RFA # QPS – 2016-02
HEALTH RESEARCH, INC.

New York State
Department of Health
Office of Quality and Patient Safety
Innovation Center

Request for Applications

Practice Transformation
Technical Assistance Services

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KEY DATES

RFA Release Date: March 16, 2016
Questions Due: April 1, 2016
Questions, Answers and Updates Posted: April 15, 2016
Letter of Intent Due: April 22, 2016
Applications Due: May 13, 2016 by 4:00PM EDT

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# Table of Contents

## I. Introduction

- Background
- SIM funded Independent Validation agent

## II. Who May Apply

- Minimum Eligibility Requirements
- Preferred Eligibility Requirements

## III. Project Narrative/Work Plan Outcomes

- Region Selection
- Advanced Primary Care Model
- Deliverables

## IV. Administrative Requirements

- A. Issuing Agency
- B. Question and Answer Phase
- C. Letter of Interest (Optional)
- D. Applicant Conference
- E. How to File an Application
- F. HRI/Department’s Reserved Rights
- G. Term of Contract
- H. Payment and Reporting Requirements of Awardees
- I. General Specifications
- J. HRI General Terms & Conditions

## V. Completing the Application

- A. Application Content
- B. Application Format
- C. Review Process

## VI. Attachments

- Attachment 1: Application Coversheet
- Attachment 2: New York Standardized Rating Regions
- Attachment 3: APC Gates and Milestones
- Attachment 4: Sample Curriculum
- Attachment 5: Budget Instructions
- Attachment 6: APC Gate Assessment Tool
- Attachment 7: APC Milestone Technical Specifications
I. Introduction

Background

In December 2014, Health Research Inc. (HRI)/the New York State Department of Health (NYSDOH) was awarded a $100 million State Innovation Models (SIM) cooperative agreement by the Centers for Medicare and Medicaid Innovation (CMMI) to implement the State Health Innovation Plan (SHIP) http://www.health.ny.gov/technology/innovation_plan_initiative/. New York has proposed a multidisciplinary approach to health system redesign that includes primary care delivery system and payment reform supported by work to improve access to care, to develop the health care workforce to support new delivery models and the promotion of health information technologies.

A key component of the SHIP is the development and implementation of an integrated care delivery system with a foundation in Advanced Primary Care (APC). APC describes enhanced capabilities, processes, and performance of primary care providers based on lessons learned from the Comprehensive Primary Care initiative (CPCi), Medicare Advanced Primary Care Program (MAPCP), and National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH). Each of these initiatives is premised on primary care assuming a central role in the coordination of care, to achieve optimal health and well-being for patients. The APC model was developed in concert with numerous external stakeholders who convened regularly as members of the Integrated Care Work Group (ICWG). The ICWG jointly has defined the APC framework, which includes:

- **Capabilities** that describe an APC practice
- **Core Measures** that reflect a practice’s impact on patient health, quality of care, and experience
- **Gates** that define practice capabilities and inform payers for purposes of value-based reimbursement
- **Milestones** that define specific expectations of a practice in terms of key capabilities and performance against core measures

New York State (NYS) is a national leader in the evolution of innovative primary care models including the APC, NCQA PCMH, CPCi, MAPCP and numerous payer-specific models. While additional providers are achieving NCQA PCMH certification each year, they remain a minority: only 25 percent of New York’s primary care providers work inside of an NCQA certified PCMH1, with wide regional variation.

In addition to the SIM funding, two other programs are providing funding to support changes in primary care toward patient-centered and value-based-payment models. These resources include:

1. The Transforming Primary Care Initiative (TCPI) awarded to the New York eHealth Collaborative (NYeC) through the CMMI for practice transformation technical assistance, anticipated to start in early 2016; and
2. Medicaid’s Delivery System Reform Incentive Payment (DSRIP) program, which has created multiple “Performing Provider Systems,” charged with assuring practices achieve PCMH or APC status.

1 United Hospital Fund, Recent Trends and Future Directions for the Medical Home in New York, 2015
Resources from these programs are not included in this Request for Applications (RFA). HRI/NYSDOH will ensure coordination and collaboration between and among these programs essential to ensure maximum efficiencies and to eliminate any potential duplication of funding.

This RFA seeks applications from responsive and qualified contractors for services related to Practice Transformation (PT) Technical Assistance (TA). PT TA contractors funded through SIM will function as part of a larger team that is inclusive of practices, payers, HRI/NYSDOH and an Independent Validation Agent. Funded contractors will be expected to assist practices and providers to develop the systems and processes necessary to meet the goals of the “Triple Aim”: improving patients’ experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of care through achievement of APC-specific milestones and gates (described below). More specifically, funded contractors will be expected to provide the following services to primary care practices in designated regions throughout the State:

1. An initial assessment of practices’ readiness to receive TA services as defined by APC milestones and gates (described below) using a tool to be developed by HRI/NYSDOH and shared with funded contractors;
2. Support to practices in building capabilities to reach APC goals and to progress through three gates for up to two years, depending on the initial readiness of the practice; and
3. Submission of reports on practice achievement of APC gates and milestones to HRI/NYSDOH, and to a separately procured Independent Validation agent. This reporting must be updated quarterly; HRI/NYSDOH reserves the right to request additional reports more frequently as needed.

**SIM-funded Independent Validation Agent**

The SIM funded Independent Validation Agent, referenced above as part of the larger team, will be separately procured to:

1. Ensure that practices’ capabilities, as measured by milestones and gates, are credible for purposes of continued transformation and payment;
2. Audit PT TA contractors’ reported data to ensure validity and reliability;
3. Collect feedback from practices on PT TA contractor performance; and
4. Aggregate contractor and practice data for use by payers and HRI/NYSDOH.

**II. Who May Apply**

A broad spectrum of applicants are eligible to submit applications, including but not limited to: organizations specializing in PT services, health systems or health plans with experience in assisting with PT, and organizations for which PT is just one component of a suite of other services.

**A. Minimum Qualifications**

To meet the RFA’s minimum qualifications, applicants must provide evidence of the following in their application:

1. Two years of either staff or organizational experience specific to PT.
2. An ability and intent to serve all eligible practices within the region specified or a subset thereof, so long as practice eligibility criteria is clearly defined.
3. Assurances that SIM funding in no way duplicates other sources of federal PT funding (e.g., TCPI, DSRIP). Applicants in receipt of more than one source of PT support must clearly describe mechanisms used to clearly distinguish between funding sources for purposes of
reimbursement and to ensure that practices/providers are not in receipt of more than one funding source for the same activity during the same time frame.

B. Preferred Qualifications

The successful applicant will document skills and experience as relevant to the execution of the PT and reflecting qualifications with:

1. Previous experience with successful PT within the bid region

III. Project Narrative/ Work Plan Outcomes

A. Region Selection and Practice Enrollment

Contractors will be selected on a regional basis with regions defined as the New York Standardized Rating Regions (Department of Financial Services [DFS] Regions - see Attachment 2). HRI/NYSDOH anticipates that each of the eight regions of New York will be served by at least one contractor. Applicants are to define the DFS region(s) that they propose to serve. Applicants proposing to serve more than one region must submit a separate application for each region. Contractors will be required to enroll practices within specified region(s) on a first-come, first-served basis. Applicants may propose to serve only certain practices in a region but must explicitly define those practices, how they are/were selected and how additional practices will be selected in the future. Applicants must also commit to continue to serve selected practices (as long as they remain eligible for support) for the duration of the Contract.

To ensure that PT is supported and reinforced by a corresponding payment model, HRI/NYSDOH will prioritize funding technical assistance in regions and for practices in which a preponderance of patients are covered by payers that have agreed to participate in the APC model. As previously stated, APC participation includes agreement to use a core set of measures, offering PT and care coordination payments as well as outcome-based payment models, contingent on fulfilling the milestones associated with each APC Gate. HRI/NYSDOH will maintain a publicly available record of payers that have agreed to participate and will update this information regularly. HRI/NYSDOH reserves the right to contract with PT TA entities serving practices in regions that do not meet this payer participation requirement as it deems appropriate.

B. APC Model Gates and Reimbursement

A summary of Gates and associated practice reimbursement is depicted below (Figure 1).

1. Gate 1: Eligibility to receive technical assistance for PT TA as well as financial support from payers during this transformation period.
2. Gate 2: Eligibility to receive care coordination payments and path to early outcome-based payments.
3. Gate 3: Eligibility to sustain care coordination payments and evolve to outcome-based payments.
See Attachment 3 for a detailed description of each Gate and the associated milestones for practices.

C. Deliverables

The PT TA contractors will be expected to perform the following activities. Applications should address all of the following:

1. Collect, **and verify**, and upload to an online portal the results of the initial self-assessment completed by practices (a standardized tool developed by the State) to determine readiness and interest in PT, to assess current capacities and transformational needs, and to verify that practices are not receiving duplicative PT resources;

2. Sign formal agreements with practices that detail roles and responsibilities;

3. Assist practices with:

   i. Development and implementation of a comprehensive work plan that addresses workflows and skill sets consistent with APC milestones and measurement goals;

   ii. Development of an administrative infrastructure to support alternative payment models; and
iii. Development and implementation of a team-based care delivery practice model with high functioning care management and care coordination capabilities.

4. Create mechanisms for each practice to facilitate reporting on a standardized or core set of variables that guide payment, incent quality improvement and facilitate the potential for shared savings.

5. Achieve satisfactory progress towards completing milestones. Satisfactory progress will be defined according to the most recently passed Gate:
   i. Practices entering at Gate 1 will qualify for up to 12 months of TA support to help them demonstrate Gate 2 milestones.
   ii. Practices passing Gate 2 will qualify for up to 12 months of TA support to demonstrate Gate 3 milestones.

D. Curriculum Development and Delivery

Applicants are expected to develop and propose a new curriculum, or propose utilization of an existing curriculum, that can be tailored to individual practices and that will allow practices to achieve APC Gate-specific transformation milestones. The curriculum is to be described in detail and must be sufficient to advance practices from one Gate to the next within the prescribed timeframes.

The proposed curriculum must delineate between activities to be performed by the Contractor and activities to be performed by the practice and should reflect a practice’s past experiences and APC entry level (Gate). All curricula must at a minimum include the following modules:

- Introduction to APC;
- Health information technology;
- Care coordination and case management;
- Patient-Centered Care;
- Practice capability building;
- Performance in outcome-based payments; and
- Integration of population and behavioral health care.
Applicants should provide a set of sample units and sample topics to form part of their completed curriculum. The curriculum should address the required modules and sample units described in Attachment 4, along with any others the applicant deems necessary; describe the learning modalities to be used in each module, unit and topics; and, describe the topics in greater detail than shown in Attachment 4.

The curriculum should be delivered using a combination of the methods described below:

1. **On-site Coaching and Practice Facilitation** – Contractors must visit any given practice site at least once per month for one-on-one coaching with the practice’s clinical and administrative leads on quality improvement techniques and leadership training. Contractors should provide an opportunity for the office team to discuss progress and challenges that they have encountered during the PT process;

2. **Learning Collaboratives** – Learning collaboratives must be held at least quarterly. They should provide practices aligned with the PT TA contractor the chance to learn from one another, share best practices, collaborate on common problems and adopt evidence-based protocols. Learning collaboratives may take place in-person, by phone or online;

3. **Group Trainings** – Group trainings should occur at least once every other month or more frequently as needed. Contractors should provide trainings during which important theories of PT can be taught to multiple practices at the same time. These trainings should provide opportunities for practices to ask questions of Contractors. These may occur in person, but webinars are recommended.

4. **Remote Support** – The Contractor should provide remote resources that practices can access at their convenience. These may include recorded webinars or web resources. These resources should empower practices to become independent in the PT process. Practices should also be able to contact PT faculty by phone and/or email with questions and receive prompt replies.

E. **Required Monitoring and Reporting**

The selected contractors must tailor their curriculum to practices based upon the practice’s baseline features, capabilities as measured during each practice’s initial gating assessment, and the practice’s location and size.

Contractors are expected to monitor and report on the progress that each practice makes against the milestones and proactively develop remedial learning plans for practices that are at risk
of not meeting timelines. Results of, and background documentation for, each gating assessment conducted must be submitted to the designated Independent Validation Agent and HRI/NYSDOH within one month of the completion of the assessment.

Contractors must be available for scheduled meetings and conference calls related to the activities associated with this contract.

In addition to information required to approve monthly payments, Contractors must submit the following reports to HRI/NYSDOH:

1. **Monthly Contractor Progress Report**: The Contractor should provide monthly progress reports of its work with practices. HRI/NYSDOH will provide a template for reporting. The reports will include but not be limited to:

   i. A list of practices enrolled by the Contractor including each enrolled practice’s current and initial Gate;

   ii. A brief description of progress to date; and

   iii. Documentation of any changes in the number or composition of practices and indicate whether the change was at the request of the practice, the Contractor or both.

2. **Semi-annual Practice Progress Report**: Contractors should conduct an assessment six months into each year of support for each participating practice site, and every six months thereafter. This assessment should include:

   i. An assessment of the practice’s participation in PT TA activities;

   ii. The milestones that have been achieved, including a description of how they were achieved and those that have been missed along with current status towards completion;

   iii. Milestone completion timeline for the remainder of the Contract year;

   iv. Contractor activities performed for each practice by type and method of delivery;

   v. An assessment of the practice’s ability to achieve APC standards over the next six months. Action plans must be developed for at-risk practices unlikely to achieve APC standards within the contract year; and

   vi. Barriers and challenges encountered (if any) in fulfilling the work scope.
G. Annual Plan

The applicant should submit a plan delineating activities anticipated over the contract years including the estimated number of practices and providers to be engaged, number of learning sessions anticipated by type and method of delivery. See Section III, C. for deliverables also required in the Annual Plan.

H. Required Meetings

HRI/NYSDOH will organize collaborative PT TA meetings and other activities to propagate best practices and insights from successful transformation efforts between Contractors, as well as communicate any updates to the APC model. Contractors will be expected to participate in monthly conference calls with NYSDOH/HRI APC team members. Scheduled in-person (or video-conferenced) meetings with APC team member(s) will take place no less than quarterly. These meetings are distinct from the learning collaboratives administered by the Contractors themselves (described in Section III.C.5.ii) and will not be attended by practices.

I. Gating Assessments

Contractors will be responsible for performing gating assessments to determine when practices meet APC milestones and pass APC Gates. Refer to the APC Milestone Technical Specifications (Attachment 7) and the APC Gate Assessment Tool (Attachment 6) for more details regarding the specific requirements for each gate. There will be a single gating assessment tool which will be developed by HRI/NYSDOH.

1. Gate 1: The assessment of a practice for Gate 1 will serve the following functions:

   i. Confirm strengths and gaps in workforce, infrastructure and workflows as they relate to APC standards and as initially evaluated in the practice’s initial self-assessment.

   ii. Confirm eligibility of the practice for PT TA support, financial transformation support and commitment to outcomes-based payment models;

   iii. Identify the investment and engagement of practice leaders in improving the practice and willingness of practice leadership to devote sufficient time and resources to successfully participate in the intervention;

   iv. Determine the Gate at which the practice will enter the APC program; and

   v. Provide a basis for determining a tailored, practice-specific transformation plan.

2. Gates 2 and 3: Contractors must conduct a gating assessment for each enrolled practice at
least once every 12 months. Each enrolled practice site can have no more than TWO gating assessments per year, PER GATE, with at least two months between gating assessments. In order to assure valid results, these gating assessments will be subject to audit and quality control by the Independent Validation Agent.

3. **Gating Assessment for Practices Participating in Other Transformation Programs** (DSRIP and TPCI): Contractors must conduct gating assessments for all practices in the region(s) served that request such from the Contractor, subject to restrictions set by the Contractor (see Section III.A), even if these practices are not receiving or not eligible for SIM-funded PT TA support. The Contractor must include a description of how they will deliver on potential demand for the gating assessment.

4. **Gating Resource Guidelines**: Applicants must propose to NYS an estimated cost for each practice gating assessment. For the purpose of developing an application, applicants should assume that they will be asked to use an **APC Gate Assessment Tool** ([Attachment 6](#)) that measures success of implementation of the activities in Attachment 3. Cost estimates should detail the number of staff required and number of staff hours to complete an assessment inclusive of both on-site work and time needed to review documentation, including the practice- completed self-assessment tool. Gating assessments may vary depending on Gate and applicants must specify cost/Gate, as appropriate. Please note there may be cost sharing with the assessed practice for assessment costs.

**IV. Administrative Requirements**

A. **Issuing Agency**

This RFA is issued by Health Research, Inc. (HRI) and the NYS Department of Health, Office of Quality and Patient Safety, Innovation Center with funding provided by Centers for Medicare and Medicaid Services – Center for Medicare and Medicaid Innovation. HRI/NYS NYSDOH are responsible for the requirements specified herein and for the evaluation of all applications.

B. **Question and Answer Phase:**

All substantive questions must be submitted by email to the following address by the date listed on the cover page of this RFA:

oqps.asu@health.ny.gov

To the degree possible, each inquiry should cite the RFA section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RFA.
Questions of a technical nature can be addressed in writing to the above email or mailing address. **Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.**

Prospective applicants should note that all clarification and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application, during the question and answer phase, by the date listed on the cover page of this RFA.

This RFA has been posted on HRI’s public website at: [http://www.healthresearch.org/funding-opportunities](http://www.healthresearch.org/funding-opportunities). Questions and answers, as well as any updates and/or modifications, will also be posted on HRI’s website. All such updates will be posted by the date identified on the cover sheet of this RFA.

C. **Letter of Intent/Interest**

Submission of a Letter of Intent/Interest is a requirement upon the applicant to submit an application in response to this RFA. Letters of Intent/Interest are due by the date listed on the cover page of this RFA.

D. **Applicant Conference**

An Applicant Conference will NOT be held for this project.

E. **How to file an application**

Applications must be received at the following address by the date and time listed on the cover page of this RFA. Late applications will not be accepted.

Justin Hausmann  
NYS Department of Health  
Corning Tower, Room 2084  
Empire State Plaza  
Albany, NY 12237  
oqps.asu@health.ny.gov

Applicants shall submit by mail 1 original, signed proposal AND 5 copies AND 1 electronic copy emailed to the address above. Application packages should be clearly labeled with the name and number of the RFA as listed on the cover of this RFA document.

*It is the applicant’s responsibility to see that applications are delivered to the address above prior to the date and time specified above. Late applications due to documentable delay by the carrier may be considered at HRI’s discretion.*

F. **HRI AND THE DEPARTMENT OF HEALTH RESERVE THE RIGHT TO**

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at HRI's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.

5. Seek clarifications and revisions of applications.

6. Use application information obtained through site visits, management interviews and the state’s investigation of an applicant’s qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency’s request for clarifying information in the course of evaluation and/or selection under the RFA.

7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.

8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.

9. Change any of the scheduled dates.

10. Waive any requirements that are not material.

11. Award more than one contract resulting from this RFA.

12. Conduct contract negotiations with the next responsible applicant, should HRI be unsuccessful in negotiating with the selected applicant.

13. Utilize any and all ideas submitted with the applications received.

14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.

15. Waive or modify minor irregularities in applications received after prior notification to the applicant.

16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer’s application and/or to determine an offerer’s compliance with the requirements of the RFA.

17. Negotiate with successful applicants within the scope of the RFA in the best interests of HRI.

18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.

19. Award contracts based on geographic or regional considerations to serve the best interests of HRI.

G. **Term of Contract**

Any contract resulting from this RFA will be effective only upon final approval by Health Research, Inc.
It is expected that contracts resulting from this RFA will have the following time period: July 1, 2016 through January 31, 2019 (31 months), issued in one six (7) month increment on July 1, 2016 and two (2) yearly increments issued on February 1, 2017 and February 1, 2018. Renewals are dependent upon satisfactory performance and continued funding availability.

HRI reserves the right to revise the award amount as necessary due to changes in the availability of funding.

H. Payment & Reporting Requirements of Awardees

1. The contractor shall submit monthly invoices to:
   
   oqps.asu@health.ny.gov

2. The contractor shall submit the following periodic reports:
   - Monthly progress reports and weekly status update meetings/conference calls.
   - All payment and reporting requirements will be detailed in Exhibit C of the final contract.

I. General Specifications

1. By signing the "Application Cover Sheet" (Attachment 1), each applicant attests to its express authority to sign on behalf of the applicant.

2. Contractor will possess, at no cost to HRI or the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by HRI during the Question and Answer Phase (Section IV.B.) must be clearly noted in a cover letter attached to the application.

4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.

5. Provisions Upon Default
   
   a. The services to be performed by the Applicant shall be at all times subject to the direction and control of HRI as to all matters arising in connection with or relating to the contract resulting from this RFA.

   b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, HRI shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.
6. Applicant must maintain an active registration in the System for Award Management (SAM) at SAM.gov, have no exclusions or delinquent federal debt.

J. HRI General Terms & Conditions

The following will be incorporated as Attachment A into any contract(s) resulting from this Request for Application.

Attachment A
General Terms and Conditions - Health Research Incorporated Contracts

1. **Term** - This Agreement shall be effective and allowable costs may be incurred by the Contractor from the Contract Start Date through the Contract End Date, (hereinafter, the “Term”) unless terminated sooner as hereinafter provided or extended by mutual agreement of the parties.

2. **Allowable Costs/Contract Amount** –
   a) In consideration of the Contractor's performance under this Agreement, HRI shall reimburse the Contractor for allowable costs incurred in performing the Scope of Work, which is attached hereto as Exhibit A, in accordance with the terms and subject to the limits of this Agreement.
   
   b) It is expressly understood and agreed that the aggregate of all allowable costs under the Agreement shall in no event exceed the Total Contract Amount, except upon formal amendment of this Agreement as provided herein below.
   
   c) The allowable cost of performing the work under this Agreement shall be the costs approved in the Budget attached hereto as Exhibit B and actually incurred by the Contractor, either directly incident or properly allocable, to the Agreement, in the performance of the Scope of Work in accordance with cost principles of the Department of Health and Human Services Cooperative agreements Policy Statement (HHS GPS). To be allowable, a cost must be necessary, cost-effective and consistent (as reasonably determined by HRI) with policies and procedures that apply uniformly to both the activities funded under this Agreement and other activities of the Contractor. Contractor shall supply documentation of such policies and procedures to HRI when requested.
   
   d) Irrespective of whether the "Audit Requirements" specified in paragraph 3(a) are applicable to this Agreement, all accounts and records of cost relating to this Agreement shall be subject to audit by HRI or its duly authorized representative(s) and/or the Project Sponsor during the Term and for three years after the final voucher is submitted for payment. This provision includes the right for HRI to request copies of source documentation in support of any costs claimed. If an audit is started before the expiration of the 3-year period, the records must be retained until all findings involving the records have been resolved and final action taken. Any reimbursement made by HRI under this Agreement shall be subject to retroactive correction and adjustment upon such audits. The Contractor agrees to repay HRI promptly any amount(s) determined on audit to have been incorrectly paid. HRI retains the right, to the extent not prohibited by law or its agreements with the applicable Project Sponsor(s) to recoup any amounts required to be repaid by the Contractor to HRI by offsetting those amounts against amounts due to the Contractor from HRI pursuant to this or other agreements. The Contractor shall maintain appropriate and complete accounts, records, documents, and other evidence showing the support for all costs incurred under this Agreement.

3. **Administrative, Financial and Audit Regulations** –
   a) This Agreement shall be audited, administered, and allowable costs shall be determined in accordance with the terms of this Agreement and the requirements and principles applicable to the Contractor as noted below, including, but not limited to, the Office of Management and Budget (OMB) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (referred to herein as the
“Uniform Guidance”) as codified in Title 2 of the Code of Federal Regulations. The federal regulations specified below apply to the Contractor (excepting the "Audit Requirements," which apply to federally-funded projects only), regardless of the source of the funding specified (federal/non-federal) on the face page of this Agreement. For non-federally funded projects any right cooperative agreemented by the regulation to the federal sponsor shall be deemed cooperative agreemented to the Project Sponsor. It is understood that a Project Sponsor may impose restrictions/requirements beyond those noted below in which case such restrictions/requirements will be noted in Attachment B Program Specific Clauses.

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<thead>
<tr>
<th>Contractor Type</th>
<th>Administrative Requirements</th>
<th>Cost Principles</th>
<th>Audit Requirements Federally Funded Only</th>
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<tbody>
<tr>
<td>College or University</td>
<td>Uniform Guidance</td>
<td>Uniform Guidance</td>
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<tr>
<td>Not-for-Profit</td>
<td>Uniform Guidance</td>
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<td>State, Local Gov. or Indian Tribe</td>
<td>Uniform Guidance</td>
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<tr>
<td>For-Profit</td>
<td>45 CFR Part 74</td>
<td>48 CFR Part 31.2</td>
<td>Uniform Guidance</td>
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<tr>
<td>Hospitals</td>
<td>2 CFR Part 215</td>
<td>45 CFR Part 74</td>
<td>Uniform Guidance</td>
</tr>
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</table>

b) If this Agreement is federally funded, the Contractor will provide copies of audit reports required under any of the above audit requirements to HRI within 30 days after completion of the audit.

4. Payments -
   a) No payments will be made by HRI until such time as HRI is in receipt of the following items:
      - Insurance Certificates pursuant to Article 9;
      - A copy of the Contractor's latest audited financial statements (including management letter if requested);
      - A copy of the Contractor's most recent 990 or Corporate Tax Return;
      - A copy of the Contractor's approved federal indirect cost rate(s) and fringe benefit rate (the "federal rates"); or documentation (which is acceptable to HRI) which shows the Contractor's methodology for allocating these costs to this Agreement. If, at any time during the Term the federal rates are lower than those approved for this Agreement, the rates applicable to this Agreement will be reduced to the federal rates;
      - A copy of the Contractor's time and effort reporting system procedures (which are compliant with the Uniform Guidance) if salaries and wages are approved in the Budget.
      - A copy of equipment policy if equipment is in the approved budget.
      - Further documentation as requested by HRI to establish the Contractor's fiscal and programmatic capability to perform under this Agreement.

      Unless and until the above items are submitted to and accepted by HRI, the Contractor will incur otherwise allowable costs at its own risk and without agreement that such costs will be reimbursed by HRI pursuant to the terms of this Agreement. No payments, which would otherwise be due under this Agreement, will be due by HRI until such time, if ever, as the above items are submitted to and accepted by HRI.

b) The Contractor shall submit voucher claims and reports of expenditures at the Required Voucher Frequency noted on the face page of this Agreement, in such form and manner, as HRI shall require. HRI will reimburse Contractor upon receipt of expense vouchers pursuant to the Budget in Exhibit B, so long as Contractor has adhered to all the terms of this Agreement and provided the reimbursement is not disallowed or disallowable under the terms of this Agreement. All information required on the voucher must be provided or HRI may pay or disallow the costs at its discretion. HRI reserves the right to request additional back up documentation on any voucher submitted. Further, all vouchers must be received within thirty (30) days of the end of each period defined as the Required Voucher Frequency (i.e. each month, each quarter). Contractor shall submit a final voucher designated by the Contractor as the "Completion Voucher" no later than sixty (60) days from termination of the Agreement. Vouchers received after the 60 day period may be paid or disallowed at the discretion of HRI.
c) The Contractor agrees that if it shall receive or accrue any refunds, rebates, credits or other amounts (including any interest thereon) that relate to costs for which the Contractor has been reimbursed by HRI under this Agreement it shall notify HRI of that fact and shall pay or, where appropriate, credit HRI those amounts.

d) The Contractor represents, warrants and certifies that reimbursement claimed by the Contractor under this Agreement shall not duplicate reimbursement received from other sources, including, but not limited to client fees, private insurance, public donations, cooperative agreements, legislative funding from units of government, or any other source. The terms of this paragraph shall be deemed continuing representations upon which HRI has relied in entering into and which are the essences of its agreements herein.

5. Termination - Either party may terminate this Agreement with or without cause at any time by giving thirty (30) days written notice to the other party. HRI may terminate this Agreement immediately upon written notice to the Contractor in the event of a material breach of this Agreement by the Contractor. It is understood and agreed, however, that in the event that Contractor is in default upon any of its obligations hereunder at the time of any termination, such right of termination shall be in addition to any other rights or remedies which HRI may have against Contractor by reason of such default. Upon termination of the Agreement by either party for any reason, Contractor shall immediately turn over to HRI any works in progress, materials, and deliverables (whether completed or not) related to the services performed up to the date of termination.

6. Representations and Warranties – Contractor represents and warrants that:
   a) it has the full right and authority to enter into and perform under this Agreement;
   b) it will perform the services set forth in Exhibit A in a workmanlike manner consistent with applicable industry practices;
   c) the services, work products, and deliverables provided by Contractor will conform to the specifications in Exhibit A;
   d) there is no pending or threatened claim or litigation that would have a material adverse impact on its ability to perform as required by this Agreement.

7. Indemnity - To the fullest extent permitted by law, Contractor shall indemnify, hold harmless and defend HRI, its agents and employees, the New York State Department of Health, and the People of the State of New York against all claims, damages, losses or expenses including but not limited to attorneys’ fees arising out of or resulting from the performance of the agreement, provided any such claim, damage, loss or expense arises out of, or in connection with, any act or omission by Contractor, or anyone directly or indirectly employed or contracted by Contractor, in the performance of services under this Agreement, and such acts or omissions (i) constitute negligence, willful misconduct, or fraud; (ii) are attributable to bodily injury, sickness, disease or death, or to injury to or destruction of tangible property, including loss of use resulting there from; (iii) cause the breach of any confidentiality obligations set forth herein; (iv) relate to any claim for compensation and payment by any employee or agent of Contractor; (v) result in intellectual property infringement or misappropriation by Contractor, its employees, agents, or subcontractors; or (vi) are violations of regulatory or statutory provisions of the New York State Labor Law, OSHA or other governing rule or applicable law. The obligation of the Contractor to indemnify any party under this paragraph shall not be limited in any manner by any limitation of the amount of insurance coverage or benefits including workers’ compensation or other employee benefit acts provided by the Contractor. In all subcontracts entered into by the Contractor related to performance under this Agreement, the Contractor will include a provision requiring the subcontractor to provide the same indemnity and hold harmless to the indemnified parties specified in this paragraph.

8. Amendments/Budget Changes –
   a) This Agreement may be changed, amended, modified or extended only by mutual consent of the parties provided that such consent shall be in writing and executed by the parties hereto prior to the time such change shall take effect, with the exception of changes and amendments that are made mandatory by the Project Sponsor under the sponsoring cooperative agreement/contract, which will take effect in accordance with the Project Sponsor’s requirements and schedule.

   b) In no event shall there be expenses charged to a restricted budget category without prior written consent of HRI.
c) The Budget Flexibility Percentage indicates the percent change allowable in each category of the Budget, with the exception of a restricted budget category. As with any desired change to this Agreement, budget category deviations exceeding the Budget Flexibility Percentage in any category of the Budget are not permitted unless approved in writing by HRI. In no way shall the Budget Flexibility Percentage be construed to allow the Contractor to exceed the Total Contract Amount less the restricted budget line, nor shall it be construed to permit charging of any unallowable expense to any budget category. An otherwise allowable charge is disallowed if the charge amount plus any Budget Flexibility Percentage exceeds the amount of the budget category for that cost.

9. Insurance –
   a) The Contractor shall maintain or cause to be maintained, throughout the Term, insurance or self-insurance equivalents of the types and in the amounts specified in section b) below. Certificates of Insurance shall evidence all such insurance. It is expressly understood that the coverage’s and limits referred to herein shall not in any way limit the liability of the Contractor. The Contractor shall include a provision in all subcontracts requiring the subcontractor to maintain the same types and amounts of insurance specified in b) below.

   b) The Contractor shall purchase and maintain at a minimum the following types of insurance coverage and limits of liability:

      1) Commercial General Liability (CGL) with limits of insurance of not less than $1,000,000 each Occurrence and $2,000,000 Annual Aggregate. If the CGL coverage contains a General Aggregate Limit, such General Aggregate shall apply separately to each project. HRI and the People of the State of New York shall be included as Additional Insureds on the Contractor’s CGL, using ISO Additional Insured Endorsement CG 20 10 11 85 or an endorsement providing equivalent coverage to the Additional Insureds. The CGL insurance for the Additional Insureds shall be as broad as the coverage provided for the Named Insured Contractor. It shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds.

      2) Business Automobile Liability (AL) with limits of insurance of not less than $1,000,000 each accident. AL coverage must include coverage for liability arising out of all owned, leased, hired and non-owned automobiles. HRI and the People of the State of New York shall be included as Additional Insureds on the Contractor’s AL policy. The AL coverage for the Additional Insureds shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds.

      3) Workers Compensation (WC) & Employers Liability (EL) with limits of insurance of not less than $100,000 each accident for bodily injury by accident and $100,000 each employee for injury by disease.

      4) If specified by HRI, Professional Liability Insurance with limits of liability of $1,000,000 each occurrence and $3,000,000 aggregate.

   c) Provide that such policy may not be canceled or modified until at least 30 days after receipt by HRI of written notice thereof; and

   d) Be reasonably satisfactory to HRI in all other respects.

10. Publications and Conferences –
   a) All written materials, publications, journal articles, audio-visuals that are either presentations of, or products of the Scope of Work which are authorized for publication or public dissemination, subject to the confidentiality restrictions herein, will acknowledge HRI, the New York State Department of Health (NYSDOH) and the Project Sponsor and will specifically reference the Sponsor Reference Number as the contract/cooperative agreement funding the work with a disclaimer, as appropriate, such as: “The content of this publication (journal article, etc.) is solely the responsibility of the authors and does not necessarily
represent the official views of HRI or the Project Sponsor. This requirement shall be in addition to any publication requirements or provisions specified in Attachment B – Program Specific Clauses.

b) Conference Disclaimer: Where a conference is funded by a cooperative agreement, cooperative agreement, sub-cooperative agreement and/or a contract the recipient must include the following statement on conference materials, including promotional materials, agenda, and Internet sites, “Funding for this conference was made possible (in part) by the <insert Project Sponsor name>. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of HRI, NYS Department of Health or the Project Sponsor, nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.”

Use of Logos: In order to avoid confusion as to the conference source or a false appearance of Government, HRI or NYSDOH endorsement, the Project Sponsor, HRI and/or NYSDOH’s logos may not be used on conference materials without the advance, express written consent of the Project Sponsor, HRI and/or NYSDOH.

11. Title -

a) Unless noted otherwise in an attachment to this Agreement, title to all equipment purchased by the Contractor with funds from this Agreement will remain with Contractor. Notwithstanding the foregoing, at any point during the Term or within 180 days after the expiration of the Term, HRI may require, upon written notice to the Contractor, that the Contractor transfer title to some or all of such equipment to HRI. The Contractor agrees to expeditiously take all required actions to effect such transfer of title to HRI when so requested. In addition to any requirements or limitations imposed upon the Contractor pursuant to paragraph 3 hereof, during the Term and for the 180 day period after expiration of the Term, the Contractor shall not transfer, convey, sublet, hire, lien, cooperative agreement a security interest in, encumber or dispose of any such equipment. The provisions of this paragraph shall survive the termination of this Agreement.

b) Contractor acknowledges and agrees that all work products, deliverables, designs, writings, inventions, discoveries, and related materials (collectively, “Works”) made, produced or delivered by Contractor in the performance of its obligations hereunder will be owned exclusively by HRI. All copyrightable Works are “works made for hire”, which are owned by HRI. Contractor will assign, and hereby assigns and transfers to HRI, all intellectual property rights in and to Works, including without limitation, copyrights, patent rights, trademark rights, and trade secret rights. The Contractor shall take all steps necessary to effect the transfer of the rights cooperative agreed upon in this paragraph to HRI. As set forth in paragraph 18(d) herein, Standard Patent Rights Clauses under the Bayh-Dole Act (37 C.F.R. 401) are hereby incorporated by reference and shall supersede any terms in this Agreement that may conflict therewith. The provisions of this paragraph shall survive the termination of this Agreement.

12. Confidentiality - Information relating to individuals who may receive services pursuant to this Agreement shall be maintained and used only for the purposes intended under the Agreement and in conformity with applicable provisions of laws and regulations or specified in Attachment B, Program Specific Clauses. Contractor acknowledges and agrees that, during the course of performing services under this Agreement, it may receive information of a confidential nature, whether marked or unmarked, (“Confidential Information”). Contractor agrees to protect such Confidential Information with the same degree of care it uses to protect its own confidential information of a similar nature and importance, but with no less than reasonable care. Contractor will not use Confidential Information for any purpose other than to facilitate the provision of services under this Agreement, and Contractor will not disclose Confidential Information in an unauthorized manner to any third party without HRI’s advance written consent.

13. Equal Opportunity and Non-Discrimination - Contractor acknowledges and agrees, whether or not required by Article 15 of the New York State Executive Law (also known as the Human Rights Law) or any other State or Federal statutory or constitutional non-discrimination provisions, that Contractor will not discriminate against any employee or applicant for employment because of race, color, creed, religion, sex, sexual orientation, gender identity, national origin, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, Contractor agrees that neither it nor its authorized subcontractors, if any, shall, by reason of race, color, creed,
disability, age, sex, sexual orientation, gender identity, national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this Agreement. Contractor is subject to fines of $50.00 per person per day for any violation of this provision, or of Section 220-e or Section 239 of the New York State Labor Law, as well as possible termination of this Agreement and forfeiture of all moneys due hereunder for a second or subsequent violation.

14. Use of Names - Unless otherwise specifically provided for in Attachment B, Program Specific Clauses, and excepting the acknowledgment of sponsorship of this work as required in paragraph 10 hereof (Publications), the Contractor will not use the names of Health Research, Inc. the New York State Department of Health, the State of New York or any employees or officials of these entities without the express written approval of HRI.

15. Site Visits and Reporting Requirements -
   a) Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance of the services under this Agreement (collectively, “Records”). The Records must be kept for three years after the final voucher is paid.

   b) HRI and the Project Sponsor or their designee(s) shall have the right to conduct site visits where services are performed and observe the services being performed by the Contractor and any subcontractor and inspect Records. The Contractor shall render all assistance and cooperation to HRI and the Project Sponsor in connection with such visits. The surveyors shall have the authority, to the extent designated by HRI, for determining contract compliance as well as the quality of services being provided.

   c) The Contractor agrees to provide the HRI Project Director, or his or her designee complete reports, including but not limited to, narrative and statistical reports relating to the project's activities and progress at the Reporting Frequency specified in Exhibit C. The format of such reports will be determined by the HRI Project Director and conveyed in writing to the Contractor.

16. Miscellaneous –
   a) Contractor and any subcontractors are independent contractors, not partners, joint ventures, or agents of HRI, the New York State Department of Health or the Project Sponsor; nor are the Contractor's or subcontractor's employees considered employees of HRI, the New York State Department of Health or the Project Sponsor for any reason. Contractor shall pay employee compensation, fringe benefits, disability benefits, workers compensation and/or withholding and other applicable taxes (collectively the "Employers Obligations") when due. The contractor shall include in all subcontracts a provisions requiring the subcontractor to pay its Employer Obligations when due. Contractor is fully responsible for the performance of any independent contractors or subcontractors.

   b) This Agreement may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet, subjected to any security interest or encumbrance of any type, or disposed of without the previous consent, in writing, of HRI.

   c) This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

   d) Contractor shall have no interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity, that may create a conflict, or the appearance of a conflict, with the proper discharge of Contractor’s duties under this Agreement or the conflict of interest policy of any agency providing federal funding under this Agreement. In the event any actual or potential conflict arises, Contractor agrees to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential or actual conflict. Contractor certifies that it has implemented and is in compliance with a financial conflict of interest policy that complies with 42 CFR Part 50 Subpart F, as may be amended from time to time.

   Contractor acknowledges that it cannot engage in any work or receive funding from HRI until they have disclosed all financial conflicts of interest and identified an acceptable management strategy to HRI. At HRI’s request, Contractor will provide information about how it identified, managed, reduced or eliminated conflicts of interest. Failure to disclose such conflicts or to provide information to HRI may be cause for
termination as specified in the Terms & Conditions of this Agreement. HRI shall provide Contractor with a

   copy of notifications sent to the funding agency under this Agreement.

c) Regardless of the place of physical execution or performance, this Agreement shall be construed according
to the laws of the State of New York and shall be deemed to have been executed in the State of New York.
   Any action to enforce, arising out of or relating in any way to any of the provisions of this Agreement may
   only be brought and prosecuted in such court or courts located in the State of New York as provided by
   law; and the parties' consent to the jurisdiction of said court or courts located in the State of New York and
to venue in and for the County of Albany to the exclusion of all other court(s) and to service of process by
certified or registered mail, postage prepaid, return receipt requested, or by any other manner provided by
law. The provisions of this paragraph shall survive the termination of this Agreement.

f) All official notices to any party relating to material terms hereunder shall be in writing, signed by the party
   giving it, and shall be sufficiently given or served only if sent by registered mail, return receipt requested,
   addressed to the parties at their addresses indicated on the face page of this Agreement.

g) If any provision of this Agreement or any provision of any document, attachment or Exhibit attached hereto
   or incorporated herein by reference shall be held invalid, such invalidity shall not affect the other
   provisions of this Agreement but this Agreement shall be reformed and construed as if such invalid
   provision had never been contained herein and such provision reformed so that it would be valid, operative
   and enforceable to the maximum extent permitted.

h) The failure of HRI to assert a right hereunder or to insist upon compliance with any term or condition of
   this Agreement shall not constitute a waiver of that right by HRI or excuse a similar subsequent failure to
   perform any such term or condition by Contractor.

i) It is understood that the functions to be performed by the Contractor pursuant to this Agreement are non-
   sectarian in nature. The Contractor agrees that the functions shall be performed in a manner that does not
   discriminate on the basis of religious belief and that neither promotes nor discourages adherence to
   particular religious beliefs or to religion in general.

j) In the performance of the work authorized pursuant to this Agreement, Contractor agrees to comply with all
   applicable project sponsor, federal, state and municipal laws, rules, ordinances, regulations, guidelines, and
   requirements governing or affecting the performance under this Agreement in addition to those specifically
   included in the Agreement and its incorporated Exhibits and Attachments.

k) This Agreement may be executed in two or more counterparts, each of which shall be deemed an original
   but all of which together shall constitute one and the same instrument. Delivery of an executed signature
   page to the Agreement by facsimile transmission or PDF shall be as effective as delivery of a manually
   signed counterpart.

17. Federal Regulations/Requirements Applicable to All HRI Agreements -
   The following are federal regulations, which apply to all Agreements; regardless of the source of the funding
   (federal/non-federal) specified on the face page of this Agreement. Accordingly, regardless of the funding
   source, the Contractor agrees to abide by the following:

   a) Human Subjects, Derived Materials or Data - If human subjects are used in the conduct of the work
      supported by this Agreement, the Contractor agrees to comply with the applicable federal laws, regulations,
      and policy statements issued by DHHS in effect at the time the work is conducted, including by not limited
      to Section 474(a) of the HHS Act, implemented by 45 CFR Part 46 as amended or updated. The Contractor
      further agrees to complete an OMB No. 0990-0263 form on an annual basis.

   b) Laboratory Animals - If vertebrate animals are used in the conduct of the work supported by this
      Agreement, the Contractor shall comply with the Laboratory Animal Welfare Act of 1966, as amended (7
      USC 2131 et. seq.) and the regulations promulgated thereunder by the Secretary of Agriculture pertaining
      to the care, handling and treatment of vertebrate animals held or used in research supported by Federal
      funds. The Contractor will comply with the HHS Policy on Humane Care and Use of Laboratory Animals
by Awardee Institutions and the U.S. Government Principles for the Utilization and Care of Vertebrate Animals Used in Testing, Research and Training.

c) Research Involving Recombinant DNA Molecules - The Contractor and its respective principle investigators or research administrators must comply with the most recent Public Health Service Guidelines for Research Involving Recombinant DNA Molecules published at Federal Register 46:266 or such later revision of those guidelines as may be published in the Federal Register as well as current NIH Guidelines for Research Involving Recombinant DNA Molecules.

d) Contractor is required to register with SAM.gov and maintain active status as stated in 2 CFR Subtitle A, Chapter 1, and Part 25. Contractor must maintain the accuracy/currency of the information in SAM at all times during which the Contractor has an active agreement with HRI. Additionally, the Contractor is required to review and update the information at least annually after the initial registration, and more frequently if required by changes in information.

c) Equal Employment Opportunity – for all agreements

This contractor and subcontractor shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

This contractor and subcontractor shall abide by the requirements of 41 CFR 60-300.5(a). This regulation prohibits discrimination against qualified protected veterans, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified protected veterans.

18. Federal Regulations/Requirements Applicable to Federally Funded Agreements through HRI -
The following clauses are applicable only for Agreements that are specified as federally funded on the Agreement face page:

a) If the Project Sponsor is an agency of the Department of Health and Human Services: The Contractor must be in compliance with the following Department of Health and Human Services and Public Health Service regulations implementing the statutes referenced below and assures that, where applicable, it has a valid assurance (HHS-690) concerning the following on file with the Office of Civil Rights, Office of the Secretary, HHS.

1) Title VI of the Civil Rights Act of 1964 as implemented in 45 CFR Part 80.
2) Section 504 of the Rehabilitation Act of 1973, as amended, as implemented by 45 CFR Part 84.
4) Title IX of the Education Amendments of 1972, in particular section 901 as implemented at 45 CFR Part 86 (elimination of sex discrimination).
5) Sections 522 and 526 of the HHS Act as amended, implemented at 45 CFR Part 84 (non-discrimination for drug/alcohol abusers in admission or treatment).
6) Section 543 of the HHS Act as amended as implemented at 42 CFR Part 2 (confidentiality of records of substance abuse patients).
7) Trafficking in Persons – subject to the requirement of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104).
8) HHS regulatory requirements on Responsibility of Applicants for Promoting Objectivity in Research and financial conflicts of interest set forth in 42 C.F.R Parts 50 and 94.
9) Contractor agrees to comply with other requirements of the Project Sponsor, if applicable, set forth in the HHS Cooperative agreements Policy Statement.

b) Notice as Required Under Public Law 103-333: If the Project Sponsor is an agency of the Department of Health and Human Services, the Contractor is hereby notified of the following statement made by the Congress at Section 507(a) of Public Law 103-333 (The DHHS Appropriations Act, 1995, hereinafter the "Act"): It is the sense of the Congress that, to the greatest extent practicable, all equipment and products purchased with funds made available in this Act should be American-made.
c) Contractor agrees that if the Project Sponsor is other than an agency of the DHHS, items 1, 2, 3 and 4 in subsection a) above shall be complied with as implemented by the Project Sponsor.

d) Contractor agrees that the Standard Patent Rights Clauses under the Bayh-Dole Act (37 C.F.R 401) are hereby incorporated by reference and shall supersede any terms in this Agreement that may conflict therewith.

c) Criminal Penalties for Acts Involving Federal Health Care Programs - Recipients and sub-recipients of Federal funds are subject to the strictures of 42 U.S.C. 1320A-7B(b)) and should be cognizant of the risk of criminal and administrative liability under this statute, including for making false statements and representations and illegal remunerations.

g) Equipment and Products - To the greatest extent practicable, all equipment and products purchased with federal funds should be American-made.

h) Acknowledgment of Federal Support – When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part by federal money, all awardees receiving Federal funds, including and not limited to State and local governments and recipients of Federal research cooperative agreements, shall clearly state (1) the percentage of the total costs of the program or project which will be financed with Federal money, (2) the dollar amount of Federal funds for the project or program, and (3) percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

i) Recipients and sub-recipients of Federal funds are subject to the strictures of the Medicare and Medicaid anti-kickback statute (42. U.S.C. 1320a-7b(b) and should be cognizant of the risk of criminal and administrative liability under this statute, specifically under 42 U.S.C. 1320 7b(b) illegal remunerations which states, in part, that whoever knowingly and willfully: (A) Solicits or receives (or offers or pays) any remuneration (including kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring (or to induce such person to refer) and individual to a person for the furnishing or arranging for the furnishing of any item or service, OR (B) in return for purchasing, leasing, ordering, or recommending purchasing, leasing, or ordering, or to purchase, lease, or order, any goods, facility, services, or item for which payment may be made in whole or in part under subchapter XIII of this chapter or a State health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years or both.

j) Clean Air Act and the Federal Water Pollution Control Act Compliance - If this contract is in excess of $150,000, Contractor agrees to comply and to require that all subcontractors have complied, where applicable, with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. § 7401-7671q.) and the Federal Water Pollution Control Act as amended (33 U.S.C. §1251-1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

k) Americans With Disabilities Act - This agreement is subject to the provisions of Subtitle A of Title II of the Americans with Disabilities Act of 1990, 42. U.S.C. 12132 ("ADA") and regulations promulgated pursuant thereto, see 28 CFR Part 35. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs or activities pursuant to this Agreement.

l) Whistleblower Policy: Congress has enacted whistleblower protection statute 41 U.S.C. 4712, which applies to all employees working for contractors, cooperative agreeementes, subcontractors, and sub cooperative agreeementees on federal cooperative agreements and contracts. This program requires all cooperative agreeementees, sub cooperative agreeementees and subcontractors to: inform their employees working on any federally funded award they are subject to the whistleblower rights and remedies of the program; inform their employee in writing of employee whistleblower protections under 41 U.S.C. 4712 in the predominant native language of the workforce; and Contractors and cooperative agreeementees will include such requirements in any agreement made with a subcontractor or sub cooperative agreeementee.
The statute (41 U.S.C. 4712) states that an “employee of a contractor, subcontractor, cooperative agreementee [or sub cooperative agreementee] may not be discharged, demoted, or otherwise discriminated against as a reprisal for “whistleblowing”. In addition, whistleblower protections cannot be waived by any agreement, policy, form, or condition of employment.

Whistleblowing is defined as making a disclosure “that the employee reasonably believes is evidence of any of the following: gross mismanagement of a federal contract or cooperative agreement; a gross waste of federal funds; an abuse of authority related to a federal contract or cooperative agreement; a substantial and specific danger to public health or safety; or a violation of law, rule, or regulation related to a federal contract or cooperative agreement (including the competition for, or negotiation of, a contract or cooperative agreement). To qualify under the statute, the employee’s disclosure must be made to: a Member of Congress or a representative of a Congressional committee; or an Inspector General; or the Government Accountability Office; or a Federal employee responsible for contract or cooperative agreement oversight or management at the relevant agency; or an authorized official of the Department of Justice or other law enforcement agency; or a court or grand jury; a management official or other employee of the contractor, subcontractor, cooperative agreementee or sub cooperative agreementee who has the responsibility to investigate, discover or address misconduct.

19. Required Federal Certifications –
Acceptance of this Agreement by Contractor constitutes certification by the Contractor of all of the following:

a) The Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transactions by any Federal department or agency.

b) The Contractor is not delinquent on any Federal debt.


d) The Contractor shall comply with the requirements of the Pro-Children Act of 1994 and shall not allow smoking within any portion of any indoor facility used for the provision of health, day care, early childhood development, education or library services to children under the age of eighteen (18) if the services are funded by a federal program, as this Agreement is, or if the services are provided in indoor facilities that are constructed, operated or maintained with such federal funds.

e) The Contractor has established administrative policies regarding Scientific Misconduct as required by the Final Rule 42 CFR Part 93, Subpart A as published at the 54 Federal Register 32446, August 8, 1989.


g) If the Project Sponsor is either an agency of the Public Health Service or the National Science Foundation, the Contractor is in compliance with the rules governing Objectivity in Research as published in 60 Federal Register July 11, 1995.

h) Compliance with EO13513, Federal Leadership on Reducing Text Messaging while Driving, October 1, 2009. Recipients and sub recipients of CDC cooperative agreement funds are prohibited both from texting while driving a Government owned vehicle and/or using Government furnished electronic equipment while
driving any vehicle. Cooperative agreement recipients and sub recipients are responsible for ensuring their employees are aware of this prohibition and adhere to this prohibition.

i) EO 13166, August 11, 2000, requires recipients receiving Federal financial assistance to take steps to ensure that people with limited English proficiency can meaningfully access health and social services. A program of language assistance should provide for effective communication between the service provider and the person with limited English proficiency to facilitate participation in, and meaningful access to, services. The obligations of recipients are explained on the OCR website at http://www.hhs.gov/ocr/lep/revisedlep.html.


The Contractor shall require that the language of all of the above certifications will be included in the award documents for all sub awards under this Agreement (including subcontracts, sub cooperative agreements, and contracts under cooperative agreements, loans and cooperative agreements) and that all sub recipients shall certify and disclose accordingly. The Contractor agrees to notify HRI immediately if there is a change in its status relating to any of the above certifications.

V. Completing the Application

Applicants proposing to serve more than one region must submit a separate application for each region.

A. Application Content

Applications should be submitted following the order of content specified below.

1. Program Summary (2 pages maximum, NOT scored)

The work to be completed must meet the stated requirements as outlined in Section I and III.

- Applicants should describe in their program summary their overall approach to meeting the requirements outlined above including anticipated time frames and resources required;
- Applicants should assume a 30-month project period beginning on July 1, 2016 with two annual renewals issued on February 1, 2017 and February 1, 2018.
2. Application Contents (50 pages maximum, 80 points)

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<th>Item #</th>
<th>Technical qualifications, experience and approach</th>
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<td><strong>Region to be covered (NOT scored):</strong></td>
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<td>• Applicants must specify which Region they are applying to serve</td>
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<td>- The applicant is willing to serve all of the eligible practices in the region, or</td>
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<td>- The applicant is willing to serve only certain practices in a region and must explicitly define those practices, how they are/were selected and how additional practices will be selected in the future.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Operating approach to PT TA (10 pages maximum, 25 points):</strong></td>
</tr>
<tr>
<td></td>
<td>Applicants should describe their approach for delivering PT support that will allow practices to achieve APC Gates and milestones. This description should include the following:</td>
</tr>
<tr>
<td></td>
<td>- A detailed curriculum to be used to guide PT support, sufficient to advance practices from one gate to another within prescribed timeframes. The curriculum must delineate the activities to be performed by the PT TA contractor and the practices being served. This should include an outline of the lessons to be delivered within each of the seven required instructional modules and a set of sample units and sample topics (see Section III.D). This is hereby referred to as the “standard curriculum.”</td>
</tr>
<tr>
<td></td>
<td>- A description of the total number of hours to be provided in support of each provider/practice in each of the required instructional methods over the course of delivering the standard curriculum, including a breakdown of how each is to be used to deliver each of the seven required instructional modules (see Section III.D).</td>
</tr>
<tr>
<td></td>
<td>- A description of resources that practices will be able to access remotely (see Section III.D.4).</td>
</tr>
<tr>
<td></td>
<td>- A proposed approach to tailoring the curriculum to the needs of each individual practice (see Section III). This description should include the applicant’s strategies and specific activities related to tailoring the curriculum to the following scenarios:</td>
</tr>
<tr>
<td></td>
<td>o A practice without an electronic health record (EHR) system vs. a practice with an EHR system that is not yet maximized versus a practice with well integrated EHR workflows.</td>
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<td></td>
<td>o A practice in a rural or isolated region vs. a practice in an urban region.</td>
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<tr>
<td></td>
<td>o A small practice with less than three primary care providers (PCPs) vs. a large practice with more than seven PCPs.</td>
</tr>
<tr>
<td></td>
<td>o A description of the region-specific advantages, if any, the applicant has in its operating approach to each of the regions it is proposing to serve.</td>
</tr>
</tbody>
</table>
## Applicant Experience and Staffing Plan (15 pages maximum, 15 points)

Applicants will be evaluated based on the experience and capabilities of their staff. Applicants should provide information on the key personnel who will be working on the project. This section should include:

- Short bios including names, relevant experience and capabilities for each individual that will be participating, including on-the-ground PT staff, management support, and subject matter experts. Include the number of hours per week that each staff person will dedicate specifically to this contract. Resumes should be submitted at the end of this application section, but do not count toward the page limit.

- Job descriptions and hiring criteria for new positions to be hired, including the number of hours per week that each staff person will dedicate specifically to this contract.

- An organizational chart that shows the management structure of the applicant organization, where the PT TA Services contract will fall within the organizational structure and the reporting structure of PT TA staff.

- A sample organizational chart from the perspective of a single enrolled practice, including information describing how many Contract personnel are dedicated to the practice, both in the field and central expertise, and management and what percentage of time each is dedicating to the practice.

- Description of the region-specific advantages, if any, the applicant has in its staffing approach to the region it is proposing to serve.

Applicants will be evaluated in part based upon their prior experience in PT. Applicants should provide up to five examples of past experiences in PT within the past five years. These should include:

- Number of practices served.

- Summary of overall goals, dates and scope of services provided, including ways in which the scope and approach were similar to or different from the scope of this RFA.

- Approach and key learnings generated from the experience.

- Outcome that was achieved.

- If the applicant is a provider organization, they should describe whether the PT was for its own and/or affiliated providers, or if the PT TA was for unaffiliated providers.

Description of the region-specific experience, if any, the applicant has in its past operation. Applicants may also attach a Letter of Reference (maximum of three letters) from practices successfully transformed by the applicant.

## Conflict of interest declaration and management plan (5 pages maximum, 10 points)

Applicants will be evaluated in part based upon their ability to provide all of their enrolled practices with an appropriate level of service, regardless of the potential conflicts of interest that they may have. For instance, health systems may have a conflict of interest in enrolling unaffiliated practice sites, and should describe how they will ensure that these unaffiliated practices receive comparable levels of service and support as enrolled practices affiliated with the health plan. Similarly, payers may serve a range of practices, some of which will have a high proportion of members and some of which may have no members, and they should describe how they will ensure that all enrolled practices will receive comparable levels of support. Specifically,
Applicants are expected to:
- Declare known and potential conflicts of interest, including with whom and the nature of the conflict
- Present a plan to address, preempt or mitigate these conflicts
- Attest that they will operate in a conflict-free way

5 Underserved populations and regions plan (5 pages maximum, 10 points).

Applicants will be evaluated in part based on their ability to engage practices that serve underserved populations and regions.

- For the purposes of this application, medically underserved populations and regions will be defined as those designated as Health Professional Shortage Areas for Primary Care by the Health Resources and Services Administration (http://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx). These areas are defined by a shortage of primary care doctors relative to the population, but the primary care needs of each community will vary according to its unique characteristics.
- Competitive applications will include plans that illustrate for each region in which the applicant plans to enroll practices:
  a. Description of the applicant’s abilities to address the region’s distinct challenges
  b. Description of the region-specific advantages, if any, the applicant has in serving underserved populations and/or the regions outlined in Attachment 2

6 Operations and Timeline (10 pages maximum, 10 points)

Applicants will be evaluated in part based on their ability to reach the scale of operations described in their applications. Applicants should describe their plan for ramping up, including establishing a presence in NYS if one does not already exist. The plan should include:

- Overall contract timeline and annual plans that will allow the applicant to serve practices within their chosen regions at scale, both for purposes of PT TA and for gating assessments (see Section III.G).
- Challenges anticipated in ramping up and ways in which they will be resolved
- Sample of the agreement that will be used when beginning interventions in each practice including a plan of approach and a timeline for accomplishing work
- Description of any previous experience in rapidly reaching scale and how lessons learned will translate to this Contract
- Description of any region-specific advantages, if any, the applicant has in ramping up to the scale of operations described

7 Approach to population health goals of APC (5 pages maximum, 10 points)

Applicants are expected to demonstrate how they will support the population health goals of APC as part of the overarching curriculum. Applicants should describe:

- Their approach to supporting primary care practices in delivering clinical preventive services that help achieve New York’s Prevention Agenda goals (https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/)
B. Application Format

ALL APPLICATIONS MUST CONFORM TO THE FORMAT DESCRIBED BELOW. POINTS WILL BE DEDUCTED FROM APPLICATIONS WHICH DEVIATE FROM THE DESCRIBED FORMAT.

Applications MUST NOT exceed 52 single -spaced typed pages (not including the cover page, budget and attachments), using 11pt Times New Roman font. The value assigned to each section is an indication of the relative weight that will be given when scoring your application.

1. Program Summary 2 page maximum (not scored)
2. Application Contents (50 page maximum) (Maximum Score: 80 points)
3. Budget (Use Attachment 5) (Maximum Score: 20 points)

C. Review Process

Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by HRI/NYSDOH.

In the event of a tie score, the highest scoring applicants will be invited to an interview to last for no longer than one hour in Albany, New York. Any cost related to this meeting or in response to this RFA is the obligation of the applicant. Applications failing to provide all response requirements or failing to follow the prescribed format may be removed from consideration or points may be deducted.

*It is anticipated that there will be one or more awards per region. An applicant may be awarded more than one region. The applications receiving the highest score in the region will receive the award.*
HRI/NYSDOH reserves the right to determine the number of awards per region. Applications will be reviewed using the criteria listed under “Application Content.”

If changes in funding amounts are necessary for this Contract, funding will be modified and awarded in the same manner as outlined in the award process described above.

Once an award has been made, applicants may request a debriefing of their application. The debriefing will be limited only to the strengths and weaknesses of the subject application and will not include discussion of other applications. Requests must be received no later than ten (10) business days from the date of the award or non-award announcement.

VI. Attachments

Attachment 1: Application Coversheet
Attachment 2: New York Standardized Rating Regions
Attachment 3: APC Gates and Milestones
Attachment 4: Sample Curriculum
Attachment 5: Budget Instructions
Attachment 6: APC Gate Assessment Tool
Attachment 7: APC Milestone Technical Specifications
Application Cover Sheet

PT TA Services RFA
RFA# QPS-2016-01

Applicant:

Contact Person:

Name

Title

Address

Phone

(  )

Email

Total Application Budget: ____________________________

I, ____________________________, for and on behalf of the applicant organization, signify that the following information is true and accurate to the best of my knowledge and that the above named network/organization agrees to abide by the content of this application and is fully able and willing to carry out the contract.

Signature

Name

Title

Date
New York Standardized Rating Regions
### APC Gates and Milestones

<table>
<thead>
<tr>
<th>Gate</th>
<th>Capability</th>
<th>Milestone</th>
</tr>
</thead>
</table>
| **Gate 1** | Participation                      | Early change plan based on Practice self-assessment tool  
  
  Designated change agent/champion  
  
  Participation in PT TA Services contractor-sponsored APC orientation  
  
  Commitment to achieve Gate 2 milestones within one year  
  
  **Patient-centered care**  
  
  Process for Advanced Directive discussions with all patients  
  
  **Care Management/Care Coordination**  
  
  Behavioral Health: begin integration of self-assessment action plan with goal planning to reach Gate 2  
  
  **Access to care**  
  
  24/7 access to a provider (synchronous and asynchronous communication with explicit response time goals)  
  
  **Health Information Technology (HIT)**  
  
  Plan for achieving Gate 2 milestones within one year  
  
  **Payment model**  
  
  Commitment to Office Based Payment payers representing 60 percent of panel within one year  
  
  **Performance**  
  
  Plan for collecting and reporting non-claims-based data relevant for core measures  |
| **Gate 2** (in addition to all previous) | Participation                      | Participation in PT TA Services contractor activities and learning (if electing support)  
  
  **Patient-centered care**  
  
  Plan for reporting on Advanced Directives and developing criteria to demonstrate patient engagement and integration into workflows within one year  
  
  **Care management and coordination**  
  
  Assign patients to a care team and implement a tracking system to identify highest risk patients for Care Management/ Care Coordination  
  
  Ramp-up plan to deliver Care Management/ Care Coordination to highest-risk patients (percentage within patient panel) within one year  
  
  Behavioral health: evidence-based process for screening, treatment when appropriate and referral  
  
  Identify key components and ramp up capability to establish structured Care Plans and establish care compacts  
  
  Develop capability for systematically tracking patients throughout referral process |
<table>
<thead>
<tr>
<th>Gate</th>
<th>Capability</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Access to care</td>
<td>Same-day appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improve patient communication for enhanced and non-emergent care using options such as a patient portal or nurse call line</td>
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<td></td>
<td></td>
<td>Culturally and linguistically appropriate services</td>
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<tr>
<td></td>
<td>HIT</td>
<td>Tools for quality measurement encompassing all core measures</td>
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<tr>
<td></td>
<td></td>
<td>Tools for community care coordination including care planning and secure messaging</td>
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<tr>
<td></td>
<td></td>
<td>Attestation to connect to Health Information Exchange (HIE) within one year</td>
</tr>
<tr>
<td></td>
<td>Payment model</td>
<td>Value-based contracts with APC-participating payers representing 60 percent of panel</td>
</tr>
<tr>
<td></td>
<td>Performance</td>
<td>Report and use data on all core measures, including data necessary to assess health disparities</td>
</tr>
<tr>
<td>Gate 3</td>
<td>Patient centered care</td>
<td>Engagement: survey, focus group or equivalent plus Quality Improvement (QI) plan based on results (yearly) that results in the use of one QI project</td>
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<tr>
<td></td>
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<td>Advanced Directives are available in electronic format and exchanged through HIE</td>
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<tr>
<td></td>
<td>Population health</td>
<td>Identification and outreach to patients due for preventative or chronic care management as needed/appropriate.</td>
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<td>Process to refer to self-management programs and community-based resources</td>
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<td></td>
<td>Participate in at least two mutual Prevention Agenda activities annually in conjunction with local health department</td>
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<tr>
<td></td>
<td>Care management and coordination</td>
<td>Care plans developed in concert with patient preferences and goals</td>
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<tr>
<td></td>
<td></td>
<td>Care Management delivered to highest-risk patients</td>
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<tr>
<td></td>
<td></td>
<td>Referral tracking system for care transitions</td>
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<td></td>
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<td>Care compacts or collaborative agreements with medical specialists and institutions including linkages with behavioral health providers.</td>
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<td></td>
<td></td>
<td>Post-discharge follow-up process for care transitions</td>
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<td></td>
<td></td>
<td>Coordinated care management for behavioral health</td>
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<tr>
<td></td>
<td>Access to care</td>
<td>At least one session weekly during non-traditional hours</td>
</tr>
<tr>
<td></td>
<td>HIT</td>
<td>24/7 secure remote electronic health record access to a qualified provider</td>
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<td></td>
<td></td>
<td>Secure electronic provider-patient messaging</td>
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<tr>
<td>Gate</td>
<td>Capability</td>
<td>Milestone</td>
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<tr>
<td></td>
<td></td>
<td>Enhance quality improvement using certified health IT</td>
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<td></td>
<td></td>
<td>Connected to local HIE qualified bidder and using data for patient care</td>
</tr>
<tr>
<td>Payment</td>
<td>Model</td>
<td>Value-based contracts with APC-participating payers representing 60 percent of panel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Minimum upside risk-sharing</td>
</tr>
<tr>
<td>Performance</td>
<td></td>
<td>A quality improvement plan on three prioritized core measures, including utilization and addressing health access and outcome disparities</td>
</tr>
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<td></td>
<td></td>
<td>Positive trajectory on utilization/cost core measures while meeting quality expectations</td>
</tr>
</tbody>
</table>
## Sample Curriculum

<table>
<thead>
<tr>
<th>Required modules</th>
<th>Sample units</th>
<th>Sample Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction to APC</strong></td>
<td><em>Goals and structure of APC</em></td>
<td>Capabilities, milestones and measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Business case for outcomes-based payments</td>
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<tr>
<td></td>
<td></td>
<td>Support provided by APC program during transition</td>
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<tr>
<td></td>
<td></td>
<td>Practice-specific milestone completion plan incorporating defined timelines and “best practice” strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing practice leadership to champion transformation process</td>
</tr>
<tr>
<td><strong>HIT</strong></td>
<td><em>Integrating HIT into practice workflows</em></td>
<td>Creating actionable data: how to integrate population health and other HIT tools into your practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connecting to and using data and services from a RHIO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incorporating clinical workflow changes to increase data quality and usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing EHR data quality through the use of tools to ensure data can be used for quality reporting and analytics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advanced EHR use for population health, care management and coordination, data measurement and reporting, and other applications</td>
</tr>
<tr>
<td><strong>Practice capability building</strong></td>
<td><em>Patient-centered care</em></td>
<td>Developing a strong practice team and role-based workflows</td>
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<tr>
<td></td>
<td></td>
<td>Tools and systems for engaging with patients: motivational interviewing, shared decision-making and more</td>
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<tr>
<td></td>
<td></td>
<td>Incorporating patient preferences and goals into care and responding to patient’s non-medical needs (including cultural competence, vulnerable populations and patient literacy considerations)</td>
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<tr>
<td></td>
<td></td>
<td>Creating a QI plan based on patient input: patient family advisory councils and patient experience data</td>
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<tr>
<td><strong>Population Health</strong></td>
<td></td>
<td>Delivering clinical prevention services, including those that help achieve Prevention Agenda goals</td>
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<tr>
<td></td>
<td></td>
<td>Identifying and supporting activities of the local county Prevention Agenda coalition</td>
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<tr>
<td>Panel Management: creating structured panels assigned to individual providers and identifying risk-valued categories for EHR tracking</td>
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<tr>
<td>Evidence-based processes for managing behavioral health that include collaborative care transitions</td>
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<tr>
<td>Strengthening community linkages and partnerships to:</td>
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<tr>
<td>■ improve delivery of clinical services</td>
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<tr>
<td>■ increase the use of effective community interventions, such as chronic disease self-management programs and National Diabetes Prevention Programs</td>
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<tr>
<td>■ connect patients to resources and supports that can help maintain health</td>
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<tr>
<td>Access to care</td>
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<tr>
<td>Increasing access to your practice by phone, internet and in person (e.g., by evaluating staffing models, hours of operation and scheduling patterns)</td>
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<tr>
<td>Serving a culturally and linguistically diverse population and addressing social determinants</td>
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<tr>
<td>Care coordination and management</td>
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<tr>
<td>Create structured risk stratification and empanelment through use of standardized risk tools</td>
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<tr>
<td>Medical neighborhoods: care compacts, closed loop referrals and managing patient transitions</td>
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<tr>
<td>Creating role-based workflows to maximize capabilities of the care team</td>
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<tr>
<td>Managing your highest-risk patients</td>
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<tr>
<td>Comprehensive Care Plan development that includes protocols for high risk patients, staff coordination and transitions in care</td>
<td></td>
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<tr>
<td>Performance in outcome-based payments</td>
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<tr>
<td><strong>Moving from milestones to sustainable outcomes-based payment</strong></td>
<td></td>
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<tr>
<td>Performance management techniques for measuring, reporting and improving on data:</td>
<td></td>
<td></td>
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<tr>
<td>■ Plan, Do, Study, Act (PDSA) cycles</td>
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<tr>
<td>■ Creating a quality improvement plan</td>
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<tr>
<td>Budgeting for financial success in outcomes-based payment models</td>
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<tr>
<td>Developing a long-term strategy for care team development: training, job descriptions and role-based workflows</td>
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<tr>
<td>Workflow optimization: pre-visit planning, team huddles and other strategies</td>
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</tbody>
</table>
Attachment 5: Budget Instructions

HRI/NYSDOH will reimburse Contractors for PT TA services delivered to eligible practices, in accordance with the approved contract, using the structure described below. Applicants should prepare for a ramp-up period with little or no payments lasting until approximately the 3rd quarter of 2016. Beginning in 2017, there is an anticipated large uptake in providers served by Contractors and as such more opportunities for payments lasting until 2019.

HRI will fund only those contractors that have been awarded contracts through this RFA, and HRI funding for this program will be limited by the terms of the HRI/NYSDOH SIM award received each year. Payments will be made based on provider volume and Gate assessments conducted.

NYS intends to award a total of $8,782,703 in 2016 to fund PT in up to eight regions throughout the State. As noted, regions will be activated premised on payer participation in APC in the designated region. It is anticipated that in some regions there may be more than one award. NYS reserves the right to fund any or all successful applications at its sole discretion.

A practice site is defined as the unique physical location, along with a roster of affiliated physicians, of a primary care practice. Applications must detail total annual budgets based on region that are inclusive of the following components:

1. **Monthly payments** – Contractors will voucher on a monthly basis for each site/practice that they are providing PT TA. PT TA payments are intended to cover initial and ongoing costs associated with staffing, infrastructure, materials, tools, vendor management and program management. Applicants should submit a budget that estimates the total annual cost per practice site for the specified region with descriptive details on:
   a. the number of providers per site;
   b. the number of on-site versus remote assistance provided;
   c. the staffing model to provide needed assistance; and
   d. any other component deemed necessary to assist practices in progressing through Gates.

2. **Gating payments** – Gate payments are intended to cover the costs associated with determining whether or not practices meet established milestones and achieve Gates necessary to ensure eligibility for alternative payment (care coordination fees, outcome based payments or other as defined in payer contracts).

3. **Cost Matrix.** Use the Tables below (PT and Gating) to document unit and practice costs described in the narrative. If costs vary per practice type, system, or other factor, include all cost matrices. Include brief descriptions within the matrix, referencing the narrative if necessary. Applicants will be eligible for both monthly payments (including incentives) as well as gating payments. Further detail on incentive and gating payments is provided below.

   In the table below, describe the proposed units for each modality of service (e.g., 60 minutes of onsite coaching with the practice manager, one 30-minute webinar with Q&A functionality) for the “standard” curriculum. For each modality, describe the average number of units of support provided in the curriculum for a typical practice and the average cost per unit. Assume the same cost per participating practice site, on average, regardless of starting point (i.e., “Gate 1” or “Gate 2”). The HRI/NYSDOH reserves the right to enter into negotiations with selected awardees that may modify this budget, including scaling up or down the intensity of support in proportion with
changes in the budget. Costs per unit should be inclusive of overhead (including costs incurred drafting the annual plan and voucher documentation), travel, and management costs. Descriptions of each of these modalities are provided in Section III. The cost per practice site per month should not exceed $1,000.

PT TA - Monthly Cost Matrix – 15 Points

<table>
<thead>
<tr>
<th>Modality of service</th>
<th>Description of unit</th>
<th># units per practice site per month</th>
<th>Cost per unit</th>
<th>Cost per practice site per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting requirements</td>
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<tr>
<td>In person coaching</td>
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<tr>
<td>Learning collaborative</td>
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<tr>
<td>Group trainings</td>
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<tr>
<td>Remote support (webinars)</td>
<td></td>
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<tr>
<td>Remote support (phone and/or email)</td>
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<tr>
<td>Other (append description)</td>
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</table>

Total per practice site per month of support
**Gating Assessment Cost - 5 points**
Cost estimates must detail the number of staff required and number of staff hours to complete an assessment inclusive of both on-site work and time needed to review documentation, including the practice-completed self-assessment tool. Gating assessments may vary depending on Gate and applicants must specify cost/Gate, as appropriate. The cost per Gate assessment should not exceed $500.

<table>
<thead>
<tr>
<th>Modality of service</th>
<th>Description of Service</th>
<th># units per practice assessment</th>
<th>Cost per unit</th>
<th>Cost per practice Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-site Data Collection</td>
<td></td>
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<tr>
<td>Desk Review</td>
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<tr>
<td>Analysis of Milestones</td>
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</tbody>
</table>

**Total Cost per Gate Assessment**
# APC GATING ASSESSMENT TOOL

## Gate 1 Milestone

<table>
<thead>
<tr>
<th>Sub-Milestone Deliverables by Gate</th>
<th>AUTO-CREDITS GATE 1</th>
<th>Full Capability</th>
</tr>
</thead>
</table>
| **MILESTONE 1**: APC Commit to Participation Agreement at Gate 1; Early Change Plan based on APC Practice Self-Assessment Tool; Commitment to Designate Change Agents/Practice Leaders | N/A                  | ● All documents signed Complete  
● Early Change Plan Completed  
● Provide contact information of designated practice leaders |
| **MILESTONE 2**: Commitment to creating a process for Advanced Directive Discussion with Patients    | N/A                  | ● Design a template that includes the minimum of: Health Care Proxy, Living Will, DNR order, and;  
● Provide narrative description of process and flagging reminders in chart or EHR template |
| **MILESTONE 4**: Commitment at Gate 1 to using Self-Assessments for BH integration and commitment to achieving Gate 2 BH Milestones within one year | N/A                  | ● Practices should be able to describe their plan to integrate BH activities, including internal workflows, capacity and arrangements for collaborative BH care of appropriate patients |
| **MILESTONE 5**: Commitment to providing 24/7 Access to a Provider at Gate 1 and improve communications with patients and health entities capabilities by Gate 2. | N/A                  | ● Provide narrative of communication workflow;  
● Create a 1-month report, log or screenshots of on-call schedule noting response times created by the practice |

## Gate 2 Milestone

<table>
<thead>
<tr>
<th>Sub-Milestone Deliverables by Gate</th>
<th>AUTO-CREDITS GATE 2</th>
<th>Full Capability</th>
</tr>
</thead>
</table>
| **MILESTONE 2**: Commitment to Patient Engagement activities Integrated into Workflows within one year (by Gate 2) | PCMH 6C, F1-4 pts; PAT Phase 1,6, Score 2 or 3 | ● Provide a copy of designed Patient Survey OR  
● Materials to begin Focus Group OR  
● Patient-Family Advisory Council (PFAC) |
| Commitment to Advanced Directives Discussion with all Patients >65 years                         | PCMH 3A, 12 points   | ● Provide a narrative description of protocols/processes to engage/record AD for eligible patients  
● Provide a 3-month spreadsheet or EHR-generated report: N=patients having ADs in chart, D=all eligible patients seen in one year; reports should include all |
<table>
<thead>
<tr>
<th>MILESTONE 4: Commitment to implementing process to Identify Highest Risk Patients for Care Management</th>
<th>PCMH 2A, 1,2 up to 3 points; PAT Phase 2.6, 3.12, 4.8, Score 2 or 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH 2A, 1.2 up to 3 points; PAT Phase 3.12, 4.8, Score 2 or 3</td>
<td>● Active patients are assigned to a provider ('active' defined as last seen in 2 years)</td>
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<td>● Generate consecutive 6-month report with N=all empaneled patients, D=all active patients</td>
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<td>● Name and describe Risk Stratification tool and generate a 6-month report or devise a spreadsheet identifying high risk patients by risk score</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Commitment to preparing and planning for Care Management and/or Care Coordination (CM/CC) delivery within one year to achieve Milestone requirements at Gate 2</th>
<th>PCMH 2D 5-7 MUST PASS, up to 4 points; PAT Phase 3.10,3.11, 3.14, 4.4, 4.5,4.6,4.7 Score 2-3 all areas above</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCMH 2D 5-7 MUST PASS, up to 4 points; PAT Phase 3.10,3.11, 3.14, 4.4, 4.5,4.6,4.7 Score 2-3 all areas above</td>
<td>● Create job description(s) for CM/CC roles that outline practice capacities and define FTE needs based upon high risk patient population</td>
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<td></td>
<td>● Describe provision of internal/external training (State-provided care management guidance currently being developed by the workforce workgroup</td>
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<tr>
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<td>● Describe in narrative format coordination of care management activities in daily practice and show proof of implementation of TCM/CCM claims codes being used by practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commitment to integrating an Evidenced-Based behavioral health screening process; engage in BH integration training; form a Collaborative Care Agreement at Gate 2</th>
<th>3C, 9 must receive score for depression screening tools; separate tool required for substance/alcohol abuse; PAT Phase 3.9 Score 2 or 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>3C, 9 must receive score for depression screening tools; separate tool required for substance/alcohol abuse; PAT Phase 3.9 Score 2 or 3</td>
<td>● Demonstrate appropriate use of screening tools</td>
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<td></td>
<td>● Completion of staff training modality through online or in-person training of behavioral health integration</td>
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<td></td>
<td>● Create a Collaborative Care Agreement with BH provider or entity which has required elements of communication and description of process on how patients are seen, treated and tracked</td>
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<td></td>
<td>● Define process and workflows to demonstrate adherence to BH quality measures</td>
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<tr>
<td>Commitment to having a Process in place for Care Plan development at Gate 2</td>
<td>PCMH 4B, 4 points; 4E 4 (up to 5 points (should also include 3,5) 1C 1-6 2 points; PAT Phases: 2.7, 2.8, 1.6, 3.7; MU: §170.314 (a)(8), §170.314 (a)(2) and (b)(1)(b)(2)</td>
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<tr>
<td>Commitment to creating a Referral Tracking System at Gate 2</td>
<td>PCMH 5B, 1-10 MUST PASS 6 points, 5B, 8 above; PAT Phase 2.5,3.8,3.10, 3.11 Score 2 or 3</td>
</tr>
<tr>
<td><strong>MILESTONE 5:</strong> Commitment to providing 24/7 Access to a Provider at Gate 1 and to improve communication capabilities at Gate 2.</td>
<td>PCMH 1B 1-3, 3.5 points; §170.314(e)(1)/§170.314(e)(3)</td>
</tr>
<tr>
<td>Commitment to provide Same Day Appointments</td>
<td>N/A</td>
</tr>
<tr>
<td>Commitment to providing Culturally and Linguistically Appropriate Services</td>
<td>PCMH 2C 1-3 All 2.5 points; PAT Phase 2.2</td>
</tr>
</tbody>
</table>
| MILESTONE 6: Commitment to utilizing Tools for Quality Measurement encompassing all Core Measures at Gate 2 | PCMH 3B, 1-11, All 4 points; PAT Phase 3.1, 5.1 | ● Show steps on how to identify the workflows in chosen technology that identify all Core Measures, provide description of how they are tracked in daily practice  
● Ability to capture calculate and report on all Core Measures  
● Demonstrate requirement and provide example of use such as printed templates or screenshots for Certified Technology, including: Common Clinical Data Set, patient demographics, vital signs, Body Mass Index, growth charts and Problem List; Clinical Quality Improvement: capture, calculate & report measures, Active Medication List, Medication Allergy List Smoking Status, Patient List Creation, Secure Messaging , View, Download and Transmit to a 3rd party |

| Commitment to Attest to Connect to HIE in Year 1 and develop basic information exchange at Gate 2 | 6G, 8 Proof of Attestation required; PAT Phase 2.5 Score 2 or 3; MU §170.314 (e)(1)-(3) | ● Develop basic Information Exchange;  
● Attestation to connect to HIE in 1 year by establishing a participation agreement with their RHIO |

| MILESTONE 7: Signed APC Payer Contracts ; readiness for VBP Models and business development by Year 3 | N/A | ● APC Payer contract signed |

### Gate 3 Milestone

<table>
<thead>
<tr>
<th>Sub-Milestone Deliverables by Gate</th>
<th>AUTO-CREDITS GATE 3</th>
<th>Full Capability</th>
</tr>
</thead>
</table>
| MILESTONE 2: Implementation of patient engagement integrated into workflows including Quality Improvement (QI) Plan (grounded in evidence-based criteria) | N/A | ● Complete a patient survey for at least 8% of discrete patients in practice at two 6-month intervals and make results available to patients  
● Provide a survey sample and provide a report of results;  
● Show area of Quality Improvement (QI) selection and results; if focus group or PFAC (quarterly), include sample Agendas, meeting minutes and QI strategies and results |
<p>| Commitment to sharing Advanced Directives across Medical Neighborhood, where feasible | N/A | ● Demonstrate that Advanced Directives are made available in electronic format for other health care providers and exchanged through HIE, and show de-identified examples of communication, where feasible |
| MILESTONE 3: Commitment to Participating in Prevention Agenda Activities | N/A | ● Communicate with county health department to discuss shared goals/priorities; engage in at least one Prevention Agenda activity per year (e.g. Integrating pre-conception care, efforts to promote mental emotional behavioral well-being) |
| Commitment to Identification and outreach to patients due for Preventive and Chronic Care Management in Gate 3 | N/A | ● Provide evidence of how preventive measures (screening) are being tracked by practice |
| Commitment to creating a process to refer to Structured Health Education Programs and Community Based Resources at Gate 3 | N/A | ● Practices provides evidence of how they refer and track referrals to community-based entities and resources for patients with chronic conditions, or with social or behavioral health needs (e.g. screenshots of logs or EHR showing tracking of referrals) |
| MILESTONE 4: Commitment to Integrate High Risk Patient data from other sources (including payers) at Gate 3 | N/A | ● Provide evidence of actively managing high risk patients (e.g. either through EHR or spreadsheet for patient panel or improved risk scores) |</p>
<table>
<thead>
<tr>
<th>Commitment</th>
<th>N/A</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Delivering Care Management to Highest Risk Patients at Gate 3</td>
<td>N/A</td>
<td>Provide 3 consecutive months of de-identified Case Management logs or EHR reports (as indicated in Gate 2, e.g. proof of continued care and use of TCM/CCM claims);</td>
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<tr>
<td></td>
<td>N/A</td>
<td>Demonstrate ability to stratify data according to diversity (e.g. race, ethnicity, high risk etc.)</td>
</tr>
<tr>
<td>(Behavioral Health): Commitment to delivering Coordinated Care Management for Behavioral Health at Gate 3</td>
<td>N/A</td>
<td>Describe connection to behavioral health case management services;</td>
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<tr>
<td></td>
<td>N/A</td>
<td>Demonstrate use of shared electronic care plan and provide screenshots of process;</td>
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<td></td>
<td>N/A</td>
<td>Demonstrate linkage with social service agencies and produce a report detailing previous 3 months of interactions;</td>
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<td></td>
<td>N/A</td>
<td>Generate a 3-month follow-up report detailing appropriateness and timeliness of follow-up for applicable patients</td>
</tr>
<tr>
<td>Commitment to Care Plan development in concert with Patient Preferences and Goals at Gate 3</td>
<td>N/A</td>
<td>Proof of patients with completed Care Plans in EHR (Numerator: patients with Care Plans, Denominator: all empaneled patients)</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td>Demonstrate improvement of percentage of patients with a care plan and include evidence of shared care planning with other providers</td>
</tr>
<tr>
<td>Commitment to establishing Care Compacts or Collaborative Agreements for Timely Consultation with Medical Specialists and Institutions at Gate 3</td>
<td>N/A</td>
<td>Describe communications, arrangements, and copy of Care Compacts or narrative process that includes expectations of both parties creating ‘closed loop’ in patient care</td>
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<tr>
<td></td>
<td>N/A</td>
<td>Measure referrals completed (numerator) over referrals made (denominator) and demonstrate improvement in a 3 month period</td>
</tr>
</tbody>
</table>
| MILESTONE 5: Commitment to providing at least one Session Weekly during non-traditional Hours at Gate 3 | N/A | • Measure the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a 6 month period and provide narrative of how improvement was achieved;  
• Provide narrative describing selection of visit types (i.e. 15-minute sick calls, Annual Physicals, post-discharge follow-ups) and time slots templated for session |
| MILESTONE 6: Commitment to utilizing Tools for Quality Measurement encompassing all Core Measures at Gates 3 | N/A | • Provide verification of transitions of care for all below: receive, display, and incorporate transition of care/referral summaries (including sharing advanced directives);  
• Provide verification of Clinical Information and medication Reconciliation, Incorporate Lab Values, test results;  
• Record Immunizations and transmit to immunization registry;  
• Clinical decision support interventions that have been enabled |
| Commitment to Securing Electronic Provider-Patient Secure Messaging at Gate 3 | N/A | • Connect to local HIE/QI and provide transmission report or letter from HIE/RHIO certifying connection |
| MILESTONE 7: Signed APC Payer Contracts; readiness for VBP Models and business development | N/A | • Report of number of patients attributed to each APC-participating payer; • Report on total current empaneled patients |
# APC Milestone Technical Specifications

As of: 4/14/16

<table>
<thead>
<tr>
<th>PARTICIPATION</th>
<th>Capability: Practice demonstrate readiness through either initial gating assessment or through certification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MILESTONE 1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>GATE 1</strong></td>
<td>What a practice achieves on its own, before any TA or multi-payer financial support to qualify for SIM-funded practice transformation</td>
</tr>
<tr>
<td>Commitment to APC Participation Agreement at Gate 1</td>
<td>Complete APC Participation Agreement: TA’s and Practices</td>
</tr>
<tr>
<td>Commitment to Early Change Plan based on APC Questionnaire at Gate 1</td>
<td>Completed APC questionnaire (developed by DOH) for evaluation of need for and level of TA support: Complete Early Change Plan form provided by State for achieving Milestones</td>
</tr>
<tr>
<td>Commitment to Designate Change Agents/Practice Leaders at Gate 1</td>
<td>Designated Clinical Practice Leader Designated Business Practice Leader Commitments to expectations, governance, meeting attendance and leadership related to APC and/or team of practice leaders</td>
</tr>
</tbody>
</table>

Page 48 of 66
<table>
<thead>
<tr>
<th>Commitment to Participate in TA Vendor Gate 1 Orientation</th>
<th>Practice participation in TA vendor Orientation</th>
<th>Attendance sheet completed by TA entity verifying participation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to work to achieve Gate 2 Milestones in one year</td>
<td></td>
<td>Sign Gate 2 commitment form completed by APC Clinical Practice Leader and APC Business Practice Leader</td>
<td>Submit Gate 2 Participation Agreement</td>
</tr>
<tr>
<td>Commitment to Participation in TA Entity activities and Learning (if electing support) at Gate 2</td>
<td></td>
<td>Attendance by one practice lead or designee as appropriate to each covered topic as required; Engagement in learning activities that include sharing practice and APC-wide learning opportunities</td>
<td>Provide Attendance records Verification of engagement by TA entity</td>
</tr>
<tr>
<td>MILESTONE 2</td>
<td>GATE 1</td>
<td>Criteria for passing Gate 1</td>
<td>GATE 2</td>
</tr>
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<tr>
<td>Commitment to Patient Engagement activities Integrated into Workflows within one year, (by Gate 2)</td>
<td></td>
<td>Plan for either a patient satisfaction survey, focus group or Patient-Family Advisory Council (PFAC) that includes representative practice populations</td>
<td></td>
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<tr>
<td>Implementation of patient engagement integrated into workflows including Quality Improvement (QI) Plan (grounded in evidence-based criteria) by Gate 3</td>
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</tbody>
</table>

Capability: Engage patients as active, informed participants in their own care, and organize structures and workflows to meet the needs of the patient population
| Commitment to creating a process for Advanced Directives | Discussion with Patients at Gate 1 | Practice can demonstrate development of a process to use and report Advanced Directives (AD) | Develop protocols/process for using Advanced Directives (AD) templates for appropriate patients (e.g., >65 yrs.) and those with advanced illness; Process for Advanced Directives Discussions with all >65 year old adult patients and those with advanced illness | Practice uses protocols/processes with goal of reporting Advanced Directives (AD) on all patients >65 years | Provide narrative description of how the practice uses protocols/processes to engage and record AD for eligible patients; Template should include the minimum of: Health Care Proxy, Living Will, DNR order | Advanced Directives (to include eMOLST) are made available in electronic form to share with other health care providers and exchanged through HIE | Demonstrate that Advanced Directives are made available in electronic format for other health care providers and exchanged through HIE, and show de-identified examples of communication, where feasible | (quarterly), include sample Agendas, meeting minutes and QI strategies and results |
### POPULATION HEALTH

**Capability:** Actively promote the health of both patient panels and communities through screening, prevention, chronic disease management, and promotion of a healthy and safe environment

<table>
<thead>
<tr>
<th>MILESTONE 3</th>
<th>GATE 1</th>
<th>Criteria for passing Gate 1</th>
<th>GATE 2</th>
<th>Criteria for passing Gate 2</th>
<th>GATE 3</th>
<th>Criteria for passing Gate 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Participating in Prevention Agenda Activities at Gate 3</td>
<td></td>
<td></td>
<td></td>
<td>Participate in local county health collaborative Prevention Agenda calls, meetings and participate in at least one activity with Prevention agenda partners on shared priority efforts</td>
<td>Communicate with county health department to discuss shared goals/priorities; engage in at least one mutual Prevention Agenda activity per year (e.g. Integrating pre-conception care, efforts to promote mental emotional behavioral well-being)</td>
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<tr>
<td>Commitment to Identification and outreach to patients due for Preventive and Chronic Care Management in Gate 3</td>
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<td>Document clinical decision support interventions that have been enabled, staff workflows and process for identifying patients due for preventive and chronic care visits (e.g. preventive screenings) and use of clinical guidelines for chronic care conditions; indicate method(s) of follow-up used</td>
<td>Provide evidence of how preventive measures (screening) are being tracked by practice</td>
<td></td>
</tr>
<tr>
<td>Commitment to creating a process to refer to Structured Health Education Programs and Community Based Resources at Gate 3</td>
<td>Ensure that referrals made to community-based entities and resources will be managed the same as all other clinical referrals and follow-up care.</td>
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<td></td>
<td>In conjunction with TA entities, the State will provide practices information on structured health education programs and other resources including local health departments, local office on aging, PPS community resource compendium, PHP, and other community resources.</td>
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<td></td>
<td>Practices provides evidence of how they refer and track referrals to community-based entities and resources for patients with chronic conditions, or with social or behavioral health needs (e.g., screenshots of logs or EHR showing tracking of referrals).</td>
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<tr>
<td><strong>CARE MANAGEMENT /CARE COORDINATION</strong></td>
<td>Capability: Manage and coordinate care across multiple providers and settings by actively tracking the highest need patients, collaborating with providers across the care continuum and broader medical neighborhood including behavioral health, and track and optimize transitions of care. Care Management is defined as: focus on the comprehensive support of the highest risk subset of practice’s patient population. Care Coordination defined as: the practice contributes to seamless care of all patient transitions across all environments</td>
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<tr>
<td><strong>MILESTONE 4</strong></td>
<td><strong>GATE 1</strong> What a practice achieves on its own, before any TA or multi-payer financial support</td>
<td><strong>Criteria for passing Gate 1</strong> Practice assigns patient to specific provider care team, small practices can serve as their own care team; Implement a Risk Stratification System for Care Management using a standardized tool (such as AAFP, AHRQ) or own developed process to define and track high risk patients; Annotate Risk Scores for easy staff/provider access and identify care management intervention on no less than 1% of highest risk patients in entire panel</td>
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<tr>
<td>Commitment to Identify Highest Risk Patients for Care Management at Gate 2</td>
<td>GATE 2 What a practice achieves after 1 year of TA, including all prior milestones</td>
<td><strong>Criteria for passing Gate 2</strong> Active patients are assigned to a provider (active patients defined as last seen within 2 years); Generate consecutive 6 month report with denominator as all active patients, numerator as all epaneled patients; Name and describe Risk Stratification tool; generate a consecutive 6-month report or devise spreadsheet identifying high risk patients by risk score</td>
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<tr>
<td>Commitment to Integrate High Risk Patient data from other sources (including payers) at Gate 3</td>
<td>GATE 3 What a practice achieves after 2 years of TA, including all prior milestones</td>
<td><strong>Criteria for passing Gate 3</strong> Practice has a system in place to actively manage high risk patients; integrate high risk patients data from other sources (including payers); Practice manages high risk patients internally or by using a collaborative “pod” model</td>
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<td>Provide evidence of actively managing high risk patients (e.g. either through EHR or spreadsheet for patient panel or improved risk scores)</td>
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<tr>
<td>Commitment to Planning for Care Management and/or Care Coordination (CM/CC) delivery within one year at Gate 2</td>
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<tr>
<td>Implements recruitment strategies and/or appropriate training for existing staff on Care/Case Management care delivery in a practice setting:</td>
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<tr>
<td>Care Management Program to include the following: CM/CC needs are accomplished for no less than 2% of total enpaneled population regardless of risk scores and/or highest need patients.</td>
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<tr>
<td>Create job description(s) for CM/CC roles that outline practice capacities and define FTE needs based upon high risk patient population.</td>
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<td>Describe provision of internal and external training (State-provided care management guidance currently being developed by the workforce workgroup)</td>
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<tr>
<td>Describe staff training for coordination of care management activities in daily practice and show proof of implementation of TCM/CCM claims codes being used by practice</td>
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<tr>
<td>Commitment to Delivering Care Management to Highest Risk Patients at Gate 3</td>
<td>Practice ensures that all high-risk patients are offered care management by the practice, contracted entity or other identified specialty practice.</td>
<td>Demonstrate CM/CC integrated delivery through introduction of services (potentially acquired through “pods”) such as nutritional care, pharmacy, behavioral health specialties.</td>
<td>Conduct structured huddles/meetings to discuss CM cases with Care Team.</td>
<td>Provide 3 consecutive months of de-identified Case Management logs or EHR reports (as indicated in Gate 2, e.g. proof of continued care and use of TCM/CCM claims).</td>
<td>Indicate Risk Score status changes and shared integrated care delivered, follow-up appointments.</td>
<td>Provide narrative description of use of payer utilization reports to identify/compare high-risk patients as defined by the practice.</td>
</tr>
<tr>
<td>Behavioral Health: Commitment at Gate 1 to using Self-Assessments for BH integration and commitment to achieving Gate 2 BH Milestones within one year</td>
<td>Practice self-assessment for behavioral health integration. Commitment and goal planning to reach Gate 2</td>
<td>Completed self-assessment for Gate 2 Milestone achievement</td>
<td>Use PHQ2/PHQ9 for screening of depression and use of a validated screening tool for substance and alcohol abuse; Engage/participate in training for behavioral health integration in primary care settings that broadens team-based care and clinical treatment of depression; Collaborative Care Agreement with BH provider which has required elements of communication and description of process on how patients are screened, treated, and tracked; Define process of adherence to Behavioral Health quality Measures (Common Score Card)</td>
<td>Demonstrate appropriate screening of eligible adults &gt; age 18; Completion of staff training modality through online or in-person training of behavioral health integration; Create/implement a Collaborative Care Agreement that defines tracking and follow-up</td>
<td>Use behavioral health care management services (using shared care management resources, including health home care managers); Capability of sharing the Care Plan with other health care providers in electronic form and track patient progress; Care team demonstrates integrated delivery through linkage with regional social services agencies, such as support groups; Demonstrate follow-up after depression and substance and alcohol abuse screening at regular intervals and referral tracking</td>
<td>Describe connection to behavioral health care management services; Demonstrate use of shared electronic care plan and provide screenshots of process; Demonstrate linkage with social service agencies and produce a report detailing previous 3 months of interactions; Generate a 3-month follow-up report detailing appropriateness and timeliness of follow-up for applicable patients</td>
</tr>
<tr>
<td>Commitment to having a Process in place for Care Plan development at Gate 2</td>
<td>Identify key components of a structured Care Plan that best fits patient needs with goals and preferences; Develop plan, and create workflows that include specific goals for patient engagement; Implement at least 3 nationally-recognized (e.g. AHRQ) or TA entity approved Shared Decision Making Tools (SDMA) tools with priority given to quality measures included in the Common Measure Set: (e.g. colonoscopy, antibiotic use, back pain management, management of weight, depression, PSA); Integrate use of technology for record tracking and secure communication methodology (e.g. portal) and educate patient in use of secure communication Establish structured Care Plans include use of a template, tracking tool, and criteria used to identify patient needs during Care Management periods</td>
<td>Guided by TA entity, review “best practice” Care Plans and demonstrate staffing workflows needed to integrate into practice by creating a workflow chart or protocol; Provide description of Care Plan process and define how patient goals and preferences are shared; Practice submits with the assistance of the TA entity, the use of 3 Shared Decision Making Tools (SDM); Provide a baseline EHR report or tracking tool showing percentage of people in high risk category with a care plan</td>
<td>Patients have a Care Plan noting patient goals and preferences for management of chronic disease in patient record; Capability of sharing the care plan with other health care providers in electronic form.</td>
<td>Proof of patients with completed Care Plans in EHR (Numerator: patients with Care Plans, Denominator: all empaneled patients)</td>
<td>Demonstrate improvement of percentage of patients with a care plan and include evidence of shared care planning with other providers</td>
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<tr>
<td>Commitment to creating (at Gate 1) and systematically utilizing a Referral Tracking System (at Gate 2)</td>
<td>Develop capability for systematically tracking patients throughout referral processes; Create clinical/non-clinical staffing workflow patterns to track referrals made, patients seen, consultation reports received and flagging of missing information</td>
<td>Practice provides plan for tracking patients throughout the referral process and submits example of workflow pattern; Demonstrate that staff workflow assignments have been operationalized and provide screenshots of EHR referral tracking workflow</td>
<td>Provide operational process for systematically tracking patients throughout referral processes including BH and substance abuse; Implement clinical/non-clinical workflow patterns to track referral sent, patient seen, and consultation report received with flagging of missing information</td>
<td>Provide 3-month de-identified EHR report or evidence of a referral tracking template used or other proof of operational process</td>
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<tr>
<td>Commitment to establishing Care Compacts or Collaborative Agreements for Timely Consultation with Medical Specialists and Institutions at Gate 3</td>
<td>Establish written Care Compacts with at least 2 high volume specialists inside or outside of practice ownership entity or demonstrate structured process for coordinated care of patients; Care Compacts or description of structured process should include primary/specialty care expectations, access to care, collaborative care management, patient communication needs, and provision of patient transition records</td>
<td>Describe communications, arrangements, and copy of Care Compacts or narrative process that includes expectations of both parties creating “closed loop” in patient care</td>
<td>Measure referrals completed (numerator) over referrals made (denominator) and demonstrate improvement in a 3 month period</td>
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</tbody>
</table>
| Commitment to creating a Post Discharge Follow-up Process for timely transitions in care at Gate 3 | Practice develops a process to receive timely notifications (e.g. ED. hospitals).  
Review discharge summaries for missing information (e.g. pursue gaps in discharge communications) and review and reconcile medications;  
Contact discharged patients within 72 hours; schedule and document follow-up within 7 days or as applicable;  
Identify patients that will need internal CM/CC or that will require coordination of care from other health or community-based services. | Document a process to receive notifications;  
Demonstrate review and reconciliation of medications of 50% of discharged patients for 3 month period;  
Demonstrate tracking of patient discharges within 72 hours, and discharges requiring patient contact report improvement over a 3 month period all known discharges (denominator) and all patients where follow-up was made;  
Provide examples of 2 de-identified patients with TCM/CCM showing coding utilization during 6-month period. |
<table>
<thead>
<tr>
<th>ACCESS TO CARE</th>
<th>Capability: Promote access as defined by affordability, availability, navigability, accessibility, of care across all patient populations</th>
</tr>
</thead>
</table>
| MILESTONE 5   | **GATE 1**  
What a practice achieves on its own, before any TA or multipayer financial support |
| **GATE 2**    | What a practice achieves after 1 year of TA, including all prior milestones |
| **Criteria for passing Gate 1** | Provide narrative of communication workflow: Create a 1-month report, log or screenshots of on-call schedule noting response times created by the practice (e.g. 30-minute response time to patient) and evidence must include patient disposition at call outcome |
| **Criteria for passing Gate 2** | Improve communication capabilities by using secure communication methods (e.g. portal) or nurse call line for other non-urgent care; assures navigation to other care coordination and referrals to educational resources (e.g. diabetic education tools, navigation to patient health questionnaires, proper utilization of ED vs office visits) |
| **GATE 3**    | What a practice achieves after 2 years of TA, including all prior milestones |
| **Criteria for passing Gate 3** | Provide 3 de-identified screenshots or examples showing patient communications for non-urgent care provided after hours through use of secure communication methods or nurse call line |

Commitment to providing 24/7 Access to a Provider at Gate 1 and to improve communication capabilities at Gate 2.
<table>
<thead>
<tr>
<th>Commitment to provide Same Day Appointments at Gate 2</th>
<th>Review hours of operation and scheduling patterns to determine most successful method of ensuring same day appointment availability; Describe policy and process for same day appointments; Assess practice’s demands for same day appointments with goal to satisfy at least 80% of demand</th>
<th>Provide narrative on method to assess and meet demands, including the policy and workflow assignments for maintaining schedules; Measure patients seen at same day appointments (numerator) over patient phone calls requesting same day appointments (denominator) and improve in a 3 months period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to providing Culturally and Linguistically Appropriate Services at Gate 2</td>
<td>Assess need and develop plan to address population diversity and cultural needs; Engage interpretation services as applicable to the practices population needs, incl. visual or hearing impaired; Print and/or electronically provide preferred language materials to patients that meet practice community needs Practice should identify their panels by language and ethnicity for services intervention and provide a screenshot of documentation in EHR or spreadsheet/log; Provide an example of printed materials used (only if diversity population exceeds 5% of panel)</td>
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<tr>
<td>Commitment to providing at least one Session Weekly during non-traditional Hours at Gate 3</td>
<td>Practice provides a minimum of one non-traditional weekly session of scheduled services defined as before 8AM or after 6PM, and/or weekends. Review hours of operation and scheduling patterns to determine most successful course in optimization of 1 non-traditional weekly session</td>
<td>Measure the ratio of patients seen in non-traditional session(s) to patients seen during normal business hours in a 6 month period and provide narrative of how improvement was achieved. Provide narrative describing selection of visit types (ie. 15-minute sick calls, Annual Physicals, post-discharge follow-ups) and time slots templated for session</td>
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<tr>
<td>HIT</td>
<td>Capability: Use health information technology to deliver better care that is evidence-based, coordinated, and efficient</td>
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<tr>
<td><strong>MILESTONE 6</strong></td>
<td><strong>GATE 1</strong> What a practice achieves on its own, before any TA or multi-payer financial support</td>
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<tr>
<td>Commitment to Achieving Gate 2 Milestones (below) within One Year</td>
<td>Criteria for passing Gate 1 Practice (with TA assistance) must submit plan for achieving Gate 2 milestones</td>
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<tr>
<td>Commitment to utilizing Tools for Quality Measurement encompassing all Core Measures at Gates 2, 3</td>
<td>Ability to capture, calculate and report all core measures; Develop basic Information Exchange; Attestation to connect to HIE in 1 year by establishing a participation agreement with their RHIO</td>
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<tr>
<td>Commitment to Attest to Connect to HIE in Year at Gate 2</td>
<td>Demonstrate requirement for Certified Technology: Common Clinical Data Set, Demographics, Vital signs, body mass index, and growth charts. Problem List; ClinicalQuality Improvement: capture, calculate &amp; report measures. Active Medication List, Medication Allergy List Smoking Status. Patient List Creation, Secure Messaging. Ability to provide 24/7 remote access through Health IT; Secure electronic provider-patient messaging; Information Exchange that includes bi-directional communication of outcome data. Enhanced Quality Improvement including Clinical Decision Support (CDS);</td>
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<td>GATE 3</td>
<td>What a practice achieves after 2 years of TA, including all prior milestones</td>
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<tr>
<td>Criteria for passing Gate 3</td>
<td>Provide verification of transitions of care for all below: receive, display, and incorporate transition of care/referral summaries (including sharing advanced directives); Provide verification of Clinical Information and medication Reconciliation. Incorporate Lab Values, test results;</td>
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<tr>
<td>Commitment to Securing Electronic Provider-Patient Secure Messaging at Gate 3</td>
<td>View, Download and Transmit to a 3rd party; Signed RHIO participation agreement</td>
<td>Certified Health It for quality improvement, information exchange; Connected to local HIE QE</td>
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<tr>
<td>PAYMENT MODEL</td>
<td>Capability: Participate in outcomes-based payment models, based on quality and cost, for over 60% of the practice’s patient panel</td>
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<td>MILESTONE 7</td>
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<td>Commitment to Value Based Contracts with APC-participating payers within 1 Year</td>
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<tr>
<td>Commitment to contracts for minimum FFS with P4P contracts with participating payers representing 40% of panel, with commitment to achieving 60% at Gate 2</td>
<td>Submit a summary list of current payers along with contract expiration dates</td>
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<tr>
<td>Commitment to value-based gainsharing contracts with APC-participating payers representing 60% of panel at Gate 3</td>
<td>Signed Contracts meeting criteria representing 40% of panel with commitment to achieve 60%.</td>
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<td>Report of number of patients attributed to each APC-participating payer or other reports that show reach/impact of contracts.</td>
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<td>Report on total current enpaneled patients</td>
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<td></td>
<td>Signed Contracts meeting criteria representing 60% of panel. Numerator: Patients attributed to APC-participating payers/ Denominator: total patients attributed to practice</td>
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