Questions and Answers Set #3 FINAL

HEAL NY – PHASE 5
Health Information Technology
Request for Grant Applications #0708160258

In an effort to expedite answers to submitted questions, this Questions and Answers document is the final Q&A posting to the Department of Health's website for RGA #0708160258. It is recommended that potential applicants continue to monitor the Department of Health's website for future posting(s).

Clarifications

1) Sections 3.1.2.1 (j) & 3.2.1.1 (g) are amended as follows: "A Rural Health Network, as defined by **Section 2951 of the Public Health Law (PHL)"**

2) For a project where the lead applicant is a Rural Health Network ***and*** the entire project is located in, and exclusively for the benefit of a rural area, the applicant match requirement is reduced to 10% of the total project. If a defined Rural Health Network is a participant or stakeholder of a project that is not exclusive to a rural area, then the match requirement remains 25%.

3) Section 5.1.3 Matching Funds: While applicants with 10% cash contributions to their match will be evaluated more favorably, the 10% cash is not a requirement.

4) Letters of Commitment referenced in Sections 5.2.6 (f) and 9.3.5 (7) are required to be two different letters. The Section 5.2.6 (f) letter is defined as an organizational commitment letter with no financial commitment information; the Section 9.3.5 (7) is defined as a financial commitment letter and should only be included in the applicant's financial application package.

5) Section 5.3 Award Process "If an applicant submits grant applications in more than one category, the respective applications should each describe the interrelationship with each other." – The interrelationship should be described in the organizational plans of each application.

6) CCHIT Certification Requirement: This requirement is clarified as: If a CCHIT certification is not currently available for an applicant's project, e.g., an EHR specializing in mental health, they must seek certification within six months of such certification becoming available. Also, applicants' projects must use CCHIT's 2007 certification criteria. If applicants' projects include vendors that are currently CCHIT certified, but not CCHIT certified based on the 2007 certification, then re-certification based on 2007 criteria must be completed within 6 months of project start date. Applicants should be aware that this requirement will be incorporated into any resulting Grant Disbursement Agreement.

7) Even though New York State did not receive funding under the CMS Transformation Grant Program, Interoperable EHRs for Medicaid remains a viable use case/clinical investment priority for the HEAL NY Phase 5 Program.

8) In Section 5.1 of the RGA (on page 24), the beginning date for costs clearly related to the project to be counted towards applicant match is clarified as October 1, 2007.

9) RGA Section 3.2.1.1.f, a legally constituted consortium of the described entities may also serve as lead applicant.

10) The Department has reposted Section 9. Applicants should obtain the new Section 9 and forms from the Department's website.

Questions and Answers

Eligible Project

Q1. Can an exception be made to allow grant funds to be used for EHR for hospital employed physicians who work in federally designated Health Professional Shortage Areas for Primary Care for Medicaid and Low-Income Special Populations? (Section 2.3.3, page 15)

A1. Yes, however, grant funds must be used for EHRs in physician practices, owned by hospitals, that operate in Health Professional Shortage Areas (HPSAs), if a majority of the care coordination zone is designated as an HPSA for primary care and is in a rural area (see clarifications 1 and 2 for the definition of a rural area).

Applicants are required to supply justification of providing services in a designated HSPA. Further information, including definitions and specific designations, can be found at http://bhpr.hrsa.gov/shortage/.

Q2. In Category 3 Projects, the RGA states that "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." Please define sufficient scale, i.e. number of practices, providers, etc.

A2. Sufficient scale should be determined by the community environment and defined care coordination zone. Community scale in implementing EHRs is an important implementation strategy as a result of one of the externalities in the context of interoperable EHRs. This is a network effect. This effect arises when one user of interoperable EHRs gains as a result of another user adopting compatible technology. Similar to telephone, fax machines or email, interoperable capability is valueless for an isolated person, but as more users have it, the benefits compound. The implication of this is that early adopters face economic burdens and few benefits of interoperable EHR adoption, while the late adopters enjoy substantial benefits. Moreover, since health care is delivered largely on a community and regional basis, the determinants of when the interoperable EHR market shifts from offering negative net benefits to positive net benefits for adopters is also likely to be determined at the community level or

regionally. Therefore, interoperable EHR adoption can be partly addressed by fostering community or regional groups of adopters of sufficient scale to realize EHR benefits internally within the group.

Q3. If the lead applicant in a Category 3 grant is a RHIO, is it required that a CHITA be involved in the implementation of the EMRs?

A3. No, as long as the RHIO provides the health IT adoption and support services and satisfies other requirements with respect to interoperability via the SHIN-NY.

Q4. Page 15 of the RGA states that grant funds are not permitted to be spent on EHR implementation in a hospital practice setting (RGA section 2.3.3). May grant funds be used to enhance a hospital's EHR system for the purposes of system interface and/or information exchange with other providers, including but not limited to ambulatory care providers and physician offices?

A4. Grant funds may be used for interfaces between the hospital and the ambulatory physician office-based EHRs supporting results delivery and other aspects of health information exchange. The HEAL NY Program will not be funding hospital EHRs.

Financial / Match

In the responses to questions release on October 12th, on page 4, there is a clarification offered for the applicant's requirement to fund the Statewide Collaboration and the Project Evaluation processes. (Section 4.2)

It states this is clarified as "Applicant budget allocations for the Health IT Collaboration Process & Project Evaluation Process must be 5% of their project's requested HEAL funding amount."

Q1. Does this mean that 5% of the project's requested HEAL funding amount for the collaboration process and another 5% for the evaluation process for a total of 10%? Or, does it mean a total of 5% of the project's requested HEAL funding amount for both the collaboration and evaluation processes?

A1. The requirement is 5% each for the collaboration and evaluation processes, for a total of 10%.

Q2. Is the 10% suggested cash match required to be cash and or cash equivalent?

A2. Yes

Q3. What is the point value of the 10% cash match, i.e. how many evaluation criteria points will be awarded for such a match?

A3. With respect to the evaluation criteria, the match requirements are evaluated as part of the Financial Application. The 10% cash match is not a requirement, however, financial applications that include a 10% cash match will be scored more favorably. DOH is not disclosing specific point values.

Q4. In Section 5.1.2 Other Grant Requirements, the RGA states, "Eligible applicants are required to confirm that the Project is fully funded prior to the execution of the GDA." Please clarify this statement. How should this be done? Will there be specific instructions for applicants to use to provide this information?

A4. This information will be provided to awarded applicants. It is expected that much of this information will be provided with letters of commitment submitted with the grant application. Funding commitments will be confirmed during the contract development process.

Q5. In Section 4, 4.2, Requirements, the RGA states "Applicants should anticipate regular meetings and factor this into their overall plans and budgets as part of the application." How many meetings should applicants budget on attending? Should this be included in the reimbursable funds or matching funds?

A5. The meeting schedule will be discussed and determined by the grant awardees at the start of the program. Applicants should budget a reasonable number of meetings in order to fulfill the goals of the project; this may vary based on grant category and/or grantee type (RHIO vs CHITA). This could be included in the reimbursable funds so long as no more than 40% of the total reimbursable funds are used for non-capitalizeable activities. See Section 9.3.5.

Q6. In Section 5, 5.1.4.2 the RGA states, "costs financed by project income from October 2008 through the term of the GDA may count toward satisfying a match." Please define project income.

A6. This date is clarified as October 1, 2007. Project income is defined as revenue earned as part of the project. Revenue earned must be expended as part of the project.

Q7. In Section 5.2.6.6 the RGA states, "Demonstrate expected costs savings and quality improvement to the health care community." Please provide examples of how applicants can demonstrate this.

A7. Applicants should explain how their proposed projects are expected to result in cost savings and quality improvement, two key goals of health IT.

Q8. In Section 5.2.6.7, Financial Application, the RGA states "Describe relationship between the savings or improved quality and the amount of the grant request." Please provide examples of how applicants can demonstrate this.

A8. Applicants should explain the expected return on investment based on the grant award amount.

Q9. In Section 9.3.4, Heal NY Phase 5 Allowable Costs, how should applicants allocate the project time period for each section of allowable costs? i.e. Planning, 3-6 months?

A9. That should be determined by applicants based on their individual projects.

Q10. Do these reserve amounts come out of NY State Heal payments or out of the matching funds from the applicant?

A10. The requirement is 5% each for the collaboration and evaluation processes, for a total of 10% your HEAL request. We expect that it would be 10% of the reimbursable (HEAL) funds.

Q11. Is the five percent of reimbursable funds to NYeC on top of the five percent of reimbursable funds for an independent project evaluation process for a total of 10% of project funds to be devoted to these purposes? (Section 4.2 and Section 5.1.4.1)

A11. The requirement is 5% each for the collaboration and evaluation processes, for a total of 10%.

Q12. Will individual award recipients contract with and pay for the collaboration process and the evaluation vendors directly, or will the State perform this function on behalf of the recipients?

A12. DOH/DASNY reserves the right to either contract with the preferred vendor for collaboration and evaluation on behalf of HEAL NY 5 Award Recipients, or to ask recipients to contract with identified vendors. If the former (DOH/DASNY contract), the identified funding would be withheld from recipient awards and paid directly to identified vendors.

Q13. If a provider has contracted with but not yet installed or paid for an EHR system and now wants to participate in a CHITA, can such costs count as matching funds or be reimbursed under an HEAL V award? (Section 5.1)

A13. Only costs incurred after October 1, 2007 that are clearly related to the applicant's Phase 5 project may be used as matching funds. Applicants should use their normal method of accounting to determine expense allocation.

Q14. Is it possible for CHITA participants to include estimated rather than actual EHR costs in their budget expense forms? (Section 9.3.6)

A14. Yes, however, we will only reimburse actual costs.

Q15. Section 5.1.4.2b (pg. 24) states: "Costs financed by project income from October 2008 through the term of the GDA may count toward satisfying the match." Is this a typo (should it be October 2007?), or does this mean project income prior to October 2008 cannot be considered as match even though the grant starts in 1st Quarter of 2008?

A15. Yes, this is a typo. The correct date is October 2007.

Q16. We find no description in the RGA of the "Eligible Applicant and Stakeholder's Financial Stability" part of the Financial Application (listed as part E of Section 9.3.3: Financial Application Template). Please specify what documentation and/or other information is required or suitable for demonstrating applicant/stakeholder financial stability.

A16. When available audited financial statements should be provided, otherwise applicants should provide tax returns, Dunn and Bradstreet reports, bank statements or similar documentation that would allow the Department and DASNY to confirm that key entities will remain financially viable through the term of the projects.

Q17. What are the minimum requirements for the financial statement of financial stability? With 20+ hospitals potentially to be added to our RHIO, what financial statements would you require. Also, what should we do about the fact that the RHIO itself, the main applicant, is less than one year old without audited financials?

A17. When available audited financial statements should be provided, otherwise applicants should provide tax returns, Dunn and Bradstreet reports, bank statements or similar

documentation that would allow the Department and DASNY to confirm that the key entities will remain financially viable throughout the term of the projects.

Q18. For the record…Can rural health networks use their DOH funding to support this project…either as in-kind through the dedication of staff & consultant time and expense and/or direct cash investment in capital purchases?

A18. New York State grant funds cannot be used to support the HEAL project as match. However, please note clarification #2 on page 1 regarding rural health networks' revised match requirement.

Q19. Maximum Funding Amounts: On page 29, the RGA states: "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." What is the maximum request for an applicant that is prepare multiple applications with partners from other geographic regions? For example, if an applicant from the Hudson Valley were to partner with a RHIO from another region on a Category 1 application for $15 million (with costs proportionally allocated to both RHIOs), could it also prepare a Category 2 application for $4 million?

A19. If the proportional cost allocated to the RHIO is less than $15M, then the applicant could apply for Category II as long as the total amount of Category I plus Category II does not exceed $15M.

Q20. Funding Allocation and Selection for Category 1 Applications: How will the review and allocation of funding be determined for applications from multiple RHIOs in Category 1? For example, if a RHIO from the Hudson Valley were to be the lead applicant and partner with a RHIO from another region, will it be competing against other applications from the partner RHIO's region? If other RHIOs are selected from the partner's region, how will it affect the allocation of funds for the cross region application?

A20. RHIO applicants are competing based on score. The Commission regions are used to allocate funds to ensure statewide participation and coverage. The dollars awarded to a multi-Commission region SHIN-NY will be prorated based on the participating regions' allocation and at the recommendation of the applicant.

Q21. How should the RHIOs involved in the CDC's Accelerating State-wide Public Health Situational Awareness proposal prepare their applications if they choose to participate in the SHIN-NY Reference Architecture HIE for Public Health? Specifically:

Q21a. Can the resources used to develop the tools, interfaces be used as a match?

A21a. Awards from non-NYS grant sources from which a commitment has been received can be used as a match.

Q21b. Can the resources used to participate in the Public Health consortium activities be used as a match?

A21b. Yes, if those resources are related to the HEAL Phase 5 project.

Q22. Do federal dollars that flow through a state agency to the RHIO count as match dollars?

A22. No. However, DOH wishes to clarify that Health Research Incorporated, Research Foundation of SUNY and similar entities are not State Agencies. Therefore, federal

dollars that flow through these entities are not considered state funding and are eligible to be used as match dollars.

Q23. Matching funds (Section 5.1.4.1) Can federal grant awards for EHR implementation count toward the 25% required match?

A23. Yes.

Q24. Are there any limitations on the type of funding that can be applied to the required match? For example: NYC capital funds, NYC expense funds, private foundation funding

A24. Yes, the restriction on match source is that it must be non-NYS funds.

Q25. Section 5.1.4.2: Costs and third party in-kind contributions must be verifiable from the records of grantees and sub-grantees: Does this imply that all dollars (particularly cash contribution matches from other CHITA members or project participants) need to flow directly through the lead (contracting) agency or applicant? Does spending need to occur solely from the lead applicant? How is spending from other CHITA members to be documented or annotated by the grantee?

A25. No, all dollars do not need to flow directly through the lead applicant. Spending from CHITA members can be documented and explained in the budget forms and justification.

Q26. Section 5.2.6: Financial Application: Provide financial obligations of each stakeholder and demonstration of financial commitment among stakeholders beyond HEAL awards:
Aside from inclusion in budget, are there any additional criteria for reporting this information?

A26. A letter of commitment as described in section 5.2.6.4.

Q27. Is the 10% cash contribution match based on the total cost of the project?

A27. The cash contribution should be 10% of the total HEAL Phase 5 budget.

Application Format

Q1. Can project categories be combined into a hybrid application?

A1. No, applications for multiple grant categories must be separate applications.

Q2. Does the 30 page limit (6.1.1) include the matrix of existing stakeholders required in section 3.1.2.1? Or can that be included as an appendix?

A2. No, the matrix is in addition to the 30 pages and therefore included as an appendix.

Q3. 9.1.2 Part One Technical Application Cover Page- Stakeholder requirements are referenced to 3.1.1.1. Is that supposed to read 3.1.2.1?

A3. Yes.

Q4. Page 34 of the grant guidelines indicates that applications should be submitted with a full .pdf formatted technical application and a full .pdf formatted financial application. Is a Word formatted application acceptable?

A4. No, the applications are required to be in .pdf format.

Q5. Can you please confirm whether the pdf files of the Technical Application and the Financial Application should be saved on the same CD or should the package include a total of 4 CDs (2 with the Technical Application and 2 with the Financial Application)?

A5. Separate technical and financial CDs, for a total of 4 CDs or USB drives.

Q6. Section 5.2.4: Leadership and Personnel Qualifications: The grant application should include the names of all key personnel that will contribute to the project including credentials, roles, qualifications, expected level of participation (expressed in hours per week)-specific attention should be given to the role of project leader for CHITAs and executive leadership participation in the governance process for CHITAs: Are resumes to be submitted as part of the grant application for all personnel who are budgeted for the project?

A6. Resumes are not required, but the qualifications of the personnel should be included.

Award Process

Q1. Over what time period will the awards in Steps 1- 4 be allocated?

A1. Awards are expected to be announced during the first quarter of the 2008 calendar year.

Q2. Could you provide a projected timeline for application review and announcement of award winners?

A2. Awards are expected to be announced during the first quarter of the 2008 calendar year.

Q3. Will awards for Category II and Category III grants be made by comparing all like applications on a regional or statewide basis? (Section 5.3.6.2)

A3. There are two dimensions to the award process: (1) numerical score on a statewide basis and (2) funds available based on regional allocations. The scoring is based on comparing applications to criteria described in section 5.

Q4. Are the evaluation criteria listed in 5.2 weighted in the scoring process? If so, how will the sections be weighted?

A4. DOH and DASNY will use a consistent and predetermined methodology for scoring applications, but will not be providing this information to the applicants.

Q5. Who will review the applications? Are outside reviewers or peer reviewers involved?

A5. Staff from DOH and DASNY will be utilized, however DOH and DASNY reserve the right to utilize external reviewers.

Q6. Regarding the required Stakeholder Involvement matrix (section 3.1.2.1, pg. 17) and Scope of Services matrix (section 3.1.2.2, pg. 19), should these be included in the application narrative, i.e., part of the maximum 30-page length, or can they be included as attachments and not be included in the 30-page count?

A6. The matrices can be included as attachments and not be included in the 30-page count.

Q7. For the evaluation of the grant are breadth, depth, and interoperability equally evaluated? In other words if I had the opportunity to bring "x" number of extra hospitals into the RHIO or do a 3rd use case, would one option weigh higher than the other.

A7. DOH and DASNY will make use a consistent and predetermined methodology for scoring applications, but will not be providing this information to the applicants.

Q8. How does the award process described in section 5.3.6.2, which is based on regions (LI, NYC, Hudson Valley, Northern, Central, Western) relate to the care coordination zones if one application includes CHITA participants that are across multiple regions?

A8. The dollars awarded to a multi-Commission region CHITAs will be prorated based on the participating region's allocation and at the recommendation of the applicant. It is expected that the prorating of funds between regions will be proportional to the relationship of the care coordination zones within the listed regions.

Q9. Will CHITA applicants be more favorably considered if they go beyond the minimum requirements for a CHITA by also meeting the requirements of RHIO applicants? (sec. 5.2.1)

A9. No. CHITAs serve a different role than a RHIO, as defined in Section 3.

Q10. In reference to the second Q&A document under Eligible Projects, Question 6, would a CHITA -- with nursing homes, ambulatory physician office settings, data exchange entities, and other provider stakeholders involved -- be more favorably considered if the lead applicant were a nursing home in comparison to an ambulatory office setting, or would it be the same so long as the lead applicant was an eligible entity?

A10. The type of eligible lead applicant will have no impact on the application's score.

Stakeholders/Participants

Q1. - Stakeholder Question- Would Rx Hub or SureScripts count for a pharmacy data feed to fulfill the stakeholder requirement 3.1.2.1.H?

A1. Section 3.1.2.1.H references "Data suppliers, including pharmacies, laboratories and imagining centers". An entity providing a data feed, but not originating the data, while important to a project, would not be considered a stakeholder.

Use Cases

Q1. 2.2.5 Decision Support Use Case – Is it required for each applicant to respond to this use case regardless if they are a RHIO, CHITA &/or whatever category they are applying to?

A1. No.

Q2. This question concerns the Interoperable EHRs Use Case for Medicaid. How does this use case relate to medicaid managed care patient data? Will the interface be appropriate for providers of fee for service medicaid and providers of managed care medicaid ?

A2. The use case can be applied to both Fee for Service (FFS) and managed care data. Note that pharmacy data for all Medicaid beneficiaries comes through FFS. The use case expects that all components should feature fully interoperable health information exchange, so that the data can follow the patient, regardless of whether the beneficiary is in the FFS or managed care program, or whether the beneficiary transitions from one program to another.

Q3. For a Category 3 grant application that focuses on the Interoperable EHR for Medicaid use case, is it required that either (a)EHR interfaces to the Immunization Registry are included or (b)quality metric and reporting capability be included in the project?

A3. No.

Q4. How much of a use case must be included in the proposed project for completion during the HEAL NY Phase 5 contract period? Can a proposal include, for instance, query of the immunization registry, but not reporting of immunization events during the grant contract period but at some future date?

A4. The applicant should propose demonstrating as much of the use case as possible.

Q5. Regarding the Interoperable EHR Use Case for Medicaid, under section 5. Pre-conditions (page 6 of 9), pre-condition #1 "includes the ability to implement eMedNY application program interfaces (APIs)" to respond to patient-level transactional inquiries. Why do we need to implement eMedNY APIs if we are communicating via the Continuity of Care Document (CCD)?

A5. The implementation of the eMedNY APIs are required to access and then share the CCD medication and visit data from the eMedNY system.

Q6. Since Quality Reporting For Outcomes (QRO) is listed as a clinical investment priority for both Categories I (SHIN-NY) and II (CIS), can a RHIO that is applying in Categories I and II demonstrate the same clinical investment priority (use case) in both categories? i.e., has NYS considered that a single entity may reasonably demonstrate the QRO priority/use case from the two different, but complementary, perspectives of interoperability (SHIN-NY) and community aggregation/reporting (CIS) with an almost mutually exclusive set of measures?

A6. No, a RHIO that is applying in Categories I and II can't demonstrate the same clinical investment priority in both categories. The SHIN-NY and CIS are required to achieve the goals of the Quality Reporting for Outcomes use case separately and distinctly without overlapping funding sources or expenditures, and each project must be independently viable

Q7. With regard to the interoperable EHR use case, are the use case requirements satisfied if a project takes data from an entity that is using an interoperable EHR and transmits it to one that is not using an interoperable EHR (or vice versa)? Any clarification with regard to this use case would also be helpful, as it is rather vague in its requirements and expectations.

A7. No. It is required that all components in the health information exchange process be interoperable. Full interoperability is a requirement to be a participant in any of the projects.

Q8. Would a standardized electronic approach to aggregating and presenting clinical information to improve coordination of care qualify as an eligible activity under the Clinical Decision Support in an HIE Environment use case? (sec. 2.3.2)

A8. No. Clinical Decision Support in a HIE Environment should include analytics to support quality interventions and disease management.

Q9. Does the Clinical Decision support in an HIE Environment use case approach to Clinical Informatics Services also need to include a 'measurement and reporting on physician quality' component or is that related to the Quality Reporting for Outcomes use case?

A9. No, it is related to the Quality Reporting for Outcomes.

Technical

Q1. Our project will seek to promote the advancement of interoperability and community wide EHR adoption. In keeping with the Governor's *People First Coordinated Care* initiative goals, we will seek to build an IT system which will be able to share data between behavioral health and primary care providers. Behavioral Health EHRs are different than primary care EHR products, and as of now, CCHIT is not certifying these products. If we can demonstrate that the behavioral health EHR solution we eventually identify, can be made to be interoperable with CCHIT certified soft ware will that be acceptable? If not, is there another acceptable solution which will allow for the incorporation of mental health, substance abuse, and developmental disabilities providers?

A1. For projects that will use products not currently being certified by CCHIT, please demonstrate how the proposed product will be made to become interoperable, with CCHIT Certification within six months of the certification becoming available. Also, applicant should note Clarification 6.

Q2. What year CCHIT certification must a vendor have in order to be named in the response?

A2. See clarification 6.

Q3. In 7.3.8, what is the difference between regional process and community process?

A3. There is no difference.

Q4. In 7.3.23 what does the word independent mean? Does it mean a person designated within your organization to handle just that role, or does it mean contracting an outside agency independent of the RHIO?

A4. The independent security officer should function as a separate authority or office with independent review and approval process over a health IT security software provider. The security officer can either be a part of the RHIO or a health information service provider, if the health information service provider is an independent integrator, not a software vendor.

Q5. In 7.3.21 -Do you want 3 references from each health information service provider, or do you want three total references of all the service providers.

A5. Three references from each health information service provider will be required.

Q6. Section 3.1.1 mentions that a RHIO cannot develop software. A RHIO will obviously need to configure or customize vendor offerings, however, to what extent can a RHIO develop its own software modules to enhance the vendor-based solutions it is offering?

A6. The intent of this requirement is to make clear that RHIOs are not technology organizations and do not develop software or provide technical integration services. For purposes of software development, configuration, customization, enhancement, etc, the expectation is that the RHIO will partner with a HIS provider.

Q7. Also, can those builds to the software be sold as intellectual property of the RHIO within the confines of the definition of the RHIO?

A7. No.

Q8. Does the Intellectual Property clause in the standard contract apply to matching funds?

A8. Yes.

Q9 Section 7.3.23: Do you have a designated and independent information security officer and security plan?: Is a security officer and designated security plan specific to the grant project required, or can one of the CHITA participants incorporate information security oversight into their overarching HIPAA plan?

A9. This is up to the discretion of the applicant.

Q10. Section 5.2.1.4: Patient Engagement Service for CHITA applicants: A description of the Process to involve New Yorkers in project activities: What specifically are the requirements to meet the criteria? For Category III applicants, is demonstration of interoperability of EHR for participating physician practices sufficient? If not, what other criteria should be utilized?

A10. This is up to the discretion of the applicant. The clinical plan requirement in section 5.2.3.3 is one way to think about how to engage New Yorkers.

Q11. Section 5.2.1.12: Privacy and security for CHITA applicants: Implementation privacy and security policies including compliance with HIPAA and a breach response plan: Does a breach response plan need to be specified as part of the grant application?

A11. No, a complete plan does not need to be included as part of the application, but an understanding of the components and implementation process should be discussed.

Q12. Defined Care Coordination Zones (Section 2.3.3 Category III and section 3.2.2.2) for CHITAs: The RGA states that the applicant defines the care coordination zone as part of their grant application. It varies by overall population size represented, number of ambulatory care clinicians…. "There are no restrictions on the definition/size of a care coordination zone other than the project requirements to involve specific type of participants"

Does this mean that a Care Coordination zone can overlap multiple regions of the state? Can one CHITA application for category III, implementation of Community-wide e-HR's be submitted that covers participants in multiple regions?

A12. Yes, as long as the scope of work for the grant category is demonstrated (Section 2.3.3) and the applicant requirements satisfied (Section 3.2)

Q13. Would a CHITA comprised of post-acute organizations, health plans, and ambulatory care clinicians interested in undertaking the Pilot Implementation of ***common*** Community-wide Interoperable EHRs qualify for Category III, understanding that they would support several different Care Coordination Zones? (sec. 2.3.3)

A13. Yes, as long as the scope of work for the grant category is demonstrated (Section 2.3.3) and the applicant requirements satisfied (Section 3.2)

Q14. For a CHITA comprised of post-acute organizations, health plans, and ambulatory care clinicians interested in undertaking the Pilot Implementation of Community-wide Interoperable EHRs, can we assume that 'point of care' includes both the ambulatory setting as well as inpatient nursing home and home care settings? (sec. 2.3.3)

A14. Yes, for the purposes of defining a CHITA. With respect to Category III, however, the scope of work is implementing and achieving significant adoption of certified, interoperable EHRs for ambulatory care clinicians in a defined care coordination zone. As defined by the care coordination zone, this would require interfaces between the ambulatory EHRs and clinically affiliated provider systems to ensure effective EHR adoption and use.

Q15. As part of their grant applications, may RHIOs and/or CHITAs propose demonstrating HIE core services for patient identity and demographics reconciliation using open standards-based methods that rely on administrative transactions between providers and payers using the HIPAA eligibility formats (X12 270/271); or is the expectation that reconciliation of patient identity and demographics be proposed only using provider sourced data and clinical HIE standards such as HL7?

A15. This is up to the discretion of the applicant. An important consideration with respect to patient identification as a core HIE service is the use of common standards statewide. A discussion of any implications of using the HIPAA eligibility formats versus HL7 should be discussed in the application. In the question, RHIOs and/or CHITAs is included, CHITAs are not eligible to respond to grant category I involving the core HIE services as part of SHIN-NY.

Q16. If an applicant has a project in category II under a clinical decision support use case, would a CHITA applicant need to exchange data with a RHIO, or could the data be exchanged with another CHITA?

A16. Yes, with a RHIO. CHITAs are not eligible to implement the SHIN-NY. The SHIN-NY is the network of networks for health information exchange across New York.

Contracting

Q1. What is the financial exposure of the lead applicant – for instance a small group physician's office- in the event that one ore more of the CHITA participants retire, go out of business, or otherwise terminate participation in the CHITA during the grant period? (Section 5.2.6)

A1. The lead applicant will be the entity under contract with DOH and will have full responsibility for the project. The lead applicant may enter into whatever contracts with project stakeholders that they deem appropriate however, DOH reserves the right to require its approval of any major subcontracts.

Q2. If an organization supplied a VRQ for HEAL Phase 1 are they required to submit another VRQ for HEAL 5.

A2. Yes. Applicants are also encouraged to submit their VRQ through OSC's new online Vendor Responsibility system, http://nysosc3.osc.state.ny.us/vendrep/systeminit.htm .

Q3. What entities are required to submit a VRQ besides the applicant?

A3. VRQs are required from any entity who will receive over $100,000 in grant funds.

Q4. What is schedule of payments over the 2 year award (quarterly, annually, etc)?

A4. Applicants are required to voucher on a quarterly schedule. Payments will be made upon DOH review and approval of submitted voucher. 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.

Q5. Though it is recognized that an extension or renewal may not be available at the end of the 2-year commitment, if a renewal or extension is awarded, what is the potential level of funding?

A5. If a renewal or extension were to be awarded, there would be no additional funding included. The renewal/extension would be only for additional time to complete the project.

Eligible Applicant

Q1. CHITA as lead applicant (Section 3.2.1.1): Does a consortium applying to be the lead applicant in a CHITA have to be legally constituted as of the date of the grant application or can it be legally constituted as of the date of grant award?

A1. It needs to be a legally constituted organization, capable of entering into a binding contract, at the time of application.

Q2. Additionally, specify the type of legally constituted organization that is acceptable for a consortium as the lead applicant, for example: LLC, 501 C.

A2. With respect to a lead applicant consortium for a CHITA, it's up to the applicant.

Q3. I have heard that to be eligible for a HEAL5, an applicant needs to either be a HIE or a provider. Could a quality alliance, i.e. an entity that is trying to create an infrastructure for physician performance measurement and reporting (using claims, EHR-reported data, patient survey data, etc) be eligible, and if so, would this be as an HIE?

A3. It would be as a RHIO, as defined in Section 3.1. If the quality alliance meets the criteria of a RHIO, as defined in Section 3.1, then it could apply. Alternatively, a quality alliance could work with a RHIO to demonstrate grant category II. If the quality alliance meets the criteria of a CHITA, as defined in Section 3.2, then it could apply.

Q4. Section 3.2.1: CHITAs do not have to be separate not-for-profit organizations, but rather smaller and looser collaborations of clinician and provider participants….: Is there a minimum number of providers/agencies required to make up a valid CHITA?

A4. No, but the emphasis should be on the number of providers/clinicians required to improve care coordination and effective adoption and use of health IT. Refer to Section 3.2.

Q5. Section 3.2.2.1: 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 the local RHIO.

Q5A: Can an agency-member of the CHITA be named as the designated project leader, or is an individual required?

A5A. We don't understand what an "agency-member" is. An individual dedicated to the project with appropriate experience and qualifications should be designated as part of the grant application.

Q5B: Are all members of the CHITA steering committee required to be named, or is demonstration of involvement from multiple participants meeting qualification as CHITA members sufficient? Can formation of the steering committee be in-process at the time of application, or does a formal steering committee list need to be provided as part of the application process?

A5B. The formal steering committee list should be named and included as part of the application.

Q5C: What are the requirements to document the formal creation of a CHITA?

A5C. Nothing more than what is required in Section 3.2.

Q6. Section 3.2.2.2: 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….

Q6A: What are the specific requirements for defining the care coordination zone for the application process? If the applicant provides a description of local and extended service area and provides high level information regarding the number and scale of physician practices in the service area and general population data, is this sufficient? Is a detailed listing of physician practices participating in the Category III grant required? If so, is a signed agreement required at time of submitting the grant application?

A6A. The physician practices and other stakeholders participating in the grant should be identified and listed.

Q6B: How will sufficient scale be measured?

A6B. It will be measured based on the participants and the defined care coordination zone (Section 3.2.2.2).

Q7. Section 3.2.2.3: A description of the services provided by CHITAs for health IT adoption and support is required, including, but not limited to: readiness assessments, workflow re-design, project management, vendor selection, user support, and process and quality improvement. Is a high-level description of the process and methods sufficient, or are copies of readiness assessments, project management plans, etc. required?

A7. This is up to the discretion of the applicant.

Q8. Section 3.2.2.4: The organization plan will be further evaluated based on signed letters of commitment of all CHITA participants and the participation of multiple insurers to support health IT adoption and effective use through letters of commitment. Is a letter of commitment required from all CHITA members before they can be included in the CHITA for grant application purposes (i.e. can the letters of commitment be in-process at the time of the grant

application) or are CHITA members to be described as part of the grant and considered inclusive? Is a copy of a signed letter of commitment from all CHITA participants required to be submitted in the grant application?

A8. Yes, signed letters of commitment from all CHITA participants is required as part of the grant application.

Q9. Grant funds for ambulatory physician office-based E-HR implementations (Section 2.3.3): The RGA requires that a majority of grant funds for EHR implementation be allocated to office-based implementations in solo and small physician practices. Please confirm that, as noted in the bidder's conference, that FQHCs would qualify as small physician practices for this purpose.

A9. Yes

Q10. Participants in a CHITA (section 3.2.2.1): Must a CHITA include different types of providers (e.g. primary care, specialty care, acute care, lab, pharmacy) or can it be limited to primary care providers?

A10. A CHITA should consist of a lead applicant (types found in Section 3.2.1.1 a-g), and, at a minimum, ambulatory care clinicians as discussed in Section 3.2.2.1. The participants should be clinically affiliated entities involved in the care coordination process.

Q11. According to the RGA, a "legally constituted consortium of community health centers" can serve as a lead applicant. Could a legally constituted consortium of post-acute providers also serve as a lead applicant?

A11. Yes, if the membership of the consortium is made up of the kinds of providers listed in 3.2.1.1.f.

Q12. Are organizations which have received HEAL funding in one of the previous phases eligible for funding in this phase?

A12. Yes, as long as they meet the Eligible Applicant criteria in section 3.

Q13a. Does an applicant have to be a NYS not-for-profit corporation at the time of submission of the grant application?
Q13b. If an applicant is in the process of forming their not-For-Profit would they qualify as an eligible applicant as long as the applicant is an approved NYS Not-For-Profit by the time the GDA is executed?

A13a. For purposes of clarification, it should be noted that the requirement for incorporation as a NYS Not-For-Profit corporation pertains to RHIO applicants (or a consortium of participants applying as a CHITA) only and does not apply to CHITA applications. An applicant who has not yet achieved NYS Not-For-Profit Corporation status would be required to include evidence of their application for incorporation under the NYS Not-For-Profit Corporation Law as part of their application.

A13b. Yes, however, the applicant must provide evidence of formation of the Not-For-Profit immediately upon notification of an award. Failure to achieve Not-For-Profit Corporation status by the time of the GDA will be grounds for automatic rescission of the award.

Q14. We are a healthcare IT organization aimed at nationally enhancing the clinical care that physicians provide to their patients. We practice interoperability of healthcare IT to promote the secure exchange of healthcare information for patients and all their healthcare providers. We are

not a RHIO, but a team of physicians and IT specialists with the goal to create an online health forum where any patient can share their information with any physician or hospital they choose. We are planning to set up a separate RHIO type structure/project, but do not have one set up currently as of this correspondence.

Are we eligible to participate in Heal NY Phase 5 in either of the following 2 Technical Frameworks: SHIN-NY and/or Information Tools (3C's)? Furthermore, are we eligible to participate in either Category I or III in any regard?

A14. Based on the description provided, it does not sound like the entity would qualify as an eligible applicant, or a defined stakeholder (as defined in section 3.1 and 3.2), but this would not preclude the entity from participating in a project in an alternate capacity.

Q15. We are incorporated pursuant to Section 402 of the New York State Not-For-Profit Corporation Law, and organized as a management services organization to provide centralized management and administrative services, as well a "Practice Plan" for the management of clinical practice income governing the faculty of a Medical School.

The Practice Plan consists of eighteen (18) practice corporations (the Corporations), which are organized exclusively for the purposes of supporting the educational mission of the Medical School by providing clinical instruction and supervision of students, interns and residents and, incident thereto, rendering professional medical services.

We are currently engaged in assisting our practice corporations toward consolidating their functions in order to achieve operating efficiencies and high quality multidisciplinary health care services. Our assistance includes the development of a common health IT system, including EHRs, that will be interoperable among the Corporations.

Given the above, is our organization eligible to serve as the lead applicant on behalf of the Corporations for the Heal NY Phase 5 IT grant, pursuant to Section 3.2.1.1 of the RGA?

A15. No, based on the information provided, it does not appear that the entity can serve as the lead applicant, but could function as a participant in the project.

Miscellaneous

Q1. In Section 6.6.6, Rights Reserved, the RGA states "Eliminate the detail specifications should an insufficient number of applications be received that meet all these requirements." Please clarify this statement.

A1. The intent of this Reserved Right is simply to allow DOH to eliminate mandatory requirements in the event that the requirements are met by too few applicants, and it is determined that elimination of the requirement would allow for additional awards without negatively impacting the grant program.

Q2. Is it the expectation that applications from CHITAs will only come from areas of the State that are not currently covered by RHIOs?

A2. No.

Q3. Is it the expectation that CHITAs will evolve into RHIOs at some future point?

A3. No.

Scope of Work

Q1. The descriptions of Categories I and III in the RGA include direct, clear statements about the scope of work for the category, but there is no statement of scope of work for Category II (section 2.3.2, pg. 16). Please define the scope of work for Category II.

A1. The scope of work for category II will be dependent upon the use case that is selected. Options are:

(1) Quality Reporting for Outcomes which includes developing and implementing methodologies of utilizing primarily clinical data to aggregate, analyze, measure and report data in a valid fashion for various uses, including quality and population health reporting. To ultimately develop the HIT capacity to calculate the complete measurement sets from the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS).

(2) Clinical Decision Support in a HIE Environment which includes providing and operationalizing 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.

Evaluation Process

Q1. Please define "appropriate staff" to support the evaluation process (section 5.1.4.2, pg.25), e.g., clerical, mid-level, senior management, etc. It is difficult to budget for this without understanding the role this staff will play vis-à-vis the outside evaluator and the RHIO.

A1. The role of this staff will be to be the liason between the 3rd party evaluation team and the RHIO stakeholders to support the study design and data collection for the evaluation process.