HEAL NY HIT RGA QUESTIONS AND ANSWERS – SET 1
Dated 10/24/05
Updated 11/8/05

Asterisk '*' denotes an answer has been modified from the original version of 10/24/05, as follows:

- Eligibility/Applicants – Q9
- Other Financial – Q6

ELIGIBILITY:

- **APPLICANTS:**

Q1) a) To be eligible for funds under this program, does the lead organization have to already have EMRs implemented within their organization or can funds be used towards implementation? b) What about for other stakeholder organizations?

A1) *a) NO. Projects can involve implementing a new system.*
b) The same applies for stakeholder organizations.

Q2) If you are a small entity and don't have access to a grant writer will you be disqualified? Applicants do not need to have a grant writer but must meet all the criteria requirements.

A2) *NO*

Q3) Can an applicant receive more than one award?

A3) *YES - Projects are evaluated and an eligible applicant can be part of more than one project.*

Q4) Can an organization apply as lead organization in more than one application?

A4) *YES, but it will probably work against one application.*

Q5) Can organizations participate in more than one HEAL grant application?

A5) *YES*

Q6) Can an organization be the lead organization in one application and a stakeholder in another application?

A6) *YES*

Q7) Please further define and discuss (3.2 - #9.) what an "Entity organized as a CIDE whose members include any combination of the listed eligible categories"?

A7) *A Health Information Exchange Organization which has multistakeholders, such as a general hospital or nursing home as described in 3.2.*

Q8) Section 3.2, # 9 states, "An entity organized as a Clinical Information Data Exchange whose members include any combination of the above." Can you please define Clinical Information Data Exchange and provide an example?

A8) *Clinical Information Data Exchanges are also called Health Information Exchanges and Regional Health Information Organizations.*

Q9) *Is an Independent Practice Association an Eligible Applicant?
A9) *YES*

Q10) Can an Internet based healthcare communications company be an eligible applicant?
A10) *NO*

Q11) Are public health officials eligible applicants?
A11) *NO, but public health entities are.*

Q12) Can Fund for Public Health, a 501 (c) (3) corp be an eligible applicant?
A12) *Only licensed entities or others described in Section 3.2 of the RGA are eligible.*

Q13) Can provider groups submit as a consortium?
A13) *Only one eligible applicant is permissible for contract purposes. GDA will be with a legally existing organization. Consortium members may be stakeholders.*

Q14) Eligible applicant is a health system with all components under one corporation.
A14) *That does not satisfy section 3.1 of the RGA which requires eligible applicants to enter into relationship with entities not under the same corporate umbrella.*

Q15) For Project Category #1, would a telehealth network made up of several different provider types be an acceptable project?
A15) *YES, as long as it meets eligibility requirements of 3.2, but this program is focused on information technology, not telemedicine.*

Q16) Pertaining to Section 3.6., will a letter of agreement which includes at a minimum the four listed requirements and signed by the Eligible Applicant and any stakeholders fulfill the requirements of this section?
A16) *YES*

Q17) If the process to create a new legal entity, organized as a Clinical Information Data Exchange, has begun but the new entity is not yet fully "legally existing" (e.g., a corporation may be formed but 501 c3 status not yet obtained) by the application deadline, can the new entity still be the Eligible Applicant (so long as information on the new organization is provided)?
A17) *YES, but evidence of the commitment of all parties (only eligible applicants as listed in 3.2) must be shown for grant funding agreements to be signed.*

Q18) Can a provider participate in multiple grant applications that may have different participants, objectives or outcomes?
A18) *YES*

Q19) May a limited liability company formed by several hospitals be the Applicant for a HIT grant or must there be a lead hospital as the named official Applicant?

A19) YES

Q20) Section 3. Can organizations participate in more than one HEAL grant application?

A20) YES

Q21) The RFA states (3.1) that "the eligible applicant and stakeholders must not be under common control or have the authority to appoint board members of the other entities". If there are one or two people who are members of the Eligible Applicant's hospital board and also on the board of a nursing home, who will be a partner in the Project, do they meet the eligibility criteria as long as they are not sharing operational or other control of each other and they independently select their board members?

A21) YES

Q22) a) Please further define and discuss (3.2 - #9.) what an "Entity organized as a CIDE whose members include any combination of the listed eligible categories" A physician's group under their independent Medical Board will be a partner stakeholder. b) Do they have to be an LLC or professional corporation?

A22) a) See answer to Question 7 of this section.
b) They must be a legal entity.

- **<u>STAKEHOLDERS</u>:**

Q1) Will the State DOH provide a boilerplate memorandum of understanding (MOU) to stakeholders for information exchange or should grant applicants include the cost to develop that legal document in their application?

A1) NO. However the cost to develop the legal documents may be included.

Q2) Can an eligible applicant be a stakeholder in more than one application if the applications are for two separate projects? (in other words, if a stakeholder is involved in two completely separate IT projects that are vying for HEAL –NY funding is that okay?)

A2) YES

Q3) X is the parent of a freestanding primary care center for uninsured and medically indigent patients. Does this center qualify as a stakeholder?

A3) NO. The eligible applicant and the stakeholder, although two separately licensed entities, must not be under one corporate entity. The primary care center may be in the project but another stakeholder unrelated to the applicant must be included.

Q4) Can a stakeholder be a community-based organization that delivers social services not medical services?

A4) NO. It must be medical entity to qualify as stakeholder but the project can involve social centers which house medical information.

Q5) Can a stakeholder be part of more than one application (both a contractor and a subcontractor)?

A5) *YES*

Q6) a) Can an application represent stakeholders from different state regions? b) Will applications that cross state regions receive special consideration?

A6) a) YES
b) NO, but broader stakeholder participation is a positive factor in the evaluation.

Q7) Can stakeholders in different counties be partners on different grant applications

A7) YES

Q8) Since the actual signed agreements between the applicant organization and the stakeholders do not need to be included with the application (as per Section 3.3), what would be judged sufficient to include as a demonstration of the organizations' commitment to the project and each other at the time of the application?

Q9) Since the actual, signed agreements do not need to be included with the application, what at a minimum does DOH wish to see included with the application?

A8 & A9) *The application should describe the expected relationship among the Eligible Applicant and the project stakeholders, and how the group will address the items set forth in section 3.6 of the RGA as specifically as possible.*

Q10) Would a Memorandum of Understanding (MOU) between the applicant organization and a stakeholder outlining the responsibilities of each under the project be sufficient to include with the application?

A10) YES

Q11) If an applicant organization and a stakeholder have an existing agreement in place unrelated to this application, can it be included as part of this application as a demonstration of their commitment to work together if a project-specific agreement cannot be generated and signed by the time of the submission of the application?

A11) YES, but the application should also include a description of the responsibilities of each project stakeholder and the items set forth in section 3.6 of the RGA as specifically as possible.

Q12) It appears that preference will be given to applicants that have "multiple appropriate stakeholders." Can you please elaborate as to what relationships between stakeholders will be given greater preference?

A12) In general the more stakeholders and more community involvement, the more preference will be given.

Q13) Can stakeholders be related as long as there is one stakeholder group that is not related to the eligible applicant? Can you provide examples of stakeholder relationships that will qualify and those that will not?

A13) YES, the requirement is for one unrelated, different category of stakeholder. Including related stakeholder is not a problem

Q14) Pertaining to Section 3.2.6., can it be interpreted as "County" versus specifically "County Public Health Department"? That is, can a County be considered as a stakeholder?

A14) YES, if County government entity is sharing clinical or public health data.

Q15) Could a regional association of human service agencies count as a partner? People Inc. would like to share outcomes and best practices with peer agencies via such a regional association but are unsure if the activity is pertinent to this grant application?

A15) NO

Q16) A physician's group under their independent Medical Board will be a partner stakeholder. Do they have to be an LLC or professional corporation?

A16) No as long as they are a legal entity.

Q17) How will eligible recipients be able to support addition of new stakeholders after the grant has been issued?

A17) This is a matter left to the discretion of each applicant.

<u>CAPITAL COSTS</u>:

Q1) Would the grant support software purchase and development for making patient results review available via the web to a physician not employed by our hospital?

A1) YES

Q2) Would funding for a clinical data repository that would enable health information exchange be within the scope of the grant?

A2) YES

Q3) Where can I find the definition in State Law of Capital purposes?

A3) NYS Finance Law Section 67-a.4. defines capital work. Within the HEAL NY HIT project, any costs that can be capitalized against a capital project can be considered a capital cost. See Attachment 5 for further information.

Q4) Does software count as a capital cost?

A4) YES, however as with any cost, it is up to the applicant to describe how the cost is directly related to the project.

Q5) Are customization and implementation of software capital costs?

A5) YES, if directly attributable to project.

Q6) Provide a detailed description of capital costs.....Are salaries for staff people to implement program allowable?

A6) See RGA Attachment 5.

Q7) Are the following acceptable Capital costs?

a. Hosting Hardware - Web Servers / Database Server (Host the application / data for all to access)

b. Interfacing - Hospital's cost to interface to our system (Lab, Radiology, ADT)
c. Training costs - Stakeholders (Ex. Office Staff, Physicians, Etc)
d. Stakeholder Equipment Costs - Network / workstation equipment (Ex. Physicians Office)
e. Initial development costs - Develop EMR application / Central repository
f. Prospective Development Costs - Development of new functionality
g. Interfacing - RHIO's cost to interface to hospitals, Labs, Pharmacy, Etc.
h. Organizational Costs - Cost to set up RHIO and other administrative costs to market the program to potential stakeholders
i. ASP Fees - Stakeholder monthly fees to access the software via the Web (Fee- $ * # of physicians per month)

A7) See RGA Attachment 5.

Q8) Are the following included in capital costs:

- Hardware costs
- Connectivity costs (e.g., T1 lines): initial and ongoing
- Software and hardware associated with creation of a data warehouse
- Data backup and archiving costs
- Software licensing/maintenance costs
- Interface costs (software and hardware)
- Software costs
- Devices for practitioners (e.g., handheld devices to support e-prescribing)
- Network
- Biometric devices (for practitioner and patient identification)
- External contractors

A8) See RGA Attachment 5.

Q9) Are the following operational costs acceptable?

a. RHIO Internet Access Fees (to allow stakeholders to connect to the application and databases)
b. Stakeholders Internet Access

A9) See RGA Attachment 5.

Q10) The RGA notes in Section 2.2.2 that all Phase I funds must be used for capital costs, "as defined by State law." Can you define this or identify where in State law this is defined?

A10) NYS Finance Law Section 67-a.4. defines capital work. Within the HEAL NY HIT project, any costs that can be capitalized against a capital project can be considered a capital cost. See Attachment 5 for further details.

Q11) Can direct administrative costs (e.g., salary and fringes of personnel to administer the project) be included in grant funds requested?

A11) YES, if they are costs that can be capitalized. See RGA Attachment 5 for further details.

Q12) Can expenses associated with training of staff be included as an eligible item in the request for grant funds?

A12) Generally, training costs are expensed and therefore would not be eligible to be capitalized against the project.

Q13) Other than equipment purchases, can you please define what categories (items) fall within the "capital funding" category for this grant? For example, would software, telehealth equipment, and supplies qualify for funding?

A13) See RGA Attachment 5.

Q14) Pertaining to Sections 2.1.1.3. and 2.2.2., is labor associated with implementation of software previously purchased (software cost would not be a part of the application) considered to be an eligible project related cost?

A14) Costs could be capitalized if they are properly attributable to the project and would not typically be expensed within an organization's accounting systems. See RGA Attachment 5.

Q15) Pertaining to Sections 2.1.1.3. and 2.2.2., is hardware associated with implementation of software previously purchased (software cost would not be a part of the application) considered to be an eligible project related cost?

A15) Costs could be capitalized if they are properly attributable to the project and would not typically be expensed within an organization's accounting systems. See RGA Attachment 5.

Q16) Pertaining to Sections 2.1.1.3. and 2.2.2., is the leasing of software, as opposed to the purchase of software, considered an eligible project cost?

A16) See FASB Statement No. 13 to determine if this cost is appropriately capitalized within your organization.

Q17) Section 2.1.1(3) provides "grant finds must be utilized for capital purposes and eligible Project costs as defined by the requirements of state law." What is meant by "capital purposes" and "eligible project costs"?

A17) *See RGA Attachment 5.*

Q18) By contrast, Section 2.2.2 states that "all Phase I funds must be utilized for capital costs." Do "capital costs" differ from "capital purposes" or "eligible Project costs"? Would software licensing fees be considered eligible project costs? Would training and maintenance fees be considered eligible project costs for which grant funds can be used?

A18) See RGA Attachment 5 and Question 13 above.

Q19) Please clarify the capital funding for the NY Heal grants. Specifically, what project costs are considered capital under these monies i.e. FTEs, consultants, interfaces, license fees, hardware assets.

A19) See RGA Attachment 5.

Q20) If this is strictly a capital project, does the State ONLY want budget information regarding costs associated with the capital expenses, i.e. installation, equipment, etc. or should an application include budget projections for monitoring, staff training, and maintenance? If the later is included, can the applicant provide in-kind funds for staff training and monitoring? Can such in-kind funds (or other non-HEAL NY funds) count toward the 50% match?

A20) See RGA Attachment 5 and question 12 above. Only those expenses that can be capitalized are eligible for reimbursement.

Q21) Please clarify if the funds will only cover capital costs or up to 50% of the total project costs?

A21) Only capital costs may be included as project costs. The application should fully describe all project costs that directly relate to the project. Of that total amount described, 50% is eligible for grant funding. The other 50% must be matching funds of the applicant including in-kind costs of applicant or stakeholder as long as it directly relates to the project.

Q22) Do direct costs include labor associated with the associated with the design and build of a system plus initial training costs for physicians and hospital personnel?

A22) Not all direct costs are reimbursable. See RGA, Attachment 5 for further details.

Q23) Please clarify the statement of "shall 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." Does this limit the ability of the Eligible Applicant to utilize implementation support from technology vendors or external consultants? If costs are incurred for these services are they considered capital costs or direct costs that can be used to demonstrate matching funds?

A23) Contractors may be external consultants and do not need to be a state agency. However the requirements that apply under Article 15-A of the Executive Law will apply to the contractors.

Q24) Will the State accept estimates of the costs if final technology vendor and equipment costs are not available by November 30th?

A24) Yes, however reimbursement will be made based on actual costs.

MATCHING FUNDS:

Matching funds are defined in Section 2.2.2 and 2.2.3 of the RGA. They are limited to costs directly related to the HIT project, from any source, and may include planning and other direct

costs incurred AND paid for from 2/1/05 until the end of the grant period, but no later than 2/28/07.

Q1) Please explain what counts toward the match?
A1) See RGA Attachment 5.

Q2) What counts toward the match? (Section 2.2.3 allows costs financed by program income to count toward match. Section 4.16 states that GDAs will begin on March 1, 2006 and will have a duration of 2 years.)
A2) See RGA Attachment 5.

Q3) Section 2.2.2 indicates that costs incurred after 2/1/05 count as matching funds. Must all project costs be incurred after that date?
A3) NO. Only those costs incurred after 2/1/05 will count as matching funds. While project costs may have been incurred prior to this date, these costs cannot be included as matching funds.

Q4) Costs incurred after 2/1/05 relating to the project may be counted as matching funds. May that be cost basis or accrual basis?
A4) Applicants should use whatever basis of cost is normally used in their financial reporting.

Q5) Please explain what costs financed by program income count toward match?
A5) Program income is any revenue generated by the project.

Q6) Other than a general institutional indirect percentage, are there other items that absolutely cannot count toward the match?
A6) Costs not related to the project, or costs incurred prior to 2/1/05 cannot count towards the match.

Q7) According to Section 2.2.3.1, "no indirect costs, such as administrative costs, will be counted toward the match." If an application itemizes specific administrative costs, can they be included in the budget?
A7) Only those costs directly attributable to the project can be included. Direct administrative costs such as supervision are allowable but indirect administrative costs are not.

Q8) Section 2.2.3.2 notes that costs financed "by program income" may count toward satisfying a match. What is "program income"?
A8) Program income is any revenue generated by the project.

Q9) Section 2.2.2 of the RGA states, "Costs incurred after February 1, 2005, which are clearly related to the Project, including planning costs, may count as matching funds. The Eligible Applicant must demonstrate that the Project is fully funded prior to the execution of the GDA (Grant Disbursement Agreement)." Can Eligible Applicants and the Stakeholder(s) use in-kind funding solely to meet the requirements for the 50% match or is funding from other sources, such as foundation grants also a requirement?

A9) Applicants may meet the match requirement entirely with in-kind funding.

Q10) Section 2.2.2 also provides that "costs incurred after February 1, 2005 clearly related to the project including planning costs may count as matching funds." Would the costs incurred by the involved stakeholders after February 1, 2005 which are related to the Project be counted as matching funds or only costs incurred directly by the Applicant?

A10) Stakeholder costs may be included in meeting the match requirement.

Q11) Section 2.2.3 states that "Only direct costs will be counted toward the match. No indirect costs, such as administrative costs, will be counted." On the other hand, Section 2.2.2 states that planning costs incurred after February 1, 2005 which are clearly related to the Project, may count as matching funds. If no administrative costs will be counted for matching purposes, what types of planning costs are eligible to be counted toward the match?

A11) Only those costs directly attributable to the project can be included (see answer to Question 7 within this section).

Q12) Can matching funds be used for non-capital expenses (e.g., conducting project evaluation, designing and implementing and analyzing patient and provider satisfaction surveys)?

A12) YES

Q13) What does the following statement mean: "only the non-State share of matching funds and/or services may be counted towards the match requirement"?

A13) Applicants may not use state funds from other awards towards meeting the matching funds requirement.

Q14) Will supplies, equipment, and space <u>donated by the Eligible Applicant and or Stakeholder</u> (as opposed to by "other parties" be counted as matching funds?

A14) YES, if directly attributable to the project.

Q15) If a party participates in multiple HEAL grants and the work is used for multiple HEAL grants can the same investment on the grantee's part be used for matching funds twice?

A15) NO. Expenses can only be charged against one grant, either as match or as a reimbursable expense.

Q16) Could you please clarify under Section 2.2.2 how matching funds are calculated, especially costs spent between Feb 1, 2005 and the actual awarding of the grant?

A16) See RGA attachment 5.

Q17) Does the matching requirement pertain expressly to the capital costs, i.e. the applicant must show/provide 50% match towards capital costs?

A17) NO. Grant funds may only be utilized for capital costs, therefore in order to have grant funding of 50%, 50% of project costs must be capital costs.

Q18) Must a certain portion of the matching funds come from either the applicant organization or the stakeholders? In other words, can all matching funds come from the applicant organization or can all matching funds come from one of the stakeholders?

A18) There is no specific requirement related to which entities contribute matching funds. While it is important that the application show that all stakeholders have a serious investment into the project, this investment may be in a manner other than financial.

Q19) Can direct administrative costs (e.g., salary and fringes of personnel to administer the project) count toward the match?

A19) YES

Q20) If direct administrative costs can be included in either request for grant funds (Question 3 above) or count toward the match (Question 4 above), is there a percentage cap on administrative expenses under this grant program?

A20) There is no cap, however costs must be reasonable and appropriate to the project.

<u>OTHER FINANCIAL</u>:

Q1) Stakeholder information is required regarding financial viability of private parties. The hospital does not have access to that info-

A1) Stakeholders are required to produce that information for the project. If they want to be part of the project it must be submitted.

Q2) Section 2.2.2 states that the applicant must "demonstrate that the project is fully funded prior to the execution of the GDA." Other than a detailed budget that specifies the sources of funding, how will a grantee be expected to make such a demonstration?

A2) The source of all funding needs to be detailed in the application.

Q3) Section 4.11.3 specifies that the application must include "pro-forma statements of operations, balance sheets, and cash flows." Is this requirement specifically for an applicant that is forming a separate legal entity specifically for purposes of this project or is this a requirement for any project being proposed? If it is a requirement for any project submitted, how would these items be produced and differ from a proposed budget plan with specific line items and specific sources of expected funding?

A3) Pro-forma financial statements and/or detailed budget plans will be considered to meet the criteria.

Q4) If an applicant organization does not have a Dun and Bradstreet report (Section 4.11.4), which is a voluntary report, is there some other evidence that DOH would suggest to demonstrate financial viability?

A4) Audited financial statements or other known credit reports.

Q5) 2.1.2.(5) To our knowledge, there are no operating RHIOs with viable and sustainable business plans at this time, and financial viability was identified as a key challenge in a recent national survey of RHIOs under development. Would DOH and DASNY consider rephrasing the requirement of demonstrating financial viability to incorporate more

exploratory language, such as identifying the conditions that would be required to be met or achieved in order to achieve viability?

A5) *We do not require the formation of a RHIO. Financial viability, in the absence of a RHIO and its business model, can be achieved by payer involvement, user fees, stakeholder funds or other measures.*

Q6) *What are the financial requirements for non-publicly held stakeholders such as private physician practice?

A6) *Balance sheet and income statements for the two preceding years, along with ownership details are preferred, but we will attempt to accommodate situations where these do not exist. See section 4.11.4 of the RGA for further details.*

FINANCIALLY DISTRESSED:

Q1) Would X qualify for 70% funding if the above described primary care center is financially indigent?

A1) *Distressed subsidiaries or closely affiliated companies of financially stable applicants will be scrutinized and qualify only if they are independent.*

Q2) 3.5 and 4.11.4 appear to be contradictory. How can an applicant be financially distressed and also provide evidence of financial stability?

A2) *The project as a whole must be financially stable. The financial stability of the financially distressed entity will be a factor only if the project is placing financial reliance on this entity.*

Q3) Section 2.2.3 notes that including a financially distressed entity within an application may allow an applicant to be awarded a grant covering up to 70% of the project's costs if the financially distressed entity has a "significant role" in the project. Can you define "significant"? Does a certain percentage of the grant funds or project cost have to be incurred under the auspices of the financially distressed entity?

A3) *It is up to the applicant to describe how the financially distressed entity plays a significant role in the project. This role does not necessarily have to be of a financial nature. We expect to judge this on an individual basis. We do not want to see financially distressed entities included to simply increase the percentage of grant funding.*

Q4) The RGA mentions that, "preference will be given to applications that include at least one financially distressed entity in the group of stakeholders entering into an agreement." Can you please explain your rationale behind this item? While less of a match will be required, the financial solvency of a particular institution may negatively impact the applicant's and/or stakeholders' ability to secure capital budgeting funds for the project due to the inherent financial risk of the distressed entity. Likewise, it may be difficult to calculate pro formas and cash flows for the project if one of the stakeholders is in a poor financial situation.

A4) *The lowered match requirement is intended to serve as an incentive to include less financially eligible entities and as a method to negate the impact this inclusion would have on the project's financial health.*

Q5) What criteria are being used to determine "financially distressed" organizations? There is a reference to past audits, but is there a matrix/guideline that will be used to make this determination?

A5) Specific requirements are defined in RGA section 3.5.

Q6) Section 2.2.3 specifies that preference may be given to an application that includes a "financially distressed entity" and Section 3.5 gives a definition of such entity. In 3.5.2, does a "negative fund balance" refer to unrestricted fund balance or operating fund balance? Temporarily restricted assets are encumbered and there are specific restrictions on how they may be used. Permanently restricted assets are even more restricted on the terms of their use.

A6) Total fund balance, both restricted and unrestricted.

TECHNOLOGY:

Q1) Have standards been established for HIT infrastructure?

A1) When the final national standards are issued you must comply and be certified within six months of certification process being available. There are some existing standards but final national standards are in the process of being created.

Q2) The RGA references the "Framework for Strategic Action" as the "Strategic HIT Plan that is being developed at the federal level" and information about the "planned national network for sharing patient data." Where can providers locate this information? Will this information be provided on the DOH website so that prospective applicants have the opportunity to review?

A2) www.hhs.gov/healthit

Q3) a) Section 2.1.2, #4 states, "Applicants must commit to achieving compliance with and certification in interoperability, privacy and security standards within six months of such standards and certification becoming available"—Are these standards referencing federal HIPAA standards –OR- are State standards going to be developed by DOH? b) Please define "interoperability."

A3) a) These are national HIT standards, separate from HIPAA standards, and certification processes are expected to be operational before the end of the grant period.
b) Interoperability is the ability of one data system to communicate with another data system.

Q4) Will providers that presently have a technology infrastructure get preference over others that are starting a project from scratch?

A4) Not specifically, although experience and implementation skills will be evaluated, which may give those with some infrastructure an advantage.

Q5) Section 2.1.2 (4) requiring that applicants "commit to achieving" compliance and certification in national standards within 6 months of promulgation. Would DOH and DASNY consider revising this requirement so that applicants could commit to making good faith efforts to comply? Since the standards have not been promulgated, the

certification process has not been designed, and the capacity of the certifiying entity is not known, it would be difficult for applicants to commit to compliance.

A5) NO. We believe that since enough of the standards are known, and vendors committed to abide by them, this requirement is fair and achievable.

Q6) In section 4.6, the Project Description Overview, we are told to describe how our Project's goals and objectives are consistent with those outlined by the federal government's National Coordinator of Health Information Technology. Where can we find the National Coordinator's goals and objectives?

A6) See Question 2 of this Technology section.

EVALUATION CRITERIA:

Q1) Does this grant support city-wide efforts? In other words, does the grant money have to support a New York state-wide initiative?

A1) It does not have to be state wide but should be broad based within the community.

Q2) What kind of information on staffing is required for eligible applicant?

A2) It is incumbent on the applicant to detail the projects staffing, and to show that it is reasonable in terms of numbers, skills and experience to accomplish the project goals.

Q3) Technical score is worth 80 points but there are only five categories. Are the categories weighted equally?

A3) The technical score will have three primary components: technology, quality of care impact, and community need/participation. Lesser weighting will be given to other factors, including a project overview and the plan for monitoring and evaluation.

Q4) Do DOH and DASNY have priorities or relative weights among items 1-11?

A4) NO. We expect to have projects receive grants that excel in different items. We will, however, expect all projects to achieve a minimum level evaluation in all the technical and financial components in "Evaluation Criteria" Question 3 above.

Q5) a) Must a project meet all of the factors enumerated in 2.1.3? b) If some factors will be addressed in later phases of the project's development, will this information be taken into consideration by DOH and DASNY in the selection process if these future plans are addressed?

A5) a) NO
b) YES

Q6) Must the Project lead to improvement of patient access to personal medical data in the first 2 years of operation with HEAL Phase 1 grant funds?

A6) NO, but those that do will receive preference.

Q7) How would you calculate the percentage of clinical support within the community? Would it be the percentage of clinicians covered by the project who agree to participate?

A7) YES, it could be that, but other measures may be acceptable in specific situations.

Q8) If we do participate in multiple grant applications, would/could this have a positive/negative/neutral effect on grant application success and or dollars awarded?

A8) Awards will be granted on the basis of the strength of applications and to achieve the best geographical distribution possible. Participation in multiple projects will not disadvantage any stakeholder, but total funds received by any one entity will be a consideration.

Q9) If the grant application potentially addresses more then one of the "Eligible Projects" areas listed on page 6 section 2.1 as items 1, 2 and 3 does that make the application stronger for potential success or is an application focused on one of the three topics considered stronger?

A9) There is no preference for any type of eligible project, selections will be made on the basis described in "Evaluation Criteria" Question 3 above.

Q10) Can you provide an example of how an applicant would demonstrate that its proposed project "will assist in building an infrastructure to share clinical information among patients, providers, payers, and the public health entities" (Section 1.3)?

A10) A project that allows easy entry of additional stakeholders technically and financially would demonstrate that.

Q11) Can you give an example of how an applicant would ensure that its project is "consistent with the goals and recommendations, when available, of the Commission on Health Care Facilities in the 21st Century" (Section 2.1.1.5)?

A11) Following the federal discussion on certification, be prepared to do what is necessary to be certified. Since the Commission's recommendations are not yet available, execution of the required certification document also demonstrates this.

Q12) For Section 2.1.2, requirements 1, 3, and 4, is the expectation that the applicant will report on studies or research demonstrating that projects similar to the one the applicant is proposing have achieved the desired results? Since the project being proposed has not been conducted yet, how else could the applicant show that?

A12) Applicants will be expected to forecast, based on other projects, experience and local factors, how the project will improve the quality of care and reduce costs in the local setting. They will also be required to propose a method of evaluating these outcomes

Q13) Section 2.1.3 #7 states, "Projects will be expected to support automated, bi-directional, standards-based reporting of critical public health information to State public health entities unless such information is already being supplied by Eligible Applicant and participating stakeholders." Can you please define what you mean by "critical public health information"?

A13) Federal HIT initiative has published health information sharing as one of its strategic goals. Applications including public health information exchanges will be evaluated favorably.

Bidirectional flow of Critical Public Health information:

Regarding data flow **to the Department** through the NYSDOH Commerce system.
- any data or information where NYSDOH regulatory authority or State/ Federal law requires it to be reported by the clinical community within the physical geographical boundaries of NY State or within the regulatory domain of NYSDOH.
- any data or information supportive of planning, preparedness, detection, surveillance, alerting, response or recovery from/for/to a public health event.

Regarding data flow **to the clinical / health care community** through NYSDOH Commerce system. Absent any law or proprietary conflict to the contrary and within specific and appropriate roles of need - to know and within specific non-disclosure requirements:
- any data or information that provides value to the clinical care community in

- improving clinical care outcomes
- decreasing cost of health care delivery
- planning, preparedness, detection, surveillance, alerting, response or recovery from/for/to a public health event.
- improving the population/community health of the catchment area served by the clinical/health care entity

Q14) Please explain how applicants should calculate "the percentage of clinical support within the stakeholder community."

A14) This calculation will vary depending on type of project and community, but should show the number of, for example, physicians using the system versus the number in the community

Q15) What methods would be appropriate to reflect a "demonstration of the commitment and support by a significant number of clinicians…" and what constitutes "a significant number"? (2.1.3)

A15) See answer to "Evaluation Criteria" Question 14 above.

Q16) Much of X's current electronic compatibility and experience is related with using electronic billing systems. Does that capacity and experience count towards demonstrating extent capability?

A16) It is up to the applicant to demonstrate how such expertise is related to this project.

Q17) Regarding e-Rx within a facility, is there a minimum number of community physicians that must participate.

A17) NO, but it effects how project is evaluated if it can demonstrate that use is wide spread

Q18) How can an Eligible Applicant ensure its project is consistent with the goals and recommendations of the Commission on Health Care Facilities in the 21st Century when these are not yet known?

A18) See answer to "Evaluation Criteria" Question 11 above.

Q19) a) What are the parameters around which HEAL $ can be used to implement one's own EMR system? b) What is the time frame for Phase I?

A19) a) Grant funds may be used to implement EMR and other systems necessary for clinical data information sharing projects. We suspect that these uses will be a major part of many awards.
b) There is a two year time frame for Phase 1.

PROJECT CATEGORIES:

Q1) Can a project fall under more than one category i.e. E Prescribing and EMR?

A1) YES

Q2) a) Can applicant project activities cover more than one category? b) Are all categories weighted evenly?

A2) a) YES
b) YES

Q3) Can project fit into more than one category?

A3) YES

Q4) Can you please tell us how Project Category #1 and #3 differ in scope (Section 1.4)?

A4) Project #1 can include clinical information that is different from, or only a part of, a full EMR.

Q5) Will DOH and the Dormitory Authority of the State of New York (DASNY) consider a statewide project over a regional one?

A5) Not necessarily, breadth is one of many factors.

Q6) Can a single application propose a project that includes more than 1 of the 3 categories in this section?

A6) YES

Q7) a) Reference Section 4.3.4.b. Is it acceptable for the Project to span 1, 2, or 3 categories as defined in Section 2.1. b) Is it attractive to span categories?

A7) a) YES
b) The depth and breadth of information exchange will influence evaluation.

Q8) Can the request for matching funds cross over Initiatives (aka project categories) as defined -- i.e., some monies in RHIO infrastructure for HIE and some for EMR roll out for doctor's offices?

A8) YES within the same application.

Q9) Has a decision been made on how much to allocate to each of the 3 categories?

A9) NO

STARK LAWS AND SAFE HARBOR:

Q1) Is the grant exempt from Stark and safe harbor regulations that might prohibit a hospital from developing and supporting I.T. services in an affiliated but non-employed physician's office?

A1) See answer 2 below.

Q2) In a cooperative project between the hospital and individual voluntary physicians, will there be any relaxing of the Stark constraints?

A2) No, grantees are not exempt from any applicable laws that might prohibit self-referrals, such as Public Health Law §§ 238 to 238-e (the State's "Stark" law). Nor are grantees given any specific safe harbor under the explicit text of laws that prohibit kickbacks, such as Education Law § 6530(18), Social Services Law § 366-d and Public Health Law § 587.

The Department of Health does, however, interpret State "Stark" and anti-kickback laws, consistent with federal "Stark" and anti-kickback laws, unless the plain meaning of the language in State law mandates a contrary interpretation. Also, the Department believes that an IT arrangement would not violate existing State "Stark" or anti-kickback laws if it satisfied the requirements for the proposed new exceptions to the federal physician self-referral prohibition and the proposed new safe harbor under the federal anti-kickback statute. These newly proposed federal exceptions and safe harbor were published in the Federal Register on October 11, 2005 (70 Fed. Reg. 59,015 to 59,027 and 70 Fed. Reg. 59,182 to 59,198).

Q3) a) In this paradigm, does the allocation of grant funds need to be allocated symmetrically? For example, if there is Practice A, Practice B and the Hospital, are there restrictions on how the funds should be allocated among the participants? b) Is it safe to assume that the moneys would be coming from the State to the physicians and not from the hospital to the physicians?

A3) a) NO

b) State funds will flow to the eligible applicant who will allocate according to the work performed by each as defined in the application and their agreements.

MONITORING:

Q1) How detailed should the proposed "methodology" be for measuring the benefits of the proposed project (Section 2.1.2)? Can the applicant simply propose specific measures or indicators for its project (e.g., number of adverse events) or is a detailed and developed evaluation methodology expected to be included within the application?

A1) The scope, detail and practicality of the measurement methodology will influence the evaluation of the application. Please refer to section 4.10 of the RGA for further detail. In addition, there are specific reporting requirements under section 4.17.2.

Q2) Other than general audit requirements for government grants, is there any special audit protocol included as part of this grant program?

A2) NO. There are no separate audit requirements, but payment and reporting requirements are listed in Section 2.1.2 of the RGA. See Attachment 7 for further detail.

Q3) a) Will State funding be made available for the evaluation portion of these projects? If so, please elaborate as to how the State will make this available and how you intend grantees to use this funding. b) If not, what are your minimal expectations for the evaluation portion of the projects? c) Is it desirable to collaborate with an entity (consulting firm, University, others) for the evaluation piece?

A3) a) NO
c) See Question 1 above.
b) It may be helpful in certain circumstances.

<u>AWARDS</u>:

Q1) How many awards will be given out?

A1) There is no set number.

Q2) Is a "grant disbursement agreement" (GDA) the same as a contract?

A2) YES

Q3) Section 2.1.1.4 notes that the work covered under the contract shall be deemed "public work" subject to the Labor Law. Can you clarify the implications of this statement?

Q4) Section 2.1.1.4 notes that contractors performing work under the contract shall be deemed to be "state agencies" under Executive Law. Can you clarify the implications of this statement?

Q5) In particular, does the comment about "state agencies" in Section 2.1.1.4 mean, for example, that work needing to be performed by a subcontractor under a GDA requires solicitation of a minimum of three bids before the contractor can grant the subcontract?

A3, A4, A5) The enabling legislation requires that work covered under the contracts between the grantee and the grantee's contractors shall be deemed public work, and that the provisions of Articles 8, 9, and 10 of the Labor Law and Article 15-A of the Executive Law shall apply. Applicants are encouraged to consult with their attorney and the enforcing entities with respect to how these provisions will impact the project.

Articles 8, 9, and 10 generally require that prevailing wage be paid to any laborers, workmen, mechanics, and building service employees, that certain working hours requirements are met, and that certain construction-related safety standards are met at the project site. Article 15-A of the Executive Law sets forth certain requirements for encouraging participation by minority group members and women with respect to state contracts.

Q6) Section 4.17.1.3 notes that payments will be made to the grantee for "eligible expenses actually incurred." Section 4.17.1.4 then states that the grantee must provide "proof of disbursement of grant funds" within 60 days of the date that such funds are disbursed to the grantee. What is the meaning of "actually incurred" if there is an additional, subsequent requirement that the grantee provide proof of disbursement?

A6) Documentation of eligible expenses incurred would include, for example, presentation of an invoice for work actually performed, but not necessarily paid for. Once the grantee uses the grant funds to pay the cost, proof of payment must be provided within 60 days. "Actually incurred" means that the service has been performed or the liability has been accrued. Disbursement of grant funds is when payment is actually made.

Q7) Will a grantee be able to receive an initial advance on its grant award prior to vouchering for incurred expenses? If so, what is the maximum percentage of the award that the grantee can request as an advance?

A7) Not for profit grantees will be eligible for an advance up to 25% of the award amount at DOH's discretion.

Q8) If the grantee is eligible for an advance, can the grantee receive an advance on the entire grant award or only the first-year portion of the award?

A8) The entire award.

Q9) If a grantee is eligible to receive an advance, will the payback of the advance be pro-rated over the term of the GDA?

A9) YES

Q10) Can grant funding that is budgeted for the initial year of a two-year project but unspent in the first year be carried over to the second year of the project?

A10) The budget is for the entire term of the project. There are no interim or annual budgets.

Q11) Will providers who apply and receive funding for FY 2005 be able to reapply in future years?

A11) YES

Q12) Section 2.2.4 states, "Upon the award of a HIT grant, DOH and DASNY will issue an award letter to the awardees. 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." Can you please explain this in detail?

A12) The award letter is designed to assist applicants who have agreements in principle for funding that is contingent on receiving the grant. GDAs will not be entered into unless all requirements, including full funding, and an agreement among project stakeholders, is entered into. Upon satisfaction of the conditions set forth in the award letter, DOH and DASNY will enter into a GDA with the awardee.

Q13) If DOH is interested in funding a project but allocation of HEAL NY funds makes funding at the level of the request difficult, will the State discuss with the Eligible Applicant a smaller scope/ smaller budget for consideration?

A13) While the State has reserved the option of doing this, applicants should be aware that this is a competitive process.

Q14) Is RIB approval required for the evaluation component of the project?

A14) Each applicant must determine whether IRB approval is required for their project.

Q15) Section 4.17.1.2 specifies that "eligible expenses incurred in connection with the project to be financed with grant funds" must be "paid" out of a separate dedicated account. If purchases of certain items are generally made by an institution in bulk through an existing group purchasing or shared services arrangement, would it be permissible to purchase an item under this grant program by means of the existing group purchasing arrangement and simply transfer funds from the dedicated account to the existing group purchasing account for this purpose? Or does the grant program require direct payment from the contractor's dedicated account to a vendor for the specific purchase of equipment to be used under the grant program?

A15) Use of a documented internal process is acceptable.

Q16) When will the award letters be issued?

A16) It is expected to be in January 2006.

Q17) a) In this paradigm, does the allocation of grant funds need to be allocated symmetrically? For example, if there is Practice A, Practice B and the Hospital, are there restrictions on how the funds should be allocated among the participants? b) Is it safe to assume that the moneys would be coming from the State to the physicians and not from the hospital to the physicians?

A17) a) NO.
b) State funds will flow to the eligible applicant who will allocate according to the work performed by each as defined in the application and their agreements.

REGIONAL:

Q1) The RGA mentions "funds have been allocated across the following regions of the State on the basis of the 2000 census population (Section 2.1.4)." Does this mean that more densely populated areas will receive more funding than less densely populated areas? Conversely, the RGA reads, "the size of individual grants may be determined based upon an evaluation of the scope of work presented, the need for the Project within the community, and the degree to which the Project meets the goals and priorities of the HEAL NY program, as more specifically set forth in Section 2 below (Section 1.5)." Can you please clarify this information?

A1) *The HEAL NY legislation authorizes $1 billion of grants over a four year period, and calls for broad, statewide distribution of that amount. The Phase I grants represent just over 5% of those funds. The intention of the award process will be to achieve as broad a geographic process as possible while also funding the highest quality projects, and the final awards will be decided based on both of these factors. No applicant should be concerned with any regional size restriction, as the relatively small size of Phase I eliminates that concern.*

Q2) What are the regional allocations for Phase I funds?
A2) See Question 1 above.

Q3) Section 2.1.4 specifies that the grant funds "have been allocated across the following regions of the State." Can you specify or give some sense of the allocation percentages?
A3) See Question 1 above.

Q4) Aside from 2000 census information, what "other appropriate considerations" will be used to allocate funds across the State's 6 regions?
A4) See Question 1 above.

Q5) When will the State announce the maximum allocation of Phase 1 HEAL NY funds for each of the 6 regions?
A5) See Question 1 above.

GENERAL:

Q1) Is there a page limitation to the narrative and the grant application?
A1) NO, but be concise.

Q2) Is a Letter of Intent required for the grant program?
A2) NO

Q3) Is it possible to participate in the conference by telephone?
A3) NO

Q4) Are there page limits?
A4) See Question 1 above.

Q5) Is there any page limit to the application?
A5) See Question 1 above.

Q6) Where are appendices?
A6) The appendices are available one the website at: http://www.health.state.ny.us/funding/rfa/0508190240/index.htm

Q7) Why are the timeframes so short (1 ½ Months)?
A7) There is a need to support projects through Phase 1 now, and it is anticipated that further funds will be available next year under HEAL NY.

Q8) Can you confirm that funding under Phase I of HEAL NY will not be a prerequisite for any future funding under the HEAL NY program?
A8) YES

Q9) If $65 million was appropriated (Section 1.5) for SFY 2005-06, why is only $52.875 million expected to be awarded? Where is the remaining $12.125 million?

A9) The remaining $12.125 million is for other HEAL NY functions not associated with the HIT Grants.

Q10) May grants be requested for projects that will be a) in progress or b) substantially completed in advance of the anticipated award date?

A10) a) YES
b) NO

Q11) Will there be an opportunity in later Phases of HEAL NY to fund expansion of projects funded during Phase I?

A11) We expect so, although the availability of funds in future years is subject to budgeting and other processes that could limit availability.

Q12) How many Phases will HEAL NY have? What are the proposed focus projects for future phases? What is the future timing of additional phases?

A12) See Question 11 above. The number of phases is undetermined.

Q13) Is it necessary to include bids for the equipment?

A13) NO

Q14) Please define "Electronic Medical Record"' for the purposes of this grant. Are digitized paper records that have been scanned considered electronic or does the record have to be a true total electronic record. Also is there a different definition for an "Electronic Health Record" or are these interchangeable terms.

A14) The terms "Electronic Medical Record" and "Electronic Health Record" are interchangeable. In order to qualify for this grant they must be true electronic records. Digitally scanned records are not acceptable.

Q15) To the extent that ambulatory clinical information systems are required to support clinical data sharing and e-Prescribing, would an ambulatory EMR that is in the process of being installed/implemented for a multi-hospital system count towards Initiative Category #2 and #3 above, even though the ambulatory EMR is used only within the health system? This is a basic infrastructure requirement to have in place, i.e. the ability to create and capture clinical data so that it can be used to drive e-Prescribing or clinical data sharing within the community.

Q16) This question could be extended to ask – could a healthcare system submit a grant request to cover the implementation costs of an Ambulatory EMR at two main facilities, which is designed to share clinical data within a multi-site health system and prepare the system to exchange clinical data with the wider community and support the implementation of e-Prescribing?

Q17) Could this same conceptual question apply to Initiative Category #3? Can the health system seek grant funding covering the expenses of implementing an EMR within the health system, which is designed to share data across (within system) multiple care locations and entities?

A15, A16, A17) NO, as detailed in section 3.4 of the RGA, clinical information must be shared between eligible applicant and unrelated stakeholder.