on Health Care Facilities in the 21st Century (Commission) will be utilized; specifically Long Island, New York City, Hudson Valley, Northern, Central and Western (as outlined below). NYS reserves the right to re-allocate funds among the regions to meet the objectives of the HEAL NY Program.

- **5.3.5.1** New York City, consisting of Manhattan, Bronx, Brooklyn, Queens, Staten Island
- **5.3.5.2** Long Island, consisting of Nassau and Suffolk counties
- **5.3.5.3** Hudson Valley, consisting of Delaware, Duchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester counties
- **5.3.5.4** Northern, consisting of Albany, Clinton, Columbia, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties
- **5.3.5.5** Central, consisting of Broome, Cayuga, Chemung, Chenango, Cortland, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Oneida, Onondaga, Ontario, Oswego, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne and Yates counties
- **5.3.5.6** Western, consisting of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming counties

5.3.6 Applicants meeting a minimum score will be arrayed and awards made using the four step process described below.

5.3.6.1 Step One

Applicants will be awarded grants for Category I, SHIN-NYs. It is expected that 55 percent of the available funds ($58.16 million / $105.75 million) will be available for awards in step one. It is expected that funds will be allocated and awarded at the Commission region level as follows:

Long Island	$ 9,208,200
New York City	$26,776,200
Hudson Valley	$ 7,447,200
Northern	$ 4,692,000
Central	$10,004,400
Western	$ 5,322,000

The maximum award for a SHIN-NY encompassing a single Commission region will be the lesser of that region's allocation (as above) or $10 million. For projects that include more than one RHIO and serve more than one region the maximum award will be the sum of the allocations for the regions involved, but

may not exceed $15 million. The dollars awarded to a multi-Commission region SHIN-NY will be prorated based on the participating region's allocation as indicated above and at the recommendation of the applicant. NYS reserves the right to review the applicant's recommended allocation and make the final determination.

It is expected that there will be up to eight awards in this category. Any funds not awarded in step one will be available for step two awards.

5.3.6.2 Step Two

Step two awards will be made for a combination of Category II (CIS) applications and Category III (EHR) applications. It is expected that 45 percent of available funds ($47.58 million/ $105.75 million) will be available for award during the step two awards process as follows:

Long Island	$ 6,138,800
New York City	$ 17,850,800
Hudson Valley	$ 4,964,800
Northern	$ 3,128,000
Central	$ 6,669,600
Western	$ 3,548,000

Additionally, regional dollars not awarded in the step one award process will be available to be awarded in step two for projects in the respective region.

During step two, it is expected that a minimum of two and a maximum of four Category II (CIS) awards will be made, assuming a sufficient number of applications with a passing score, at a maximum of the lesser of the regional allocation or $5 million each. It is expected that a maximum of eight Category III (EHR) awards will be made at a maximum award value of the lesser of the regional allocation or $8 million each.

Category II (CIS) and Category III (EHR) applications will be arrayed together from highest to lowest score. The awards process will then proceed as follows (to the maximum award levels described above) and no more than one Category II grant will be awarded per region:

a. The highest scoring application from Category II will be awarded
b. The highest scoring application from Category III will be awarded
c. The next highest scored application from Category II will be awarded
d. The next highest scored application from Category III will be awarded
e. The next highest scoring application from Category II or III, based on score, will be awarded.
f. Repeat "e" until regional funds available to fully fund projects have been exhausted, or the maximum number of awards has been made
g. Any un-awarded funds will be available for Round Three Awards

5.3.6.3 Step Three

Step three awards will include all grant funds that have not been awarded, regardless of the region in which the project is located. If an eighth SHIN-NY was not awarded in step one, these funds will be utilized to fund the next highest scoring Category I application (SHIN-NY), regardless of where the projects will be located. If an eighth SHIN-NY was awarded in step one, no additional category I awards will be made in step three.

Any un-awarded funds will be available for step four grants.

5.3.6.4 Step Four

Step four will award any remaining grant funds. All remaining Category II (CIS) and Category III (EHR) applications will be arrayed from highest to lowest score and fully fundable projects will then be awarded grants, regardless of where the project will be located. If any funds remain after step four, a determination will be made to either utilize these funds to partially fund the next highest scoring projects, fund the next highest scoring fully fundable application, or roll the funds to future procurements under the HEAL NY program.

SECTION 6: APPLICATION FORMAT & ADMINISTRATIVE REQUIREMENTS

6.1 General Application Format

6.1.1 Applications should be concise, single-spaced, and use a 12 point type, including timeline and budget. The application should be not more than 30 pages in length, excluding resumes, documentation of stakeholder commitments and required forms. Each page must be clearly numbered.

6.1.2 Applications must be submitted in two separate and distinct parts, following the formats shown in Section 9.

Part 1: Technical Application (two original and three CDs or USB drives)
Part 2: Financial Application (two original and three CDs or USB drives)

Include all sections described in all applicable forms in Section 9. 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 should be included in the Technical Application. Failure to adhere to this requirement may result in disqualification of your application.

Each cover page must be signed by an individual authorized to bind the Eligible Applicant to any GDA resulting from the application.

6.2 Question and Answer Phase

6.2.1 All substantive questions must be submitted in writing to:

Robert Schmidt, Director, HEAL NY Implementation Team
New York State Department of Health
Hedley Building, 6th Floor
433 River Street
Troy, NY 12180
email: healnyhit@health.state.ny.us

6.2.2 To the degree possible, each inquiry should cite the RGA section and paragraph to which it refers. Written questions will be accepted through **October 12, 2007.**

6.2.3 Questions regarding the application format or submission process can be addressed in writing or via telephone by calling Robert Schmidt at (518) 408-0845.

6.2.4 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 ***October 12, 2007*****.**

6.2.5 *By* ***October 26, 2007,*** written answers to all questions raised will be posted on the DOH website at http://www.health.state.ny.us/. Written answers to subsets of questions may be posted at an earlier date. Applicants wishing to receive an e-mail notification of the posting should submit a request, including the applicant's e-mail address, to healnyhit@health.state.ny.us.

6.3 Applicant Conference

An applicant conference will be held **September 28, 2007** ***at Meeting Room 6, New York State Museum, from 1:00pm to 4:00pm.*** DOH requests that potential applicants register for this conference by sending an email to healnyhit@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 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.

6.4 Completing the Application

The Technical Application Format is included in Section 9.1 for RHIOs and 9.2 for CHITAs. The Financial Application Format is included in Section 9.3 for RHIOs and CHITAs. Applicants are required to follow these formats to complete the application.

6.5 How to File an Application

6.5.1 Eligible applicants shall submit two original, signed technical applications and three CDs or USB drives each with a full .pdf formatted technical application, and two original, signed financial applications and three CDs or USB drives each with a full .pdf formatted financial application. Application packages should be clearly labeled with the name and number of the RGA as listed on the cover of this RGA document. Technical and financial applications may be packaged together, but must be clearly labeled and separated within the package. Applications *WILL NOT* be accepted via fax or e-mail.

6.5.2 It is the Eligible applicant's responsibility to see that applications are delivered to the address noted above prior to the date and time specified. Late applications due to delay by the courier or not received in the Department's mailroom in time for timely transmission to the Hedley Building will not be considered.

6.6 Rights Reserved

NYS reserves the right to**:**

- **6.6.1** Reject any or all applications received in response to this RGA.
- **6.6.2** Award more than one GDA resulting from this RGA.
- **6.6.3** Waive or modify minor irregularities in applications received after prior notification to the applicant.
- **6.6.4** Adjust or correct cost figures with the concurrence of the applicant if errors exist and can be documented to the satisfaction of DOH and DASNY.
- **6.6.5** Negotiate with awardees within the requirements of the HEAL NY Program to serve the best interests of the state.
- **6.6.6** Eliminate the detail specifications should an insufficient number of applications be received that meet all these requirements.
- **6.6.7** Reject any application submitted by an eligible applicant which is not in compliance with all state and federal requirements.
- **6.6.8** Award grants based on geographic or regional considerations to serve the best interests of the state.
- **6.6.9** If NYS is unsuccessful in negotiating a GDA with one or more awardees within an acceptable time frame, they may award the funds to the next most qualified applicant(s) in order to serve and realize the best interests of the state.

6.7 Term of GDA

Any GDA resulting from this RGA will be effective only upon approval by the New York State Office of the Comptroller. It is expected that GDAs resulting from this RGA will begin on or about the first quarter of 2008 and will have a duration of two years with a DOH option to renew the contract for up to two additional one year periods to ensure completion of the project. Any renewal must be approved by the Office of the NYS Attorney General and the Office of the State Comptroller.

6.8 Payment & Reporting Requirements

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

- **6.8.1** Payment of such invoices by the State (NYS DOH) 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 GDA budget. Advances will only be authorized in exceptional circumstances to eligible Applicants. Not all Applicants may be eligible for payment advances.
- **6.8.2** 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, 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.

6.8.3 In no event will DOH make any payment which would cause the aggregate disbursements to exceed the Grant amount.

6.8.4 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 one of the Project stakeholders.

6.8.5 **Reporting Requirements:** During the 2 year grant period, the grantee is required to submit quarterly reports to DOH, which at a minimum includes:

6.8.5.1 Discussion of milestones achieved and evaluation of Project status;

6.8.5.2 Discussion of any delays or other issues encountered;

6.8.5.3 Plan of action for addressing any delays or other issues encountered;

6.8.5.4 Objectives for the next reporting period;

6.8.5.5 Objectives for the remaining Project period;

6.8.5.6 Discussion of any quality control monitoring performed;

6.8.5.7 Financial report of Project expenses and revenues;

6.8.5.8 Description of any collaboration with other grant recipients in their region and with the DOH on the development of statewide standards; and

6.8.5.9 Post implementation reports are also required annually for three years.

6.8.6 All RHIO grantees will be required to develop and maintain a public website within 3 months of project award.

6.9 General Specifications

6.9.1 By signing the Application cover page each signatory attests to its express authority to sign on behalf of the eligible applicant.

6.9.2 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.

6.9.3 Submission of an application indicates the eligible applicant's acceptance of all conditions and terms contained in this RGA. If an eligible applicant does not accept a certain condition or term, this must be clearly noted as described in Section 6.2.4.

6.9.4 An eligible applicant may be disqualified from receiving awards if such eligible applicant 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, or

has failed to meet all regulatory requirements relating to Certificate of Need (CON) and federal and state standards of care.

6.9.5 All deadlines are critical, and awardees will be expected to meet all timeframes.

6.10 Provisions Upon Default

6.10.1 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.

6.10.2 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 the State, shall thereupon have the right to terminate the GDA by giving notice in writing of the fact and date of such termination to the Applicant.

6.10.3 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 the state, DOH and DASNY, acting on behalf of the State, shall thereupon have the right to terminate any GDA resulting from this RGA 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 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.

6.11 Appendices

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

6.11.1 APPENDIX A: Standard Clauses for All New York State GDAs

6.11.2 APPENDIX A-1: Agency Specific Clauses

6.11.3 APPENDIX A-2: Program Specific Clauses

6.11.4 APPENDIX B: Budget

6.11.5 APPENDIX C : Payment and Reporting Schedule

6.11.6 APPENDIX D : Workplan

6.11.7 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, of coverage for:

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

6.11.9 **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers'

Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR

- **WC/DB-101**, Affidavit That An OUT-OF-STATE Or FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; 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.

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

- **WC/DB-100**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
- **WC/DB-101**, Affidavit That An OUT-OF-STATE Or FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage; OR
- **DB-120.1** – Certificate of Disability Benefits Insurance OR the **DB-820/829** Certificate/Cancellation of Insurance; OR
- **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 a part of the contracting process should you receive an award.

SECTION 7: ATTACHMENTS

7.1 HEAL NY Phase 5 Health IT Candidate Use Cases
7.2 Technical Discussion Document: Architectural Framework for New York's Health Information Infrastructure
7.3 Technical Task List
7.4 Minimum Requirements for Evaluation Process

SECTION 8: REFERENCES

8.1 List of Acronyms
8.2 Public Health Law Section 2818
8.3 Public Authorities Law Section 1680-j
8.4 GDA Appendix A: Standard Clauses for all NYS Contracts
8.5 GDA Appendix A-1: Agency Specific Clauses
8.6 GDA Appendix A-2: HEAL NY Specific Clauses
8.7 GDA Appendix B: Budget
8.8 GDA Appendix C: Payment and Reporting Schedule
8.9 GDA Appendix D: Project Work Plan
8.10 GDA Appendix F: Project/Contract Contingencies

SECTION 9: FORMS & CHECKLISTS

9.1 Technical Forms for RHIOs
- 9.1.1 Technical Application Checklist
- 9.1.2 RHIO Technical Cover Page
- 9.1.3 Consent Form for Co-Applying RHIOs
- 9.1.4 Eligible Applicant Certification
- 9.1.5 RHIO Technical Application Format
- 9.1.6 Vendor Responsibility Information/Attestation

9.2 Technical Forms for CHITAs
- 9.2.1 Technical Application Checklist
- 9.2.2 CHITA Technical Cover Page
- 9.2.3 Eligible Applicant Certification
- 9.2.4 CHITA Technical Application Format
- 9.2.5 Vendor Responsibility Information/Attestation

9.3 Financial Forms for RHIOs & CHITAs
- 9.3.1 Financial Application Checklist
- 9.3.2.a RHIO Financial Cover Page
- 9.3.2.b CHITA Financial Cover Page
- 9.3.3 Financial Application Template
- 9.3.4 HEAL NY Health IT Phase 5 Allowable Costs
- 9.3.5 Overview of Budget Forms and Process
- 9.3.6 Expense Budget Form

9.3.7 Revenue Source Budget Form
9.3.8 Expense & Revenue 2 Year Projection Budget Form
9.3.9 Budget Justification Template

ENDNOTES

[i] Institute of Medicine, "To Err is Human: Building A Safer Health System" (November 1999); Crossing the Quality Chasm (.

[ii] Commonwealth Fund, "Achieving a High Performance Health System Report (August 2006)

[iii] S. Rosenfeld, C. Bernasek, and D. Mendelson, "Medicare's Next Voyage: Encouraging Physicians to Adopt Health Information Technology," *Health Affairs* 24, no. 5 (2005): 1138-1146.