

HEAL NY – Phase 10
Question and Answers Set #4 (as of May 11, 2009)

In an effort to expedite answers to submitted questions, this Questions and Answers document is the first of several Q&A postings to the Department's website for RGA # 0903160302. It is recommended that potential applicants continue to monitor the Department of Health's website for future posting(s).

CLARIFICATIONS

- Throughout the Question and Answer process many similar questions have been received. The purpose of the Question and Answer documents are to address concepts in the RGA, and may not directly respond to each individual question. As such, many similar questions have been combined and answered generically.
- Table (f), Attachment 6.3 "Region" should be interpreted as "CCZ".
- Due to funding restrictions associated with the Federal State Health Reform Partnership (F-SHRP) program the deadline for the RGA cannot be extended.
- Attachment 6.3, Section III tables (a) – (c). Applicants should include Nurse Practitioners and Physician Assistants as clinicians/providers if they maintain their own independent panel of patients.

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ELIGIBLE APPLICANTS

Question	Response	See RGA	References for More Information
Do CHITA's only have to have PECs when they are serving as the lead applicant on a project? How does the PEC differ from the Steering Committee referenced in Section 4.1.4.2.2 ("Organizational Plan")?	All CHITAs must have a PEC, which is responsible for ensuring that clinical input is present in the project. The Steering Committee has overall project responsibilities.	<ul style="list-style-type: none"> – Section 3.2.1 – Section 3.3.5 	
Can an unincorporated rural health network qualify as a lead agency under the RGA? Would it qualify if it names a separate, incorporated entity that otherwise meets the requirements of a lead applicant to serve as a fiscal intermediary?	Eligible applicants must be a legal entity and meet the requirements specified in the RGA.	<ul style="list-style-type: none"> – Section 3.2 	
Can a rural health network apply that includes three communities spread across four rural counties qualify as a CCZ, if it focuses on a targeted diagnosis as defined in the RGA, incorporates all providers integral to the care of patients with the diagnosis, and otherwise complies with the requirements of the RGA?	CCZs should be based on referral patterns for the target patient population and participants required for the coordination of care and not geography.	<ul style="list-style-type: none"> – Section 3.3.2 	
Are there organizational criteria for defining a CHITA lead applicant, beyond the types of organizations eligible and services it is required to coordinate? Specifically, what determines if an organization is a "health IT adoption and services organization"? E.g., should this be in the organization's mission statement? Must they currently be coordinating these services, or do they just need to have the capability? Attachments 6.1, p. 25 and RGA 3.2.1 and 3.3.5.	See RGA for the definition of a CHITA.	CHITA <ul style="list-style-type: none"> – Section 3.2.1, p. 15 and 17 – Section 3.3.5, p. 26 and 27 – Attachment 6.2 	

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Question	Response	See RGA	References for More Information
<p>Could a stakeholder in a PCMH apply on behalf of itself and other PCMH projects, for which a CHITA will be formed? Q&A Set 2, page 1; seeking clarification on whether this applies to all lead applicants.</p>	<p>A stakeholder may apply if they meet the criteria of a lead applicant as articulated in the RGA. The proposal must also include provision of CHITA services.</p>	<ul style="list-style-type: none"> – Section 3.2 – Section 3.3.5 – Attachment 6.2 	
<p>Would DOH clarify the “active participation” requirement? For example, if an applicant is listed in the table (e.g., general hospital caring for a significant proportion of target patient population with the chronic disease chosen for the project) and has recently become involved with a RHIO, does the applicant qualify as a lead applicant? Or does HEAL 10 require an applicant’s past involvement under HEAL 5, for example?</p>	<p>“Active participation” refers to the level of involvement that stakeholders have in the various activities, committees, functions including decision making of the RHIO.</p> <p>Past involvement in HEAL 5 is not considered in the evaluation of HEAL 10.</p>		
<p>If an organization has multiple potential stakeholders (applicants), ie, hospital, payer, CHHA, LTC facility, etc. and are either part of the same overall entity or a subsidiary with a different EIN number, can they file multiple grant applications to the State for Heal 10. The CHITA and RHIO would be the same but the stakeholder, patient base and possibly physicians would be unique for each application. Please clarify the relationships of each of the entities that can or can not apply with multiple submissions.</p>	<p>There are two categories of participants, Lead Applicant and Stakeholder(s). See the RGA for associated definitions.</p> <p>An entity may be a lead applicant or stakeholder in more than one region, but may not be the lead applicant for more than one application in the same region.</p>	<p>Section 3.2</p>	
<p>The RGA appears to focus on adult populations. Would a proposal that focuses on a pediatric population be likely to receive funding?</p>	<p>Diagnostic choices are not restricted to a particular age group.</p>		
<p>If a CHITA is in one region and is the applicant and the patients and physicians are in another region, which region is the primary region for the submission?</p>	<p>The region should be selected based on the location of a majority of the target patient population.</p>		

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<p>Included clinicians and providers, which are clinically affiliated for the purposes of care coordination, but not a part of the same corporate structure.</p> <p>We are a primary care practice. It is part of a Department of Pediatrics of a Medical Faculty Practice Group within a University. We would like to use this primary care practice as the pilot site in our HEAL NY proposal.</p> <p>Please confirm if we will be eligible.</p>	<p>Applicants must meet all the requirements in the RGA for lead applicant to apply as such.</p>	<p>Section 3.2.1</p>	
<p>CHITAs (Section 3.3.5) If there is no CHITA serving the proposed CCZ, the RGA states that the proposed project may form a CHITA with whom they will work. Question: If the lead applicant is an eligible PCMH Stakeholder and legal entity and also proposes to form a CHITA, may the start-up CHITA be organized initially under the auspices of the lead applicant and not have a separate legal existence?</p>	<p>CHITAs are not required to be legally incorporated. If they are the lead applicant they must meet all requirements in the RGA including the ability to legally contract with the state in order to receive funds.</p> <p>The proposal must also include provision of CHITA services.</p>	<p>CHITA</p> <ul style="list-style-type: none"> – Section 3.2.1, p. 15 and 17 – Section 3.3.5, p. 26 and 27 – Attachment 6.2 	
<p>What entities are eligible to apply for the HEAL NY Phase 10 RGA?</p> <p>Can non-profits apply?</p>	<p>Refer to the RGA for examples of eligible entities.</p> <p>Non-profits can apply.</p>	<p>Section 3.2</p>	
<p>Can a sub-acute pediatric rehabilitation facility serve as a lead applicant?</p>	<p>Refer to the RGA for examples of eligible entities.</p>	<p>Section 3.2</p>	

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Question	Response	See RGA	References for More Information
Can a Lead Applicant also be a Stakeholder in another application?	Yes		
Are for-profit, private sector companies eligible to receive funding?	Eligible applicants and grant recipients may be for-profit or not-for-profit, but must fall within the requirements stipulated in Section 3.2. In addition, it is likely that the eventual grant recipients will contract with vendors and others to work with them in utilizing the funds to accomplish the goals of their projects.	Section 3.2	
Are 'Article 28 Clinics' eligible for HEAL 10 Grants?	Yes	Section 3.2	
If an applicant to become a CHITA is denied a HEAL NY 10 award, do all the awards of affiliated PCMH applicants become null and void?	HEAL 10 is not an application process for becoming a CHITA.		
Must a for-profit vendor that offers CHITA-like services apply for a HEAL NY 10 grant to be recognized as a CHITA for purposes of this grant application?	Services may be provided by for-profit or not-for-profit organizations or vendors. To be considered a CHITA, requirements in the RGA must be met.	CHITA – Section 3.2.1, p. 15 and 17 – Section 3.3.5, p. 26 and 27 – Attachment 6.2	

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Question	Response	See RGA	References for More Information
<p>What evidence must a project provide to establish Eligible Applicant Financial Stability as described in Section 8.2, 8.2.1?</p>	<p>It is incumbent upon the applicant to provide supporting documentation to demonstrate the financial stability of the proposed project.</p>	<p>Section 8.2</p>	
<p>If the Lead Stakeholder is an integrated delivery system and it is proposing that only several of its ambulatory care sites are going to be considered as a PCMH for the purposes of the application, how should that be reflected on the Project Stakeholders table?</p>	<p>Applicants should include all components of the delivery system that will be included in the project and identify their roles and responsibilities in the Stakeholder Template. It should be noted that only the listed stakeholders that meet RGA requirements are eligible for HEAL 10 funding.</p>	<p>Section 3.2</p>	

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STAKEHOLDERS/PARTICIPANTS

Question	Response	See RGA	References for More Information
<p>Please clarify whether the physician figures requested under the Stakeholder Template (6.3, III a-c) should represent full-time equivalents or individual physicians. The Stakeholder Template (Attachment 6.3, III. c) requests aggregate payer mix for physicians participating in the project including breakouts of “Percentage of patients with Medicaid,” “Percentage of patients with Medicare” and “Percentage of Patients with Other Payers” and indicates that this information should sum to 100%. How should individuals covered by two different types of insurance, e.g. for instance Medicaid and Medicare or Medicaid and another payer, be captured?</p>	<p>The tables refer to the number of physicians/clinicians rather than an FTE.</p> <p>Decisions on insurance coverage should be made based on the patient’s primary coverage.</p>	<p>Attachment 6.3</p>	
<p>For the purposes of the RGA, is it allowable for the same organization to serve as both the CHITA and the RHIO on the project?</p>	<p>Yes</p>		

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For the purpose of filling out the “Project Stakeholders” chart in the Stakeholder Template at Attachment 6.3 found on page 41, would an Article 28 clinic be considered one stakeholder or would the applicant have to list (and obtain a letter of support) from each physician, nurse or other caregiver in the clinic?	Each individual clinic is considered a unique stakeholder and must have a letter of support (irrespective of Article 28 status).	Attachment 6.3	
May an applicant include primary care physicians and psychiatrists in a PCMH to treat chronic mental disorder while assigning other specialists (e.g. endocrinologists and others) simply to be part of the CCZ (e.g. to be the “consultant physicians” as shown in the picture on page 10 of the RGA)?	Yes	Section 3.2.2	
On page 33 of the RGA it appears that the RGA draws a distinction between organizations/institutions and individual providers for the 50% stakeholder participation requirement. Does the RGA require that 50% of organizational and institutional stakeholders be included in the PCMH, or that 50% of individual caregiver stakeholders be included in the PCMH, or both?	Both, 50% is considered the minimum. The preferred participation level is >70%.	Section 3.5	
Is it acceptable to have a PCMH consist of only primary care, hospital providers and specialists? Must long term care providers, laboratories and other stakeholders be included?	All appropriate stakeholders involved in the care of the target patient population must be included.	Section 3.3.3	

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Should all organizational/institutional providers be given equal weight in the 50% provider participation calculation? I.e., should a hospital, a lab, and a small primary care practice be treated as equal in meeting the 50% provider participation threshold? If not, how should weights be apportioned when calculating whether the 50% threshold for provider participation has been met?	There is no weighting of stakeholder participation.		
Do all of the categories of stakeholder providers listed in the chart on page 17-18 of the RGA have to be included in the 50% provider participation calculation, assuming that they are applicable to the target population as defined?	Yes, all appropriate stakeholders involved in the care of the target patient population must be included.	Section 3.3.3	
Can a project include all of the Primary Care providers who serve this target population even though they are not in the same physical location and/or are under multiple organizations?	The CCZ is not based on geography, but care of the target patient population.	Section 3.3.1	
Certain providers are integral in supporting patients with the identified diagnosis however other specialty or ancillary providers may be involved in the patients' care, though not for the purposes of the specified diagnosis. Is representation from all of these providers expected (of different stakeholder types) expected? Will applications without provider representation from all stakeholder types be viewed unfavorably?	For the purposes of the HEAL 10 RGA only the stakeholders involved in the specified diagnosis must be included.	Section 3.3.3	

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<p>Are all PCMH providers considered stakeholders?</p> <p>Can organizations (such as community based organizations) be identified as willing “collaborators” who are not stakeholders?</p>	<p>All PCMH providers that are providing care to the target patient population and are relevant to the project are considered stakeholders.</p> <p>Projects are encouraged to include any and all resources that will contribute to the care of the target patient population and goals of the project.</p>	Section 3.3.3	
<p>Is each physician practice or ambulatory care site to be listed on the table or should the information be aggregated for all practices and sites? Alternatively, should Table (a) be completed for each Stakeholder within a PCMH? (e.g. If there is a Lead Stakeholder with multiple PCMH sites, plus several other Stakeholders with PCMHs, how should Table a be completed?</p>	Section III, table (a) does not require information at the individual physician level, but aggregate numbers for the project.	Attachment 6.3, table (a)	
<p>Does the information about the number of insurers in the Region sought in this table include all insurers licensed to provider coverage or only those with a contract to cover Medicaid beneficiaries?</p>	All insurers	Attachment 6.3, table (f)	
<p>On Attachment 6.3: III.f. - Please provide a definition for "participating" insurer. Is it an insurer whose patients are in the PCMH; an insurer participating in reimbursement reform to support health IT adoption in the PCMH; or other?</p>	A participating insurer is one involved in the application that provides an alternative or new form of PCMH reimbursement.	Attachment 6.3, table (f)	
<p>If a payer is included as a stakeholder, do they have to be an active participant in a RHIO's governance structure? (See response to the second question under Stakeholders/Participants in Questions and Answers Set #3)</p>	<p>All stakeholders are required to participate in the sharing of pertinent/available RHIO data, as it is relevant to the care of the target patient population.</p> <p>Only lead applicants are required to be active participants in a RHIO's governance structure.</p>		

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<p>Could a payer be a stakeholder if they are not able to share RHIO data? (Payers sometimes contribute data to a RHIO but do not have access to the all of the RHIO's data.) (See response to the second question under Stakeholders/Participants in Questions and Answers Set #3)</p>	<p>Data suppliers to a RHIO are considered to be sharing data. All stakeholders are required to participate in the sharing of pertinent/available RHIO data, as it is relevant to the care of the target patient population.</p>		
<p>The response to the fifth question under Stakeholders/Participants in Questions and Answers Set #3 allows for a stakeholder be designated as an "advisor" or "participant". Would these types of organizations also have to be "active participants in a RHIO's governance structure"?</p>	<p>Only lead applicants are required to be active participants in a RHIO's governance structure.</p>		
<p>On Attachment 6.3: III.e. Is it assumed that the hospitals and long term care providers to whom applicants refer patients will provide data on discharges filtered by diagnosis and by PCPs participating in the PCMH?</p>	<p>Successful projects will include clinical data from all providers in the PCMH.</p> <p>Table (e) requires aggregate data for the project, rather than data on a specific stakeholder.</p>	<p>Attachment 6.3, table (e)</p>	
<p>On Attachment 6.3: Section III tables a. - c. - Are these sections only to be completed for physicians in solo and small practices? Are the physicians who practice in community health centers/FQHCs not included in III.a.- c.?</p>	<p>Table (a) includes <u>all</u> physicians and a breakdown of small/solo practice participants.</p> <p>Table (b) uses the information in Table (a) and stratifies based on Medicaid participation.</p> <p>Table (c) uses the information in Table (a) and stratifies based on payer.</p>	<p>Attachment 6.3, tables (a)-(c)</p>	
<p>Attachment 6.3., Section I: Is the Lead Stakeholder requested on Line 1 of the Project Stakeholders Grid be the same as the Lead Applicant? If not, what is the difference between the Lead Stakeholder and the Lead Applicant?</p>	<p>Yes</p>	<p>Attachment 6.3, Section I</p>	

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Attachment 6.3., Section III Table d: What is the difference between the information sought in the two cells? Why would you include a PCMH that was not participating? Can't an integrated delivery system that includes multiple FQHCs define its PCMH to include only those FQHCs participating in the HEAL 10 application as being in the PCMH?	If all of the health centers in the CCZ are participating, the numbers will be the same.	Attachment 6.3, table (d)	
Is a survey a sufficient way to identify stakeholders that work with a primary care provider?	It is incumbent upon the applicant to identify the most appropriate method for identifying the most appropriate stakeholders for the project.		
Can a stakeholder organization apply on behalf of its affiliated providers?	Only lead applicants listed in the RGA are eligible to apply.	Section 3.2	
Is an e-signature acceptable for LOS?	Yes		
Since the number of patients in the CCZ will not be defined until after Letters of Support are collected, can the "total number of patients with the specified diagnosis covered by the stake holder" stand alone in the Letter of Support, until the CCZ has been defined?	The CCZ is defined by all relevant stakeholders and is not limited by participation.	Section 3.3.1	

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<p>Preliminary analysis of our health system shows that less than 20% of our 4,700+ credentialed physicians are associated with more than 80% of our discharges. Must we still involve 70%+ of their providers if only a minority of our credentialed physicians are responsible for most admissions of the selected disease entities?</p>	<p>The CCZ is defined by all stakeholders relevant to the care of the target patient population.</p>	<p>Section 3.3.1</p>	
<p>On pg. 20 of the RGA, the application requests that we ideally include “70 percent of the appropriate providers and care givers”. We would like clarification of the parameters for defining the denominator for that 70 percent. An example for how to calculate the 70% would be especially helpful.</p>	<p>The denominator is the total number of providers and caregivers caring for the targeted patient population in the CCZ. The numerator is the number of providers and care givers participating in the project who are taking care of the target patient population.</p>		
<p>Is there another category of participant for providers such as small physician practices who may have access to RHIO data but not be "active participants in a RHIO's governance structure" (See response to the second question under Stakeholders/Participants in Questions and Answers Set #3)</p>	<p>There are two categories of participants, Lead Applicant and Stakeholder(s). Only lead applicants are required to be active participants in a RHIO's governance structure.</p>	<p>Section 3.2</p>	

HEAL NY – Phase 10
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FINANCIAL

Question	Response	See RGA	References for More Information
Can the "matching" funds be funds that are spent in support of the EHR or CHITA implementation anytime in 2009 2010 2011 or only during the actual grant implementation period?	Matching funds for appropriate project expenditures can be counted April 1 st 2009 through the end of the contract term.	Attachment 6.10	
Can enhanced payments from insurance companies to participating providers for implementation and compliance with medical home standards and reporting requirements qualify as matching funds for the purposes of the HEAL 10 Grant? Does it matter if the insurance company is a Medicaid Managed Care provider and the funds come from their capitated payments under the Medicaid Managed Care program? Does it matter if payments are made directly by the state as a payment under Medicaid fee for service?	Any source of revenue, except New York State funds, may be considered matching funds, if expended according to the guidelines in the RGA for allowable costs and fundamentally related to the project.	Attachment 6.10	
The second set of Q&A states on page 3, "...funds may not be counted toward the match for projects, or components of projects funded by other sources (i.e. grants, contracts, etc.)" If an applicant has raised funds through grants or contracts to fund components of the proposed PCMH project that are integral to the RGA proposal, can these funds count toward the match?	New York State will not fund, or allow matching funds to be counted toward a duplicative project.		
The RGA may not provide sufficient resources to fund EHRs all PCMH provider participants. Is it acceptable to direct EHR resources to primary care providers and provide other health information exchange capabilities to specialists?	Yes, it is the responsibility of the applicant to propose the most appropriate expenditure of HEAL 10 funds.		
My question concerns the allowable use of Heal 10 funds. Specifically, can a portion of Heal 10 funds be used to increase physician reimbursements for the services they provide under the grant? If so, are there any limits to this allocation?	No, HEAL 10 funds should focus on providing tools to primary care providers as part of the PCMH as well as to those specialists and providers delivering services most directly relevant to the targeted patient population.		

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FINANCIAL

Question	Response	See RGA	References for More Information
<p>Payment and Reporting Requirements. Sections 5.8.2 , 5.8.4 and 8.2.3. The subsections states that the voucher must include eligible expenses “actually incurred by the Grantee.” Question: Is the “Grantee” limited to the lead applicant so that only the expenses of the lead applicant are reimbursable? Specifically, must the lead applicant purchase or otherwise incur all the eligible, reimbursable project expenses for all stakeholders (e.g., information portals) as suggested in Section 8.2.3, or may eligible expenses of a stakeholder be “passed through” the lead applicant for DOH reimbursement?</p>	<p>The lead applicant will be responsible for submitting vouchers and reimbursing costs on behalf of all project participants (including appropriate stakeholders, vendors/suppliers, etc...).</p>	<p>Section 3.2</p>	
<p>Is it acceptable to finance the required 50 percent match and have the depreciation and interest cost recognized as reimbursable expenses through the filing of a CON application?</p>	<p>All project costs must be directly related to improving the care of the target patient population.</p>		
<p>Our Physician Organization is already working to develop a disease registry/portal HIE that will help us bridge the gap until the full exchange with the RHIO is up and running. Can this be used as a match?</p>	<p>Project costs must be directly related to the care of the target patient population specified as part of the project and also should be scalable and transferrable.</p> <p>Matching funds for appropriate project expenditures can be counted April 1st 2009 through the end of the contract term.</p>		
<p>Can matching funds include costs spent for items that would not be allowable in the funding request, such as administrative costs that exceed the allowable percentage?</p>	<p>All project funding must adhere to allowable costs requirements as specified in the RGA and be directly related to the care of the target patient population specified as part of the project.</p>		

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Question	Response	See RGA	References for More Information
The response to the second question under Financial in Questions and Answers Set #3 states, "Only resources that are wholly and exclusively dedicated to the execution of the project can be counted as in-kind." Would mean that a CIO who might otherwise spend time working with the SHIN-NY, the SCP and other state entities and officials as required by the RGA would not have his or her time counted as an in-kind contribution?	The portion of an employee's time "wholly and exclusively" dedicated to the project may be counted as an in-kind contribution.		
May a provider contribute to the match even if he/she/it does not receive grant funds?	Yes		
Section 4.1.8.1 (p. 37) of the RGA refers to a "Business/Reimbursement Plan". Is there any guidance regarding what should be included in this plan?	The Business/Reimbursement Plan should provide the complete plan and budget for the project. This should include, but not be limited to, the Sustainability Plan 3.3.8 and Reimbursement and Sustainability Programs and Measures.		
Section 8.2.1 (p. 95) refers to "Cost Effectiveness". Is there any guidance regarding what the application should include under this heading?	It is the applicant's responsibility to demonstrate the cost effectiveness of the project.		
Where in the Application should the Reimbursement Model Examples (Attach. 6.6) be referenced?	In the narrative component of the Financial Application.		

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Is it acceptable to create or use an internal tool (rather than buying) that will help provide better decision support than what is currently available on the market?	The applicant must demonstrate that the tools selected are the most appropriate, integral and necessary for improving the care of the target patient population. Technologies should be both scalable and transferrable to other similar care settings in order to be eligible for HEAL 10 reimbursement.		
Do capitalizable costs, under this grant program, include office staff and other implementation and development personnel that will be needed to manage this sizeable project?	See the allowable costs section of the RGA.	<ul style="list-style-type: none"> – Section 3.3.6 – Attachment 6.10 	
Given the current economic climate, would the state consider altering the amount of the required match (50%)?	No		
The RGA states that "All budgeted expenses and revenue sources should be accompanied by a written budget justification (maximum of 3 pages)." For the Revenue and Expense Projections Worksheet, does this mean that _each_ of the Revenue and Expense items can or should be accompanied by a written budget justification of up to 3 pages?	Applicants must justify the project budget in the appropriate manner.	Section 8.2.4	
Are stand alone practice management/billing software considered allowable costs?	The projects are required to show how the use of this software is necessary for the completion of the project.		

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Please clarify what <u>can</u> be counted for the match requirements? (from Q&A #2: "funds may not be counted towards the match for projects, or components of projects funded by other sources")	Payment for components of the project (previously or currently) funded by other sources may not be counted as match. For example, if an EHR was purchased with funds from a federal grant, those funds may not be counted as match for purchasing the same EHR for the same providers under HEAL 10 (ie. HEAL 10 funds can not be used to pay for something that has already been paid for by another source of revenue).		
The RFP specifies two different ways to structure and label the Financial Application, one on p. 95 (Section 8.2, 8.2.1) and one on p. 37 (Section 4.1.8). Which format do you prefer? How, for example, do the Reference Attachments (4.1.8.2) fit into the format defined on p. 95?	The items listed on page 95 are embedded in those listed on page 37.		
Would personnel required for patient outreach/follow-up and education costs to achieve coordination of care, per the chronic care model be allowable?	HEAL 10 funds may be used to pay for technology, or training and implementation support required for the use of technology (including personnel providing training and implementation support).		

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DEFINITIONS

Question	Response	See RGA	References for More Information
In section 3.3.2, the RGA notes that the applicant should provide "Detailed information with supporting data demonstrating that the target population chosen includes a significant portion of the population in the defined CCZ or is a population that is high risk in the CCZ". What percentage of the population is considered to be "significant"?	The project must provide sufficient supportive and convincing documentation.	Section 3.3.2	
Is there a minimum number of members of a target population that an applicant must exceed?	The size of the target patient population should be appropriate for meeting the requirements for a CCZ as specified in the RGA.	Section 3.3.2	
May an applicant select as its target population the patients with 'chronic mental disorder' who receive primary and/or mental health outpatient services at their Article 28 and /or Article 31 clinics, thus incorporating virtually all of the target population by virtue of its source of patients and construct the CCZ around that group of patients?	Applicants must select one of the specified mental disorders (schizophrenia, bipolar disorder, depression) or may choose another specific mental disorder and include supportive documentation as outlined in the RGA requirements.	Section 3.3.2	
What are the definitions of "caregiver," "provider," "stakeholder" and "participant" for purposes of the RGA?	Stakeholders/participants are defined in Section 3.2 of the RGA. Provider/caregivers/clinicians are physicians, NPs and PAs (if they maintain their own independent panel of patients).	Section 3.2	
If no hospital provider is available/willing to participate in the PCMH, is it acceptable to construct a CCZ without a hospital?	For a selected diagnosis applicants must have a minimum of 50% of the required stakeholders of any given type.	–	

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DEFINITIONS

Question	Response	See RGA	References for More Information
<p>The Medical Home Model described in the RGA calls for the practice to focus on one chronic disease. Current thought on Medical Home suggests that such a single focus can result in a net result in overall lower care quality. Would this grant allow the applicant to take the approach of the chronic care model where practices are trained to evaluate the complete clinical care needs of the patients?</p>	<p>The choice of a single diagnosis is not meant to alter the care pattern or clinical decisions for the target patient population, but is intended to define the specific scope of a HEAL 10 project. The expected outcome of the project is intended to benefit patients with multiple diagnoses across the continuum of care.</p>	<p>Section 3.3.3</p>	
<p>Can a CCZ be defined to include patients with a specific disease, covered by a specific set of payers, with patients having PCPs at a number of PCMH sites across different provider organizations?</p>	<p>CCZs should be defined per the guidelines in the RGA. It is the responsibility of the applicant to identify and describe an appropriate CCZ. Applicants should also identify appropriate resources for identifying the target patient population. Although the CCZ cannot be defined by coverage of a specific health plan, payer data can be used as contributing data if appropriate.</p>	<ul style="list-style-type: none"> – Section 3.1 – Section 3.3.1 – Section 3.3.2 – Attachment 6.3 	

HEAL NY – Phase 10
 Question and Answers Set #4 (as of May 11, 2009)

DEFINITIONS

Question	Response	See RGA	References for More Information
<p>Is the Region to be considered all of New York City, for example, or just the Region in which the CCZ exists, such as the Bronx?</p>	<p>There are six regions for the purposes of distribution of grant awards across NYS, the region in which the proposal is submitted should be determined by where the majority of the target patient population is located.</p> <p>In Table (f), Attachment 6.3 “Region” should be interpreted as “CCZ” which is NOT the same as the grant award regions referred to above. The CCZ should not be determined by geography.</p>	<p>Attachment 6.3, table (f)</p>	
<p>If the proposer’s CCZ includes only part of a Region, can the information sought on this table on the total number of insurers and the total lives covered refer only to those in the CCZ?</p>	<p>Table (f), Attachment 6.3 “Region” should be interpreted as “CCZ” and the total number of insurers and the total lives covered should refer only to those in the CCZ.</p>	<p>Attachment 6.3, table (f)</p>	

HEAL NY – Phase 10
Question and Answers Set #4 (as of May 11, 2009)

DEFINITIONS

Question	Response	See RGA	References for More Information
Tracking of physician referrals is one requirement of the RGA. Is the applicant organization permitted to define referral patterns?	Yes, with sufficient supporting documentation.		
With End Stage Renal Disease, is it the state's intent to address ESRD patients and their treatments during kidney failure, such as dialysis or transplant, or to address chronic kidney disease (CKD) patients who may be progressing towards ESRD? We had thought for a time that it was the latter (CKD), but your classification of it as "High Risk, High Cost" would imply that you are focusing specifically on actual rather than potential ESRD patients. Please clarify.	It is incumbent upon the applicant to define the target patient population for the project with supporting documentation.		
Is there a limit to the scope of the PCMH's affiliated clinician network?	Applicants must have supporting documentation for extended scope that is associated with the primary diagnosis.		
Can a large multi-specialty group be a PCMH?	It is incumbent upon the applicant to justify the selection of PCMH stakeholders according to requirements listed in the RGA.	Section 3.2	
Is there a preferred way of addressing co-morbidities? For example, in response to other questions, the Department has indicated that they want proposals that focus on one chronic condition. How does the State propose that lead applicants address the high prevalence of co-morbidities such as depression among people with diabetes?	HEAL 10 is only centered around a single diagnosis.	Section 3.3.1	
Can "health information technology" include alternatives to EHRs (such as a portals)?	Alternatives must be appropriate for the care of the target patient population.		

HEAL NY – Phase 10
 Question and Answers Set #4 (as of May 11, 2009)

DEFINITIONS

Question	Response	See RGA	References for More Information
<p>If the target population cannot be defined by coverage of a specific health plan as noted in the response to the first question under Definitions in Questions and Answers Set #3, how will the lead applicant and stakeholders have access to information on the participating patients' utilization and costs (which payers could supply for their covered population)?</p>	<p>Applicants should identify appropriate resources for identifying the target patient population. Although the CCZ cannot be defined by coverage of a specific health plan, payer data can be used as contributing supportive data if appropriate.</p>		

HEAL NY – Phase 10
Question and Answers Set #4 (as of May 11, 2009)

RESOURCES

Question	Response	See RGA	References for More Information
Are there PCMH resources that can be provided as a reference?	See the following resources		<p>Examples of resources include:</p> <ul style="list-style-type: none"> – NYS Public Health Law Article 30, §3073. Definitions: "Medical home" means an organized system of medical care for an individual patient that embraces all of the patient's potential medical needs, including primary, secondary, and tertiary health care as well as emergency care. – NYS Medicaid Update - http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-04_special_edition.htm – NYS DOH Prevention Agenda - http://www.nyhealth.gov/prevention/prevention_agenda/ – American College of Physicians - http://www.acponline.org/running_practice/pcmh/ – National Committee for Quality Assurance - http://www.ncqa.org/tabid/631/Default.aspx – American Academy of Family Physicians - http://www.aafp.org/online/en/home/publications/news/news-now/pcmh.html – American Medical Association - http://www.pcpcc.net/files/DemoGuidelines.pdf
Is there a list of currently certified CHITAs? What is the process to be designated as a CHITA?	See RGA for the definition of a CHITA.	<p>CHITA</p> <ul style="list-style-type: none"> – Section 3.2.1, p. 15 and 17 – Section 3.3.5, p. 26 and 27 – Attachment 6.2 	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Section 4 of the RGA states that the Program Application must consist of the following five sections: 1.) Organizational Plan; 2.) Clinical Plan; 3.) Technical Plan; 4.) Leadership and Personnel Qualifications; and 5.) Project Management. However, Section 8.1.4 ("Application Format") lists sections of the application in a different order, as follows: A.) Cover Page; B.) TOC; C.) Executive Summary/Project Description; D.) Eligible Applicant; E.) Organizational Plan; F.) Technical Plan; G.) Clinical Plan; H.) Leadership and Qualifications; and I.) Project Management. Note that the Technical Plan comes before the Clinical Plan in the application format as laid out in Section 8.1.4. Which order should be followed?</p>	<p>The application should be assembled according to Section 8.1.4 of the RGA. Note that the Eligible Applicant description should be clearly included as part of the Organizational Plan.</p>	<p>Section 8.1.4</p>	
<p>Section 4 requires the Program Application to include a Project Management section. However, there is no description in the RGA of what the Project Management Section must cover. Section 4 merely instructs applicants to "provide detail in Attachment 6.2" ("CHITA Services Template") for the Project Management Section of the Program Application. Does this mean that applicants need only to refer to their CHITA's project management activities (which are designed to be specifically in support of EHR and HIE deployments) to satisfy this section of the application?</p>	<p>There are two types of project management (ie. overall project management vs. CHITA management services). Projects must address both types. A description of overall project management should be included the Program Application, Organizational Plan (as referenced in Section 4.1.4.2.1) narrative and a description of CHITA Project Management Services should be provided in Attachment 6.2.</p>	<ul style="list-style-type: none"> – Section 4.1.4.2 – Attachment 6.2 	

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Question and Answers Set #4 (as of May 11, 2009)

OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Are providers serving as a PCMH under the project required to provide medical home services to all patients in their respective practices or simply to patients in the target population (e.g. with the chosen diagnosis)? If providers are required to provide medical home services to all patients in their respective practices, what is the significance of defining a target patient population based on diagnosis? Is it only the target population that should be reported on for performance measurement purposes and/or used for the clinical scenario illustration?</p>	<p>It is only the target population that should be reported on for performance measurement purposes and/or used for the clinical scenario illustration.</p>	<p>Attachment 6.8</p>	
<p>Once the target patient population is defined based on the chosen diagnosis, should the target patient population be further defined geographically, or in some other way? For example, would a target population defined as patients of the participating PCMH provider(s) with a specified diagnosis (diabetes) be acceptable?</p>	<p>It is up to the applicant to provide the parameters that identify the target patient population and provide sufficient supportive documentation.</p>		

HEAL NY – Phase 10
Question and Answers Set #4 (as of May 11, 2009)

OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
The application does not mention a 50% requirement for participating patients; however, slide 15 of the PowerPoint from the bidder’s conference states, “At least 50% of appropriate patients, providers and caregivers that are part of the PCMH who provide care to the target patient population.” Is there a separate threshold 50% test for patients? If so, how should this be calculated – what should be the numerator and what should be the denominator for this calculation?	Projects are required to include 50% of patients from the target patient population. 50% is the minimum, however, projects with a higher percentage of the population will be scored higher. Projects are required to provide supporting documentation and should include multiple sources of support relevant to target patient population.	<ul style="list-style-type: none"> – Section 3.3.2, p. 20 – Section 3.3.3, p. 21 	<p>Examples Include:</p> <ul style="list-style-type: none"> – Community Health Assessments – Prevention Quality Indicators (PQI)¹ – US Census
<p>If a CCZ is principally located within one geographic zone as defined under the RGA, but a minority or providers or patients cross into another zone (e.g. a multi-county rural health network that is principally located in one zone, but incorporates a small portion of a second zone), can it apply as a single CCZ in the primary geographic zone?</p> <p>Can the applicant use HEAL 10 funds for providers/services that are located in the second zone?</p>	<p>Geographic zones are not referenced in the RGA, however, the region should be selected based on the location of a majority of the target patient population.</p> <p>HEAL 10 funds can be used for any allowable cost as outlined in the RGA associated with the project irrespective of geography.</p>		
The RGA states on page 26 that CHITAs are encouraged to work with multiple projects. Will the number of projects that a CHITA is serving impact the application score?	Applications will be evaluated based on criteria outlined in the RGA.		
Is there a distinction between “References” and “Reference Attachments”? See page 35, 4.1.4.4 and 4.1.4.5.3.	4.1.4.4 should read “Reference Attachments”	Section 4	

¹ https://apps.nyhealth.gov/statistics/prevention/quality_indicators/start.map;jsessionid=DF0ADBC5F7A5F6DD183A84A29E74FDD8

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Question and Answers Set #4 (as of May 11, 2009)

OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Are the attachments to be included within the Program Application or as an appendix? If included within the application, are some attachments included twice? For example, the Stakeholder template is listed twice – on page 35, 4.1.4.4.1 and on page 36, 4.1.5.3.2.</p>	<p>Attachments are to be included in the application as such. If the information has been provided in the form of an attachment the application narrative should briefly make reference to it.</p>	<p>Section 4</p>	
<p>Should the applicant include the CHITA services matrix in Attachment 6.11 with the CHITA Services Template in Attachment 6.2? Where is the applicant supposed to include the “intended results with respect to both patient care and care coordination improvements” and “specific actions for achieving the goals during the grant period” – in Attachment 6.2 or Attachment 6.11?</p>	<p>Financial information for the CHITA Services Template should appear in Attachment 6.11 and the CHITA Service Narrative should appear in Attachment 6.2.</p> <p>Intended results with respect to both patient care and care coordination improvements should be included in the Clinical Plan narrative and in the Clinical Scenario.</p>	<ul style="list-style-type: none"> – Attachment 6.2 – Attachment 6.11 	
<p>To whom should the stakeholder letters of commitment be addressed? Does the State require original copies of the letters or will scanned copies suffice?</p>	<p>Scanned copies are acceptable. Letters of support should be addressed to the Lead Applicant.</p>		
<p>Does a provider planning to use HEAL 10 funds to purchase/install EHRs have to identify the final vendor or can it identify final the two to three choices and use HEAL 10 funds or matching funds to finalize the decision-making process?</p>	<p>If applicants have not selected a vendor the process for vendor selection should be included in the application.</p>		

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Beginning with section 4.1.4 of the RGA, the five major sections and subsections of the narrative are listed. In several instances, the information referenced in the headings is already included in detail in the attachments (i.e., 4.1.7.1 <i>Describe the roles and responsibilities of all project staff</i> is information listed in detail in attachment 6.12 <i>Leadership and Personnel Qualifications</i>). Should we copy information from the attachments into the narrative, or is it sufficient to reference the attachment?</p>	<p>If the information has been provided in the form of an attachment the narrative should briefly make reference to it.</p>		
<p>For Section 5 <i>Project Management</i> the only reference is to provide detail in Attachment 6.2. Should we also simply list the heading and include just a reference to the attachment?</p>	<p>There are two types of project management (ie. overall project management vs. CHITA management services). Projects must address both types. A description of overall project management should be included the Program Application, Organizational Plan (as referenced in Section 4.1.4.2.1) narrative and a description of CHITA Project Management Services should be provided in Attachment 6.2.</p>	<ul style="list-style-type: none"> – Section 4.1.4.2.1 – Attachment 6.2 	
<p>There is no reference to attachment 6.8 <i>Clinical Scenario Template and Examples</i> in the Pass/Fail Review. Should the information in this attachment be included or referenced within the subsections of 4.1.5 <i>The Clinical Plan</i>?</p>	<p>The Clinical Scenario Attachment should be briefly referenced in the Clinical Plan.</p>	<ul style="list-style-type: none"> – Section 4.1.5 – Attachment 6.8 	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
The attachments are confusing - some appear to be informational only and some must be completed by the applicant. Could you provide a list of the Attachment numbers that the applicant completes?	Attachments 6.2, 6.3, 6.4, 6.5, 6.8, 6.9, 6.10, 6.11 and 6.12 must be completed and included as part of the application.		
The RGA provides guidelines for a percentage of patients with targeted conditions and physicians who treat those conditions to be included in the application. Does that mean percentage of patients/physicians within the geographic area covered by the application?	CCZs should be based on referral patterns for the target patient population and participants required for the coordination of care and not necessarily geography.		
The submission address, which is located only on page 106 of the RGA and on slide 42 of the Applicant Conference slides, does not include a phone number. If the application is sent by overnight carrier, what telephone number can be used?	(518) 474-4987		
Section 5.1.1 requires the application to be completed in 12 point type. Can tables and graphics be in smaller type as long as they are legible?	Yes		
Section 8, Forms and Checklist on Page 87 lists the items to be included in the Program Application (item #1). That list includes, after the Executive Summary, "Eligible Applicant Description" - this specific title for a section of the application is not included in the list in Section 4 on page 35. That section only lists five items. Is the "Eligible Applicant Description" a sixth section in the Program Application or is it to be included within the "Organizational Plan" section of the Program Application?	The Eligible Applicant description should be clearly included as part of the Organizational Plan.		

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Section 3.5 General Criteria, number 11. If a rural area CCZ includes very few solo and small physician practices in general, will the applicant be scored low on this criterion, even if a number of these solo providers participate? Will DOH take into account the scarcity of such providers in a rural area?</p>	<p>Applications will be evaluated based on criteria outlined in the RGA.</p>		
<p>Section 3.3.4.2 states that applicants that incorporate other clinical data, including measures described in Section 3.3.7, will be evaluated more favorably. This is not listed in the Criteria for Emphasis table on page 33. Please clarify.</p>	<p>The Criteria with Emphasis should include Section 3.3.7. Section 3.3.7 states:</p> <p>“An application will be evaluated more favorably if it includes a detailed description of measures that will be used to monitor coordination of care, that are:</p> <ul style="list-style-type: none"> • evidence based; • previously shown to be effective or are new measures involving the use of EHRs and HIE; and • able to demonstrate the ability to share information.” 	<p>Section 3.3.7</p>	
<p>Please clarify the difference between number 3 and number 4 in the table on Criteria for Emphasis. Does number 3 refer only to <i>types</i> of stakeholders (e.g., primary care doctors, specialists, hospitals), so that if the applicant identifies 8 types of stakeholders, it must include at least 4 types in its PCMH, or it something else intended? (Number 4 would then require the applicant to include at least 50% of the members of each included type?)</p>	<p>50% is considered the minimum. The preferred participation level is >70%.</p> <p>Number 3 refers to <i>types</i> of stakeholders (e.g., primary care doctors, specialists, hospitals).</p> <p>Number 4 requires the applicant to include at least 50% of the members of each stakeholder type.</p>	<p>Section 3.5</p>	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Program Application. Section 4. Scoring of Grant Applications. The Stakeholder Template is “referenced” in subsections 4.1.4.4.1 and 4.1.5.3.2. Questions: Please clarify what narrative is being looked for in the “References” subsections. Is the relevant content of the Stakeholder Template to be described in each subsection or just a citation to the attachment? Same with (1) subsections 4.1.5.1.1.4 CHITA services and 4.1.5.3.3 CHITA Services Template and (2) subsections 4.1.4.4.2 and 4.1.7.2.1 on Leadership and Personnel Qualifications.</p>	<p>The narrative should briefly reference information included in the attachments.</p>		
<p>Section 8 Application format. The file structure requires that the Program Application Attachments follow the Program Application and the Financial Application Attachments follow the Financial Application. Question: Should the Attachments be attached in numeric order following the Program or Financial Application, as relevant, even if the attachments are referenced differently in the text? (E.g., Section 4.1.8 lists the Financial Application Reference Attachments as Sustainability (Att. 6.5), then Budget Forms (Att. 6.11) then Allowable Project Costs (Att 6.10)).</p>	<p>Numeric order by Attachment.</p>		
<p>Will a PCMH with interoperable HIT for an initial population of 1,000 patients with significant developmental disabilities compounded with high risk/high cost co-morbid chronic health conditions and chronic mental health disorders in all 5 boroughs of NYC be an acceptable and justifiable compound diagnosis scenario to target in this RGA?</p>	<p>HEAL 10 is only centered around a single diagnosis. It is incumbent upon the applicant to identify the appropriate CCZ based on requirements detailed in the RGA.</p>	<p>Section 3.3.1</p>	
<p>This question seeks to determine if the prevalence of compound diagnoses in the population of individuals with a significant developmental disability are RGA acceptable and further seeks to review some acceptable avenues of justification.</p>	<p>Projects are required to choose a single diagnosis. Any diagnosis other than those on the list require supporting documentation.</p>	<ul style="list-style-type: none"> – Section 3.3.1 – Section 3.3.2 	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
Is there an advantage in having primary care sites in practices <5?	Applicants are encouraged to include providers that most appropriately care for the target patient population.		
On Table A on page 42 of the Attachments (Section 6.3.111), is each individual primary care site that meets NCQA standards as a medical home to be filled in as part of the overall PCMH model if the proposal's reach is beyond one site?	Table (a) should include all PCMH providers regardless of NCQA status.	Attachment 6.3, table (a)	
On Table D on page 44 of the Attachments (Section 6.3.111), if you define your PCMH to include 5 FQHCs for example, how would the number of participating FQHCs be different than 5?	If all of the health centers in the CCZ are participating, the numbers will be the same.	Attachment 6.3, table (d)	
On Table E on page 44 of the Attachments (Section 6.3.111), does the number of discharges include only those associated with the selected diagnosis? If so, does the selected diagnosis have to be the principal diagnosis? Also, it is not clear how to distribute discharges into boxes "Total in the PCMH" and "Total participating in the project"?	The project must only include discharges associated with the selected diagnosis. The diagnosis may be primary or secondary. If all of the discharges in the PCMH are participating in the project, the numbers will be the same.	Attachment 6.3, table (e)	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
Should the application use the numbering system in Section 4 to label sections, or is the alphabet (A. – H. in Section 8.1.4, and A. – E. in Section 8.2.2.) sufficient?	The alphabet is sufficient.		
What is the state looking for in a RHIO’s “governance plan”?	Section 3.1.2.1 of the HEAL 5 RGA can be used as guidance. For further guidance on NYS RHIOs see Attachment A to Questions and Answers Set #1.		– http://www.nyhealth.gov/funding/rfa/0708160258/
Must the proposal include plans for an electronic PHR?	No		
Are there length requirements for the attachment narratives?	All grant applications must include two narratives, not to exceed 30 pages each – Program and Financial. See individual Attachments for length requirements.	– Section 4.1 – Attachments	
Is there a difference between the narrative required in Section 4.1.7.1 (“describe the roles and responsibilities of all project staff”) and the narrative required to accompany Attachment 6.12 (“describe the roles and responsibilities of all staff involved in the proposed project”)?	If the information has been provided in the form of an attachment the narrative should briefly make reference to it. It is preferred that a narrative of all items in 4.1.7.1 be included in the 30 page Program Application narrative and additional detail (including staff resumes) should be provided in Attachment 6.12.	– Section 4.1.7.1 – Attachment 6.12	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
Is Attachment 6.3.111.d where you would record individual ambulatory care sites of an integrated delivery system?	Table (d) is only for community and FQHCs, ambulatory care sites are not required to be specifically identified but the associated providers should be included in the relevant tables	Attachment 6.3, table (d)	
Please explain what is being sought by the following: (1) “number of discharges among clinicians and hospitals” and (2) number of discharges between physicians and long term care providers”. Isn’t the number of discharges tied to a specific set of patients, rather than to a set of clinicians?	The table should include discharges and or transfers from hospitals and long term care for the identified patient population.	Attachment 6.3, table (e)	
On the table of General Criteria in Section 3.5—Grantee Evaluation Criteria (page 32 of the RGA) Row 1 asks applicants to discuss the "caliber of measures to demonstrate improved care coordination." What is meant by the term "caliber"? Is it whether the measures are evidence based, previously shown to be effective, or what?	Projects should include sufficient supporting documentation/references to justify the measures selected. The term “caliber” refers to whether the measures are evidence based and/or previously shown to be effective.		
Can you provide any specificity or details of the measures described in Attachment 6.6 (Reimbursement Model Examples)?	Attachment 6.6 includes Reimbursement Model Examples. It is incumbent upon the applicant to determine the most appropriate model for their project.	Attachment 6.6	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
<p>Is the following an acceptable approach to determining how many and which providers must be included in the PCMH?</p> <p>a. 50 primary care providers have been identified as caring for patients with the selected diagnosis.</p> <p>b. Each provider identifies the network of other providers (specialists, acute care facilities, home health agencies, etc.) to whom his/her/its patients with this diagnosis are referred for care.</p> <p>The referral network includes 300 providers.</p> <p>c. Total providers that must be included as part of the PCMH = 50% of 350, or 175.</p>	<p>The described example/approach is acceptable. Although 50% is considered the minimum, and projects are encouraged to include greater than 70% of providers.</p>		
<p>In the example above, we are assuming that the project does not have to provide funding to each of these 175 providers, but that they must participate in the care coordination program. Is this correct?</p>	<p>Yes</p>		
<p>Does the 50% requirement also apply to care organizations (50% of the total referral provider organizations identified? and/or 50% of the types of referral provider organizations [primary care doctors, general hospitals, long-term care providers, etc.], or just to individual providers within those organizations?</p>	<p>Both</p>		
<p>Where in the Application should the Project Workplan (Attach. 6.4) be referenced? Is this the same document as the Project Management/Monitoring Plan mentioned in Section 8.1.1 (p. 87)?</p>	<p>The Project Work Plan should be included as part of the Program Application.</p> <p>The documents are the same.</p>	<p>– Attachment 6.4</p> <p>– Section 8.1.1</p>	
<p>If an application includes the measures listed in Attachment 6.5, are the times indicated there (“within 3 days”) binding, or can the measure be adjusted?</p>	<p>The measures included in Attachment 6.5 are only examples and applicants must include measures most appropriate to their project with associated documentation.</p>	<p>Attachment 6.5</p>	

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
Section 8.1.5 (p. 93) refers to Attachment 9.2.5. Is this a typo?	Yes. The Vendor Responsibility Attestation is found on page 95.		
Can “letter of support #” be alphanumeric (include letters as well as numbers) and non-consecutive, as long as it is unique?	Yes		
Pg. 44 of the attachments asks for the total number of insurers in the region. Is there a source to identify all insurers in a given region?	It is up to the applicant to identify appropriate sources.		Examples include: – http://www.nyhealth.gov/health_care/managed_care/reports/index.htm
What form should a PHR take?	It is incumbent upon the applicant to determine the most appropriate approach for their project.		
Does the applicant have to commit to pre-defined metrics for a PHR?	If PHR metrics are identified in the application, they become binding for the scope of the project and may not be significantly altered at a later date.		
Would the state be more favorably disposed to a project in which the participants exchange data through a RHIO, rather than exchanging data directly with the lead applicant in a “hub-and-spoke” manner?	The most appropriate available method for data exchange is required. Point-to-point proprietary interfaces are excluded. One-to-one or proprietary interfaces between an EHR and hospitals, labs, pharmacies, patients, radiology centers, etc., are not permitted. An application will not be eligible for evaluation if a one-to-one or proprietary interface approach is included.	Section 3.3.4.2	
On page 22, 3.3.4.1 EHRs, it states that “Stand-alone e-prescribing systems, however, must be CCHIT certified for the most recent year (starting with 2009).” If the e-prescribing system is not currently CCHIT certified but submits an application for 2009, would that requirement be considered fulfilled pending issuance of the certification?	It is not required to select a vendor prior to submission of an application. HEAL 10 dollars can only be used to pay for current year CCHIT certified software.		

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OTHER REQUIREMENTS

Question	Response	See RGA	References for More Information
If an applicant selects 'Chronic Mental Health Disorder' as its disease choice, can the proposal focus on just one of the three types specified -- depression, schizophrenia, bipolar disease -- or do all three have to be included?	Applicants must choose only one diagnosis. In this case either depression or schizophrenia or bipolar disease must be chosen.		
Our existing EHR is a CCHIT Certified Ambulatory EHR 2006 system. The vendor intends to apply for Ambulatory EHR 2009 certification by the end of this year. Given the existing certification and pending certification, does this system meet the CCHIT criteria set forth in Section 3.3.4.1 of the RGA?	It is not required to select a vendor prior to submission of an application. HEAL 10 dollars can only be used to pay for current year CCHIT certified software.		
What level of detail is required for: "Type of Provider and Health Care Services Provided?" Provider Specialty? Services provided by organization (like our application)?	The detail should reference and apply to the chosen diagnosis.		