RFP Number QPS-2016-01

HEALTH RESEARCH, INC.

New York State
Department of Health

Office of Quality and Patient Safety
State Health Innovation Plan / State Innovation Model Initiative

Request for Proposals

Evaluation Services

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KEY DATES

RFP Release Date: January 25, 2016
Questions Due: February 8, 2016
RFP Updates Posted: February 22, 2016
Proposals Due: March 7, 2016 by 4:00 pm ET

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I. Introduction

The New York State Department of Health (NYSDOH) and Health Research Inc. (HRI) seek a highly qualified entity to provide expert Evaluation Services to the State Innovation Model (SIM) testing grant. The SIM Narrative and State Health Innovation Plan (SHIP) can be found here: https://www.health.ny.gov/technology/innovation_plan_initiative/.

NYSDOH/HRI was awarded $100 million to achieve the “Triple Aim” of improving the health of populations, enhancing patient access to and experience of care and spending health care resources more wisely through:

1. Implementation of a statewide program of regionally-based primary care practice transformations to help practices across NYS adopt an Advanced Primary Care (APC) model. NYS is in the process of developing details of the practice model in concert with external stakeholders’ represented payers, providers and consumers. Once developed, funding will be awarded to regional Practice Transformation contractors to assist with implementation in 2016.

2. Development of reimbursement approaches and models to support the APC model for a wide range of practices, while also promoting improved performance on quality, access and efficiency needed for payer support. The ultimate goal is to ensure 80% of New Yorkers have access to this enhanced model of primary care, supported by a reimbursement structure that moves away from strict volume based, fee-for-service and reimbursement and by an evolved workforce whose skills are well matched with the APC model of care. Alternative reimbursement solutions need to be flexible enough to meet the needs of a wide range of provider/practice types based on size or organizational capacity while sufficiently standardized to meet the objective of alignment across payers.

3. Provision of health system redesign supports to promote better integrated care inclusive of the following:
   - Promoting innovations in professional education and training;
   - Integrating APC with population health through “Public Health Consultants”, funded to work with regional Population Health Improvement Program contractors;
   - Developing a common scorecard/ shared quality metrics across multiple payers and providers and enhanced data/analytics to assure that delivery system and payment models support Triple Aim objectives;
   - Integrating NYS funded leading-edge health information technology, including greatly-enhanced capacities to exchange clinical data and an All Payer Database to support the APC model inclusive of integrated care delivery; and
   - Testing new models through data collection and performance monitoring.

To achieve SIM goals and objectives, a series of topic specific workgroups are being convened to develop recommendations to inform policy and program for health care in New York State. Information on these workgroups may be found on the NYSDOH’s website (see: https://www.health.ny.gov/technology/innovation_plan_initiative/workgroups.htm)
In addition to the SIM cooperative agreement, NYS is engaged in numerous payment reform pilots in various stages of development including the Delivery System Reform Incentive Payment Program (DSRIP) impacting New York’s population that receives Medicaid benefits, numerous Accountable Care Organizations (ACOs), and several Center for Medicare and Medicaid Innovation (CMMI) funded initiatives including the Comprehensive Primary Care Initiative (CPCI) and the Transforming Clinical Practice Initiative (TCPI). NYS is committed to evaluating delivery system and payment reform pilots and all models being tested under the SIM cooperative agreement. More information regarding reform initiatives in NYS can be found at [http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/) and [http://www.nyehealth.org/nysptn/](http://www.nyehealth.org/nysptn/).

The successful bidder will assist in identifying the appropriate measures to evaluate the State’s mechanisms and processes for creating and promoting these innovative care delivery and payment models and to be able to provide feedback to HRI/NYSDOH and to CMMI on a regular basis, throughout the remainder of the 34 month initiative. Measures and models are to be completed in early 2016 and data collection to begin no sooner than the first quarter of 2017.

In support of HRI/NYSDOH’s independent evaluation as required by CMMI ([http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf](http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf)), the successful bidder will develop and conduct a comprehensive, statewide evaluation to assess the major program processes and outcomes, including:

a. the identification of appropriate measures for monitoring and feedback throughout this 34-month initiative;
b. a cost-benefit analysis to assess improvements in clinical practice and health outcomes as a result of the APC model; and
c. long-term reductions in health care costs in terms of investments in the NYS health care system under SIM.

The selected bidder must have the ability to perform both the broad SIM project evaluation and the evaluation of component parts of the initiative, including health information technology, workforce and value-based payment. In addition to assessing performance related to process and performance measures, the evaluation must also consider use of the following measures as part of the evaluation plan: patient experience, provider experience, access to care, APC and reduction in the growth of health care expenditures.

The contractor will work with Centers for Medicaid & Medicare Services (CMS) program staff, NYS DOH evaluation staff and the CMS Federal Evaluation Contractor for the broad SIM project evaluation. The collaboration with CMS requires sharing of both data and methodologies.
II. Who May Apply

Minimum Eligibility Requirement

Eligible bidders must meet the minimum requirement of:

at least five (5) years of experience in conducting large-scale, multi-year program evaluations.

Preferred Qualifications:

The successful bidder will document skills and experience in their proposal as relevant to the execution of the SIM evaluation plan and reflecting qualifications for each of the items listed below:

a. A designated lead evaluator with extensive training and expertise in public health, statistics, social sciences or a related field.

b. Demonstrated expertise and capacity to develop and implement qualitative analyses, inclusive of data collection and data analytics.

c. Demonstrated expertise with quantitative data analysis including:
   i. claims data and data from other large data systems, including the goals of such analyses, manner of data access, and data extraction.
   ii. Statistical analysis relevant to executing the proposed evaluation plan, including the types of analyses and software used.
   iii. Ensuring data quality and integrity of results.
   iv. Quantitative and/or qualitative data collection procedures, including the gaining of access to respondents and scheduling.

d. Demonstrated expertise with report preparation (up to three samples may be attached as an appendix) including
   i. Preparation of reports including results of quantitative and qualitative analysis.
   ii. Summative reporting of findings of large scale program evaluation or research projects.

e. Demonstrated expertise with evaluation of government health care delivery reform initiatives.

III. Available Funding

The amount of funding available for this contract is $500,000 for the budget period (April 1, 2016, to January 31, 2017). There are two subsequent 12 month periods (February 1, 2017 through January 31, 2018 and February 1, 2018 through January 31, 2019), for which total funding available is $1,000,000 per year. Therefore, the Proposal should not exceed $2,500,000 for the project period.

IV. Project Narrative/ Work Plan Outcomes

This RFP seeks an entity to assist NYSDOH/HRI with development of performance measures, benchmarks and an evaluation process for the SIM, both overall and by initiative including an evaluation of the mechanisms used to develop and refine the APC delivery model; value based payment and workforce initiatives. Bidders should articulate a plan to address all questions
noted in Section V below including the hypotheses to be tested, measures to be used (and, if appropriate, developed) and a research design that accounts for the multiple initiatives currently under way in NYS which may confound the impact of SIM.

NYS is committed to evaluating how best to develop, promote and sustain innovation. The bidder shall utilize a variety of approaches to examine the overall impact of the SIM model, the effectiveness of policy and regulatory levers, and determine which program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes and reductions in costs. The evaluation strategy shall assess the sustainability of the model to inform work beyond the project period and to inform other states and jurisdictions. This RFP will support the HIRI/NYSDOH’s independent evaluation as required by the CMMI FOA: http://innovation.cms.gov/Files/x/StateInnovation_FOA.pdf.

The independent evaluation will ensure that issues are reported to NYSDOH in a timely manner so that NYSDOH can improve the process of health care transformation. The bidder should have the ability to conduct both the broad SIM project evaluation and perform the evaluation of discrete component parts of the initiative including health information technology (HIT), workforce, access, population health and value-based payment. In addition to assessing the outcomes related to process and performance measures, the evaluation should also consider measures correlated to patient experience, provider experience, access to care, quality of care and reduction in the growth of health care expenditures.

The bidder must be willing to work with CMS program staff, NYS DOH evaluation staff, and the CMS Federal evaluation contractor for the broad SIM project evaluation. The collaboration with CMS includes sharing both data and methodologies.

1. **Deliverables**

The selected contractor must describe its plan to carry out the following components of an evaluation of the broad SIM project and component parts of the initiative. The contractor will be expected to report results in a timely manner, no less than quarterly (see Attachment 7 for details), to support rapid cycle evaluation that results in ongoing feedback and adjustments in accord with evaluation findings. The contractor will be expected to track and report on model progress that addresses the following:

a. Identification of all data sources to be used and their relation to proposed outcome measures;

b. Outline a process for use of NYSDOH data given the multiple available data sets available;

c. How the proposed model improves population health, health care delivery and reduces costs;

d. How the proposed model leverages State regulatory and policy levers;

e. Methods used to identify providers, provider organizations, and payers participating in the model and to evaluate payer and provider-specific success and challenges;

f. Identification of gaps in available measures and proposals for how best to address identified gaps;
g. Outline of a proposal to utilize rapid cycle feedback evaluation reports to improve model performance and meet target milestones for improving health, health care quality, and lowering costs. (See Attachment 4 for SIM driver diagram inclusive of target goals and objectives).

2. Plan for Data Collection and Benchmarks, and Plan for Assuring Continuous Feedback
The bidder should propose appropriate benchmarks against which the project performance will be measured (these may be existing benchmarks currently reported by NYS), for example see https://apps.health.ny.gov/doh2/applinks/ebi/SASSStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard) and define how these measures will be retrieved from various data sources (i.e. claims data, or clinical data or other as proposed by the bidder). In addition bidder will be expected to outline a process for ensuring data timeliness and a method of assuring continuous feedback.

3. Performance Measures Development and Reporting
The bidder should develop performance measures to be used to evaluate the SIM evaluation with respect to the goals and objectives of the project (see driver diagram, Attachment 4 for specific goals and objectives, and Appendix 5 for a more detailed description of the measures) with respect to health, health care and cost. The bidder must describe its ability to develop performance measures appropriate to the goals as enumerated in the attached operational plan of the overall project including:
   i. Financial targets to demonstrate a reduction in the rate of growth; and
   ii. Clinical process and outcome measures appropriate to the project/pilot.

The bidder must clearly describe the proposed research design that must include both multivariate analyses to adjust for the impact of other initiatives and interventions in NYS on providers, payers and consumers. The bidder should also recommend the time period after the beginning of the project when the evaluation should take place.

4. Evaluative Strategy
The selected bidder must detail an approach to evaluating the impact of delivery system changes on health care costs, utilization, quality, and access. The contractor will be expected to propose a comprehensive evaluative strategy to determine if the model promotes access and quality, reduces expenditures, creates net savings, and/or reduces health care costs trends compared to initial projections, or a control-group cohort if possible.

A. Quality
The bidder must propose a plan to evaluate the impact of the initiatives on the quality and experience of care for patients, providers and caregivers, as reported directly by patients, providers and caregivers. In addition, scientific quality measure sets and outcome data reports should be used to report quality as measures such as the following (not an exhaustive list):
   i. Clinical process changes leading to compliance with standard guidelines, clinical pathways, and evidenced based clinical care;
   ii. Provider satisfaction;
   iii. Patient satisfaction; and
   iv. Caregiver satisfaction.
B. **Access - Promotion of Integrated Care Delivery**

The selected evaluator must propose a mechanism and measures to determine the extent to which, the project results in continuous improvements and better outcomes in primary care. The model posits that the following characteristics of the proposed primary care model will result in improved quality and health outcomes:

i. Care planning;

ii. Care coordination;

iii. Interdisciplinary team care; and

iv. Changes in patient behavior that lead to improved outcomes.

C. **Health care costs**

Specific measures to be addressed may include, but are not limited, to the following measures of cost:

i. Hospital spending per capita;

ii. Professional services spending (physician) per capita;

iii. Post-acute spending per capita;

iv. Pharmaceutical spending per capita; and

v. Total health expenditures per capita and statewide.

D. **Health services utilization**

Specific measures to be addressed may include, but are not limited to, reductions, changes or increases of particular services such as:

i. Avoidable acute health care services;

ii. Readmission rates;

iii. Admission rates;

iv. Outpatient hospital services use and rates of use;

v. Ancillary services use and rates of use;

vi. Primary care service usage;

v. Emergency room visits and rates of use;

vii. Referral rates from hospitals to post-acute care facilitates and appropriateness of referrals;

viii. Referral rates to palliative and hospice care;

ix. Rates of ambulatory care sensitive admissions such as Prevention Quality Indicators (PQIs); and

x. Inappropriate use of imaging (High-Tech Radiology MRI, CT, PET scans, etc.).

E. **Self-Monitoring Plan**

The Contractor shall work in collaboration with NYSDOH/HRI to develop and implement the program self-monitoring efforts. The goal of this collaboration is to establish the capability and infrastructure to enable the State to develop and sustain rigorous outcome measure driven program self-monitoring beyond the period of the cooperative agreement. More specifically, the contractor should be able to determine the following:

i. Is the State achieving targeted per member per month (PMPM) cost trend reductions in while at least maintaining, if not improving, quality and access?
ii. What is the spread overtime of APC by payer including public employees and Medicare?
iii. What is the spread overtime of APC by provider?
iv. What is the degree and pace of spread of APC key elements (care coordination and management, outcome-based payment methods, etc.) to payers? Are other payers or populations experiencing cost trend reductions and improvements in quality?
v. Which of the key elements, or which combination of key elements, are most strongly associated with success for Triple Aim outcomes? Is there any evidence regarding whether and how community setting, payer or other contextual differences affect which model elements or combination of elements are most predictive of success?
vi. Does the model implementation lead to changes in service utilization patterns and reduced per member per month, total, medical and behavioral health care costs?

vii. Does the model lead to improvements in care coordination and less fragmentation of care and for what populations?
viii. Does the model lead to improvements in quality and process of care?
ix. To what extent does the model improve the level of integration of physical and behavioral health?
x. Does the model lead to improvements in member health, functioning and in reduction of health risk behaviors?
xii. What factors influence the adoption and spread of model enhancements?
xiii. To what extent are model components implemented consistently and with fidelity?
xiv. What system, practice and person-level factors are associated with the model outcomes?

5. Reporting Requirements

Proposals should include a projected schedule of reports to NYSDOH for distribution to all relevant stakeholders. The bidder will be expected to report results on an ongoing basis to support rapid cycle evaluation that provides feedback to guide program modifications and refinements. Additionally, the proposed schedule of reports should include a report of major program outcomes on an annual basis at minimum.

Bidders should describe their ability to meet the following expectations to submit recommendations to the NYS SHIP Council. Presentation of findings and recommendations are expected to address the following:

a) Is the initiative on track to meet established metrics and goals?
b) What adaptations are needed to refine the model to assure goals and objectives are achieved?
c) What are the characteristics of the model that are most/least successful?
d) What are the characteristics of particular providers’ and payers approaches that led to the associated outcomes?

e) What are the characteristics of the patients whose care was delivered under the APC model?

HRI/NYSDOH is required to report to CMMI on a quarterly basis beginning with a report due on June 30, 2016. The successful bidder will provide data and reports to HRI/NYSDOH 30 days prior to reporting deadlines. Bidders must provide a timeline for the work described in this RFP, noting appropriate internal deadlines to fulfill this obligation. All bids should include a chart outlining the project requirements and deadlines (See Attachment 7 for CMMI deadlines).

Upon completion of the contract requirements the contractor will leave HRI/NYSDOH with electronic copies of all materials developed under the period of performance. All material developed as part of this agreement is the property of HRI/NYSDOH.

V. Administrative Requirements

A. Issuing Agency

This RFP is issued by the NYSDOH, Office of Quality and Patient Safety and HRI with funding provided by the CMMI. HRI/NYSDOH are responsible for the evaluation of all proposals.

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 RFP:

ogps.asu@health.ny.gov

To the degree possible, each inquiry should cite the RFP page number, section and paragraph to which it refers.

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 proposal (e.g., formatting) rather than relating to the substance of the proposal.**

Prospective bidders 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 a proposal, during the question and answer phase, by the date listed on the cover page of this RFP.

This RFP has been posted on HRI’s public website at: 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 RFP.
Submission of a letter of intent to Bid is not a requirement for submitting a proposal.

C. **Bidder Conference**

A Bidder Conference will not be held for this procurement.

D. **How to file a proposal**

Proposals must be received at the following address by the date listed on the cover page of this RFP. Late proposals will not be accepted.

Office of Quality and Patient Safety  
Attn: Justin Hausmann  
NYS Department of Health  
Corning Tower, Room 2084  
Empire State Plaza  
Albany, NY 12237

[mailto:oqps.asu@health.ny.gov](mailto:oqps.asu@health.ny.gov)

Bidders shall submit by mail one (1) original, signed proposal AND one (1) electronic copy emailed to the address above. Proposal packages should be clearly labeled with the name and number of the RFP as listed on the cover of this RFP document.

*It is the bidder’s responsibility to see that proposals are delivered to the address above prior to the date and time specified on the cover page of this RFP.*

E. **THE DEPARTMENT OF HEALTH & HRI RESERVE THE RIGHT TO**

1. Reject any or all proposals received in response to this RFP.

2. Withdraw the RFP at any time, at HRI’s sole discretion.

3. Make an award under the RFP in whole or in part.

4. Disqualify any bidder whose conduct and/or proposal fails to conform to the requirements of the RFP.

5. Seek clarifications and revisions of proposals.

6. Use proposal information obtained through site visits, management interviews and the NYSDOH/HRI’s investigation of an bidder’s qualifications, experience, ability or financial standing, and any material or information submitted by the bidder in response to the agency’s request for clarifying information in the course of evaluation and/or selection under the RFP.
7. Prior to application opening, amend the RFP specifications to correct errors or oversights, or to supply additional information, as it becomes available.

8. Prior to proposal opening, direct bidders to submit proposal modifications addressing subsequent RFP 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 RFP.

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

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

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

15. Waive or modify minor irregularities in proposals received after prior notification to the bidder.

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 proposal and/or to determine an offerer’s compliance with the requirements of the RFP.

17. Negotiate with successful bidders within the scope of the RFP in the best interests of HRI.

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

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

F. Term of Contract

Any contract resulting from this RFP will be effective only upon approval by Health Research, Inc.

It is expected that contracts resulting from this RFP will have the following time period: April 1, 2016 through January 31, 2019 (34 months), issued in one 12 month increment.
on February 1 of 2016 and two yearly increments issued on February 1st of 2017 and 2018. Renewals are dependent upon satisfactory performance and continued funding.

G. Payment & Reporting Requirements

1. The contractor shall submit *quarterly deliverables based* 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 A of the final contract.

H. General Specifications

1. By signing the "Proposal Form" each bidder attests to its express authority to sign on behalf of the bidder.

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 a proposal indicates the bidder's acceptance of all conditions and terms contained in this RFP, 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 proposal.

4. A bidder may be disqualified from receiving awards if such bidder 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 Bidder 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 RFP.
   b. In the event that the Bidder, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFP, 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 Bidder.

6. Entities must maintain an active registration in the System for Award Management (SAM) at sam.gov, have no exclusions or delinquent federal debt.

I. HRI Boilerplate Agreement

Selected contractor will be expected to sign the below Agreement.

THIS AGREEMENT, made as of «Start Date» (the “Effective Date”), by and between HEALTH RESEARCH, INC., a not for profit corporation organized and existing under the laws of the State of New York, with principal offices located at Riverview Center, 150 Broadway, Ste. 560, Menands, NY 12204, hereinafter referred to as HRI, and «CONSULTANT_NAME», located at «Address_One», «Address_Two», «City», «STATE», «Zip», herein after referred to as the CONSULTANT.

WITNESSETH

WHEREAS, HRI has been awarded a grant from «Sponsor_Name» for the conduct of a project entitled "«Project_Title»"; and,

WHEREAS, HRI desires the Consultant's performance of certain services for HRI in connection with such project; and,

WHEREAS, Consultant has represented to HRI that "he/she/it" is competent, willing and able to perform such services for HRI.

NOW THEREFORE, in consideration of the promises, mutual covenants, and agreements contained herein, it is mutually agreed by and between the respective parties as follows:

1. Consultant agrees to perform, as an independent contractor and not as an employee or agent of HRI, all the services set forth in Exhibit "A", appended hereto and made a part hereof, to the satisfaction of HRI's Principal Investigator, «PI_Name».

2. The Agreement shall be effective and allowable costs may be incurred by the Consultant from the Effective Date and shall continue until «End_Date» (the “Term”) unless terminated sooner as hereinafter provided or extended by written agreement of the parties.

3. In full and complete consideration of Consultant's performance hereunder, HRI agrees to compensate Consultant pursuant to the breakdown in Exhibit "A" attached. Final invoices are due within 60 days of the termination date of this Agreement. Requests received after this 60-day period may not be honored. Any reimbursement payable hereunder by HRI to the Consultant shall be subject to retroactive reductions and/or repayment for amounts included therein which are identified by HRI, on the basis of any review or audit, to not constitute an allowable cost or charge hereunder.
4. The Scope of Work and Budget in Exhibit "A" may be modified as conditions warrant by mutual agreement between HRI and Consultant, and confirmed in writing. In no event shall the total consideration under this Agreement exceed «Total Contract Amount Typed Out» Dollars ($«Total_Contract_Amt_In_Numbers»).

5. Consultant acknowledges and agrees that all work products, deliverables, designs, writings, inventions, discoveries, and related materials, (collectively "Works") made, produced or delivered by Consultant in the performance of its obligations hereunder will be owned exclusively by HRI. All copyrightable Works are "works made for hire." Consultant 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. Consultant further agrees that "he/she/it" shall not claim or assert any proprietary interest in any of the data or materials required to be produced or delivered by Consultant in the performance of its obligation hereunder. Consultant warrants that all Works shall be original except for such portion from copyrighted works as may be included with Consultant’s advance permission of the copyright owner(s) thereof, that it shall contain no libelous or unlawful statements or materials, and will not infringe upon any copyright, trademark or patent, statutory or other proprietary rights of others. Consultant further agrees that "he/she/it" will not publish, permit to be published, or distribute for public consumption, any information, oral or written, concerning the results or conclusions made pursuant to this Agreement without the prior written consent of HRI.

6. Neither party shall use the name of the other or any adaptation, abbreviation or derivative of any of them, whether oral or written, without the prior written permission of the other party.

7. It is understood and agreed that the services to be rendered by Consultant are unique and that Consultant shall not assign, transfer, subcontract or otherwise dispose of its rights or duties hereunder, in whole or in part, to any other person, firm or corporation, without the advance written consent of HRI.

8. The nature of the relationship which the Consultant shall have to HRI pursuant to this Agreement shall be that of an independent contractor. Under no circumstance shall the Consultant be considered an employee or agent of HRI. This Agreement shall not be construed to contain any authority, either express or implied, enabling the Consultant to incur any expense or perform any act on behalf of HRI.

9. Consultant is solely responsible for complying with all applicable laws and obtaining, at Consultant’s sole expense, any and all licenses, permits, or authorizations necessary to perform services hereunder. Without limiting the generality of the foregoing, Consultant acknowledges and agrees, to the extent required by Article 15 of the New York State Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, that Consultant will not discriminate against any employee or bidder for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, Consultant agrees that neither it nor its authorized subcontractors, if any, shall, by reason of race, creed, color, disability, sex, or 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 Contract. Consultant is subject to fines of $50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this Contract and forfeiture of
all moneys due hereunder for a second or subsequent violation. Consultant further agrees to the related terms and conditions set forth in Appendix A.

10. This Agreement shall be void and no force and effect unless Consultant shall provide and maintain coverage during the life of this Agreement for the benefit of such employees as are required to be covered by the provisions of Workers’ Compensation Law.

11. Unless otherwise agreed by HRI, Consultant shall maintain, or cause to be maintained, during the Term of this Agreement, insurance or self-insurance equivalents of the following types and amounts: a) Commercial General Liability (CGL) with limits of insurance of not less than $1,000,000 each occurrence and $2,000,000 annual aggregate: b) HRI shall be included as Additional Insureds on the Consultant’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 Consultant. It shall apply as primary and non-contributing insurance before any insurance maintained by the Additional Insureds; c) other such insurance as may be specified by HRI, depending on the project and services provided by Consultant.

12. Consultant 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 the balance of the calendar year in which they are created and for six years thereafter. HRI shall have reasonable access to such records as necessary for the purposes of inspection, audit, and copying. Records shall be maintained as Confidential Information and protected from public disclosure.

13. This Agreement, including all applicable attachments and appendices thereto, represents the entire Agreement and understanding of the parties hereto and no prior writings, conversations or representations of any nature shall be deemed to vary the provisions hereof. This Agreement may not be amended in any way except by a writing duly executed by both parties hereto.

14. HRI may terminate this Agreement with or without cause at any time by giving advance notice, when, in its sole discretion, HRI determines that it is in the best interests of HRI to do so, or as directed by the project sponsor. Such termination shall not affect any commitments which, in the judgment of HRI, have become legally binding prior to the effective date of termination. Upon termination of the Agreement by either party for any reason, Consultant 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. It is understood and agreed, however, that in the event that Consultant is in default upon any of its obligations hereunder at the time of such termination, such right of termination on the part of HRI shall expressly be in addition to any other rights or remedies which HRI may have against Consultant by reason of such default.

15. Consultant acknowledges and agrees that, during the course of performing services for HRI, it may receive information of a confidential nature, whether marked or unmarked (“Confidential Information”). Consultant agrees to protect such Confidential Information with the same degree of care it uses to protect its own confidential information of similar nature and importance, but with no less than reasonable care. Consultant will not use Confidential Information for any purpose other than to facilitate the provision of services
under this Agreement, and Consultant will not disclose Confidential Information to any third party without HRI’s advance written consent.

16. Consultant 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 Consultant 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.

17. Consultant shall have no interest, financial or otherwise, direct or indirect, or engage in any business, transaction, or professional activity, that may create a conflict with the proper discharge of Consultant’s duties under this Agreement. In the event any actual or potential conflict arises, Consultant agrees to notify HRI in writing within ten (10) days to allow HRI to evaluate any potential impact on Consultant’s performance under this Agreement.

18. Consultant agrees to defend, indemnify and hold HRI, its agents and employees, harmless from any losses, claims, damages, expenses, and liabilities (including reasonable attorneys’ fees arising out of: (i) any act or omission by Consultant in connection with the performance of services constituting negligence, willful misconduct, or fraud; (ii) the breach of the confidentiality obligations set forth herein; (iii) any claim for compensation or payment asserted by any employee or agent of Consultant; (iv) Consultant’s failure to carry out Consultant’s responsibilities under this Agreement; (v) any intellectual property infringement or misappropriation by Consultant in connection with the services provided under this Agreement.

19. Should any provision of this Agreement be proven to be invalid or legally ineffective, the overall validity of this Agreement shall not be affected. Unless the parties agree on an amended provision, the invalid provision shall be deemed to be replaced by a valid provision accomplishing as far as possible the purpose and intent of the parties at the date of the Agreement.

20. The failure of HRI to assert a right hereunder or to insist on compliance with any term or condition of this Agreement shall not constitute a waiver of that right of HRI, or other rights of HRI under the Agreement, or excuse a subsequent failure to perform any such term or condition by Consultant.

21. This Agreement shall be governed and construed in accordance with the laws of the State of New York. The jurisdictional venue for any legal proceedings involving this Agreement shall be in the State of New York. Disputes involving this Agreement may not be submitted to binding arbitration.

22. In addition to the methods of process allowed by the State Civil Practice Law & Rules (CPLR), in any litigation arising under or with respect to this Agreement, Consultant hereby consents to the service of process upon it by registered or certified mail, return receipt requested, and will promptly notify HRI in writing in the event there is any change of address to which service of process can be made.

23. 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.

Consultant agrees to abide by the terms and conditions of Appendix "A" attached hereto and
made a part hereof, including the provisions required for federally funded projects, if applicable.

APPENDIX A to CONSULTANT AGREEMENT
The parties to the attached Agreement further agree to be bound by the following terms, which are hereby made a part of said Agreement:
1. During the performance of the Agreement, the Consultant agrees as follows:

(a) The Consultant will not discriminate against any employee or bidder for employment because of race, creed, color, sex, national origin, age, disability or marital status.

(b) If directed to do so by the Commissioner of Human Rights, the Consultant will send to each labor union or representative of workers within which the Consultant has or is bound by a collective bargaining or other agreement or understanding, a notice, to be provided by the State Commissioner of Human Rights, advising such labor union or representative of the Consultant's agreement under clauses (a) through (g) (hereinafter called "non-discrimination clauses"). If the Consultant was directed to do so by the contracting agency as part of the bid or negotiation of this Agreement, the Consultant shall request such labor union or representative to furnish a written statement that such labor union or representative will not discriminate because of race, creed, color, sex, national origin, age, disability or marital status and that such labor union or representative will cooperate, within the limits of its legal and contractual authority, in the implementation of the policy and provisions of these non-discrimination clauses and that it consents and agrees that recruitment, employment, and the terms and conditions of employment under this Agreement shall be in accordance with the purposes and provisions of these nondiscrimination clauses. If such labor union or representative fails or refuses to comply with such a request that it furnishes such a statement, the Consultant shall promptly notify the State Commissioner of Human Rights of such failure or refusal.

(c) If directed to do so by the Commissioner of Human Rights, the Consultant will post and keep posted in conspicuous places, available to employees and bidders for employment, notices to be provided by the State Commissioner of Human Rights setting forth the substance of the provisions of Clauses (a) and (b) and such provisions of the State's laws against discrimination as the State Commissioner of Human Rights shall determine.

(d) The Consultant will state, in all solicitations or advertisement for employees placed by or on behalf of the Consultant, that all qualified bidders will be afforded equal employment opportunities without discrimination because of race, creed, color, sex, national origin, age, disability or marital status.

(e) The Consultant will comply with the provisions of Sections 290-299 of the Executive Law and with the Civil Rights Law, will furnish all information and reports deemed necessary by the State Commissioner of Human Rights under these non-discriminatory clauses and such actions of the Executive Law, and will permit access to the Consultant's books, records, and accounts by the State Commissioner of Human Rights, the Attorney General, and the Industrial Commissioner for the purposes of investigation to ascertain compliance with these non-
discrimination clauses and such sections of the Executive Law and Civil Rights Law.

(f) This Agreement may be forthwith canceled, terminated or suspended, in whole or in part, by the contracting agency upon the basis of a finding made by the State Commissioner of Human Rights that the Consultant has not complied with these non-discrimination clauses, and the Consultant may be declared ineligible for future agreements made by or on behalf of HRI, the State or a public authority or agency of the State, until the Consultant satisfies the State Commissioner of Human Rights that the Consultant has established and is carrying out a program in conformity with the provisions of these nondiscrimination clauses. Such finding shall be made by the State Commissioner of Human Rights after conciliation efforts by the Commissioner have failed to achieve compliance with these nondiscrimination clauses and after a verified complaint has been filed with the Commissioner, notice thereof has been afforded to the Consultant, and an opportunity has been afforded to the Consultant to be heard publicly in accordance with the Executive Law. Such sanctions may be imposed and remedies invoked independently of or in addition to sanctions and remedies otherwise provided by law.

(g) The Consultant will include the provisions of clause (a) through (f) in every subcontract or purchase order in such a manner that such provisions will be binding upon each subcontractor or contractor as to operations to be performed within the State of New York. The Consultant will take such action in enforcing such provisions of such subcontract or purchase order as the State Commissioner of Human Rights or the contracting agency may direct, including sanctions or remedies for non-compliance. If the Consultant becomes involved in or is threatened with litigation with a subcontractor or contractor as a result of such direction by the State Commissioner of Human Rights or the contracting agency, the Consultant shall promptly notify HRI.

2. Assurances Required by DHHS--PHS (Where Applicable)

(a) Human Subjects, Derived Materials or Data
The Consultant and HRI both agree to abide by DHHS regulations concerning Human Subjects. The DHHS regulation, 45 CFR 46, provides a systematic means, based on established ethical principles, protecting the rights and welfare of individuals who may be exposed to the possibility of physical, psychological or social injury while they are participating as subjects in research, development or related activities. The regulation extends to the human fetus (either in utero or ex utero), the dead, organs, tissues, and body fluids, and graphic, written or recorded information derived from human sources.

The DHHS regulation requires institutional assurances, including the implementation of procedures for review, and the assignment of responsibilities for adequately protecting the rights and welfare of human subjects. Safeguarding these rights and welfare is, by DHHS policy, primarily the responsibility of the grantee. The Consultant is responsible for ensuring that the activity described or covered by this Agreement, and additional information relating to human subjects, derived materials or data are annually reviewed and approved by the Institutional Review Board of the Consultant. The Consultant and HRI agree to complete a HHS 596 form on
an annual basis.

(b) Laboratory Animals
The Consultant agrees to abide by PHS policy requiring that laboratory animals not suffer unnecessary discomfort, pain or injury. The Consultant must assure PHS, in writing, that it is committed to following the standards established by the Animal Welfare Acts and by the documents entitled "Principles for Use of Animals" and "Guide for the Care and Use of Laboratory Animals."

(c) Recombinant DNA
The Consultant agrees to abide by the current PHS Guidelines for Research involving Recombinant DNA Molecules. All research involving recombinant DNA techniques that is supported by the Public Health Service must meet the requirements of these Guidelines, which were developed in response to the concerns of the scientific and lay communities about the possible effects of recombinant DNA research. Their purpose is to specify practices for the construction and handling of recombinant DNA molecules and organisms or viruses containing recombinant DNA. As defined by the Guidelines, "recombinant DNA" corresponds to: (1) molecules that are constructed outside living cells by joining natural or synthetic DNA segments to DNA molecules that can replicate in a living cell; or (2) DNA molecules that result from the replication of a molecule described in (1).

Several types of studies involving recombinant DNA are exempt from the Guidelines while others are prohibited by the Guidelines. For the remainder, the Consultant must establish and implement policies that provide for the safe conduct of the research in full conformity with the Guidelines. This responsibility includes establishing an institutional biosafety committee to review all recombinant DNA research to be conducted at or sponsored by the Consultant and to approve those projects that are in conformity with the Guidelines. For each approved project, a valid Memorandum of Understanding and Agreement (MUA) shall be prepared for submission when solicited by an appropriate PHS staff member. The MUA is considered approved after review and acceptance by ORDA and by the Consultant.

(d) Promoting Objectivity in Research
Consultant agrees to comply with the DHHS/PHS regulatory requirements on Responsibility of Bidders for Promoting Objectivity in Research and financial conflicts of interest set forth in 42 C.F.R Parts 50 and 94.

(e) Other DHHS-PHS Regulations
The Consultant agrees to comply with applicable DHHS regulations concerning Civil Rights and Equal Opportunity, Student Unrest Provisions, Handicapped Individuals and Sex Discrimination.

(f) Additional Assurances
Under this grant, should any additional DHHS-PHS regulations be promulgated, the Consultant and HRI will review and agree, if feasible, to include them as part of this Agreement.

Appendix B – Additions to Consultant Agreement
1. **System for Award Management (SAM) – for all agreements**
Consultant is required to register with SAM.gov and maintain active status as stated in 2 CFR Subtitle A, Chapter 1, and Part 25 of Code of Federal Regulations. Consultant must maintain the accuracy/currency of the information in SAM at all times during which your entity has an active agreement with HRI. Additionally, your entity is required to review and update the information at least annually after the initial registration, and more frequently if required by changes in your information.

2. **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.

3. **Whistleblower Policy – for all federally funded agreements**
Congress has enacted whistleblower protection statute 41 U.S.C. 4712, which applies to all employees working for contractors, grantees, subcontractors, and subgrantees on federal grants and contracts. This program requires all grantees, subgrantees 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 grantees will include such requirements in any agreement made with a subcontractor or subgrantee.

The statute (41 U.S.C. 4712) states that an “employee of a contractor, subcontractor, grantee [or subgrantee] 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 grant; a gross waste of federal funds; an abuse of authority relating to a federal contract or grant; a substantial and specific danger to public health or safety; or a violation of law, rule, or regulation related to a federal contract or grant (including the competition for, or negotiation of, a contract or grant). 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 grant 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, grantee or subgrantee who has the responsibility to investigate,
discover or address misconduct.

VI. Completing the Proposal

A. Proposal Content

Program Summary (4 pages)

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

a. Bidders should describe in their program summary their overall approach to meeting the requirements outlined above including anticipated time frames and resources required;

b. Bidders should assume a 34-month project period, beginning on April 1, 2016, with two annual renewals issued on February, 2017 and 2018.

Bidder Experience (10 pages)

In addition to providing resumes for applicable staff dedicated to this project, bidders must provide specific information and examples that demonstrate AND describe the organization’s experience with the Minimum Eligibility Requirement listed in Section II (also listed below).

a. At least 5 years of experience in conducting large-scale, multi-year program evaluations.

Bidders will also be expected to provide specific information and examples that demonstrate AND describe experience with each of the Preferred Qualifications as listed in Section II (also listed below). The bidder should indicate the section number and subsection (e.g., II-b-ii, II-c) of the requirement being addressed.

a. A designated lead evaluator with extensive training and expertise in public health, statistics, social sciences or a related field.

b. Demonstrated expertise and capacity to develop and implement qualitative analyses, inclusive of data collection and data analytics.

c. Demonstrated expertise with quantitative data analysis including:
   i. claims data and data from other large data systems, including the goals of such analyses, manner of data access, and data extraction.
   ii. Statistical analysis relevant to executing the proposed evaluation plan, including the types of analyses and software used.
   iii. Ensuring data quality and integrity of results.
   iv. Quantitative and/or qualitative data collection procedures,
including the gaining of access to respondents and scheduling.

d. Demonstrated expertise with report preparation (up to three samples may be attached as an appendix) including
   i. Preparation of reports including results of quantitative and qualitative analysis.
   ii. Summative reporting of findings of large scale program evaluation or research projects.

e. Demonstrated expertise with evaluation of government health care delivery reform initiatives.

Staffing Plan:

a. Describe the proposed staffing plan that will provide the bidder with the resources necessary to meet the project activities and requirements. For each position, provide a job description, detailing staff qualifications that will be required for the position. If it is known who will fill the position, a resume should be provided as an appendix. The proposed staffing plan should demonstrate that project staff have appropriate training and experience in:
   i. program evaluation,
   ii. quantitative data analysis using large and complex data systems,
   iii. data collection and analysis, and
   iv. report preparation.

b. An organizational chart showing how this contract will fit into the organization’s management structure should be submitted as an appendix.

Scope of Work/Project Narrative (10 pages)

The detailed scope of work to be addressed is outlined in Sections I and IV of this RFP. The bidder should indicate the section number and subsection (e.g., I-b-ii, IV-h) of the activity being addressed. The scope of work/project narrative should also:

- Include a project plan to demonstrate how scope of work will be achieved, with milestones, responsible parties and required resources. The requirements from the project plan should connect to the Budget Template deliverables (Attachment 3) and should be clearly identified.
- Describe any risk mitigation strategies to avoid missing deadlines.
- Describe activities in terms of meeting the deliverables Sections I and IV.
- Provide an estimated timeline for the completion of activities in a chart.
- Describe how the bidder will conduct internal management of this project. Management oversight should be adequate to ensure integrity of products throughout the course of the contract period.
4. **Budget and Justification (5 pages)**

- Follow the budget directions in Attachment 2. Bidders should submit a 34-month budget broken down into one 10-month period from April 1, 2016, through January 31, 2017, and two 12-month periods, assuming a February 1 start in 2017 and 2018, aligned to the project plan submitted. All costs must be related to the provision of services as described in this RFP.
- Budgets should be fiscally and programmatically sound. Requests should be consistent with the proposed scope of services, reasonable and cost effective. Budgets must relate directly to activities described in the project narrative and work plan. No direct health care services will be funded by this program. The composite hourly rates for personnel described must be inclusive of all costs, including salaries, fringe benefits, administrative costs, presentation costs, and profit.
- Expenditures will not be allowed for the purchase of major pieces of depreciable equipment or remodeling or modification of structure.
- Any ineligible budget items will be removed from the budget prior to contracting. The budget amount requested will be reduced to reflect the removal of the ineligible items.
- Justification for each requirement should be submitted in narrative form. Explain how the cost was calculated and how each item is essential to the operation of the network. For all staff, the Budget Justification must delineate how the percentage of time devoted to this initiative has been determined. Items that cannot be justified as integral to the operation of the network will not be allowed.

**B. Proposal Format**

ALL PROPOSALS MUST CONFORM TO THE FORMAT PRESCRIBED BELOW. POINTS WILL BE DEDUCTED FROM PROPOSALS WHICH DEVIATE FROM THE PRESCRIBED FORMAT.

Proposals MUST NOT exceed 29 single-spaced typed pages (not including the cover page and appendix/attachments), using an 11 point font. The value assigned to each section is an indication of the relative weight that will be given when scoring your proposal.

1. **Program Summary**
   - (4 pages) (Maximum Score: 10 points)

2. **Bidder Experience**
   - (10 pages) (Maximum Score: 30 points)

3. **Scope of Work/Project Narrative**
   - (10 pages) (Maximum Score: 40 points)

4. **Budget and Justification**
   - (5 pages) (Maximum Score: 20 points)

5. **Appendix:** The appendices may include the following documents with corresponding page limits:
a. Primary Project Team List: List of personnel on the primary team working most closely with HRI/NYSDOH—include primary contact and other team members. Staff will not be required to be based in Albany although space can be provided to them at no cost (limit 2 pages)
b. Resumes for key personnel, including primary team (limit 2 pages per person)
c. An organizational chart showing how this contract will fit into the organization’s management structure (limit 1 page)
d. Samples demonstrating experience with preparation of reports including results of quantitative analysis and qualitative analysis (if applicable) and summative reporting of findings of large scale program evaluation or research project. (limit 10 pages)
e. The selected contractor must be able to act as an independent, unbiased third party in conducting the evaluation. Any potential conflicts of interest, including but not limited to current contracts with NYSDOH/HRI or with CMS should be described on a case by case basis (limit 1 page)

C. Review Process

Proposals 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 Bidders 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 RFP is the obligation of the Bidder and not the responsibility of the NYSDOH or HRI. Proposals 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 award. The proposal receiving the highest score will receive the award. Proposals will be reviewed using the criteria that are listed under Proposal Content.*

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

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the subject proposal and will not include any discussion of other proposals. Requests must be received no later than 10 business days from date of award or non-award announcement.

VII. Attachments

Attachment 1: Proposal Coversheet
Attachment 2: Budget Instructions
Attachment 3: Proposal Budget Template
Attachment 4: SIM Driver Diagram
Attachment 5:  Alignment of Prevention Agenda Indicators with SIM APC Scorecard Indicators
Attachment 6:  References
Proposal Cover Sheet

Evaluation Services RFP Response
RFP #QPS-2016-01

Bidder:

______________________________________________________________

Contact Person

Name

______________________________________________________________

Title

______________________________________________________________

Address

______________________________________________________________

______________________________________________________________

( )

Phone

______________________________________________________________

Email

______________________________________________________________

Total Proposal Budget Total: ________________________________

I, ______________________________________, for and on behalf of the bidder
organization(s), 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 terms of this
application and is fully able and willing to carry out the terms of the project.

______________________________________________________________

Signature

______________________________________________________________

Title

______________________________________________________________

Date
Attachment 2

Budget Instructions

Bidders should develop a deliverables based budget that include detailed information as described below. The selected contractor will be paid by deliverable and no payment will be made for partial deliverables.

The budgets submitted should include total proposal cost and justification of proposal costs for each deliverable. The selected contractor provides this information as a back-up to show a deliverables cost, but will invoice based on the completed deliverables. Budget requests should be based on a 34-month budget broken down into one - 10 month period (April 1, 2016 through January 31, 2017) and two additional 12-month periods, assuming a February 1 start in 2017 and 2018, and should relate directly to activities described in the project narrative. No direct health care services will be funded by this program.

Follow these directions for developing and completing the budget form:

Budget and Justification – Total Proposal Cost using “Budget Template”:

- Use the template provided for the cost associated for each team member that would be assigned to this contract. The total cost of the proposal should not exceed $500,000 for year 1, $1,000,000 per year for years 2 and 3.
- The Budget Template includes columns to identify the staff person’s title, hourly rate, estimated hours for the deliverable and total cost. The composite hourly rates described must be inclusive of all costs, including salaries, fringe benefits, administrative costs, travel costs, presentation costs and profit.
- Provide a breakdown of the composite hourly rate. The breakdown should demonstrate how each cost category fits into the overall rate (e.g.: 30% salary, 25% Fringe, 10% supplies, 15% equipment, 10% travel, 10% indirect). Also provide a brief justification for each cost. All columns should be completed.
Budget Template

Instructions:
- For the total cost of the proposal, complete the template in section A below.
- Follow instructions in Attachment 2.

A. Proposal Cost Template:

### Year 1

#### Deliverable 1 – 1st Quarter Report

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#### Deliverable 5 – Annual Report

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## Year 2

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### Deliverable 3 – 3rd Quarter Report

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### Deliverable 4 – 4th Quarter Report

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### Deliverable 5 – Annual Report

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### Deliverables Year 2

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### Year 3

#### Deliverable 1 – 1st Quarter Report

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#### Deliverable 4 – 4th Quarter Report

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**Deliverable 5 – Annual Report**

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**Deliverables Year 3**

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SHIP Drivers diagram (1/2)

**Aim**

By the end of 2019, New York will:

**IMPROVE HEALTH**

Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement.

**IMPROVE CARE QUALITY AND CONSUMER EXPERIENCE**

Achieve high standards for quality and consumer experiences.

**SPEND HEALTH CARE DOLLARS MORE WISELY**

Assure that 50% of the care delivered in NYS utilizes payment models that promote and incent high value care.

---

**Primary drivers**

- **Access to Care**
  - Improve access to care for all without disparity
  - Assure 80% of New Yorkers have access to integrated
  - Reduce disparities in premature death and avoidable hospitalizations

- **Integrated Care and Pay for Value**
  - Assure 80% of New Yorkers access to advanced primary care that meets consumer needs seamlessly
  - Assure 80% of primary care is paid for using value-based payment models that incent quality and value.
  - Develop standardized, statewide approach to measure impact of APC

---

**Secondary drivers**

- Evaluate access and recommend policy to advance Affordability, Accessibility, and Acceptability
- Improve primary care access through state-wide roll-out of APC model

- Design, implement, and monitor APC model
  - Ensure 80% of New Yorkers receive care and treatment through an Advanced Primary Care model
  - Produce state, regional, payer, and provider dashboards / scorecards that are payer agnostic
  - Implement APC scorecard launch November 2016

- Provide practice transformation support to
  - Increase number of providers in Advanced Primary Care model to 80%

- Design value-based payment models to support APC
  - Ensure 80% of health care spending is contracted under value-based payment models by 2019
  - Increase percent of insurers using value-based payment to 50% by 2019

- Utilize Rate Review process to promote value-based payment

- Implement value-based insurance design

---

1 Unless otherwise specified
SHIP Drivers diagram (2/2)

Aim

By the end of 2019, New York will:

IMPROVE HEALTH
Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement.

IMPROVE CARE QUALITY AND CONSUMER EXPERIENCE
Achieve high standards for quality and consumer experience.

SPEND HEALTH CARE DOLLARS MORE WISELY
Assure that 80% of the care delivered in NYS utilizes payment models that promote and incent high value care.

Primary drivers

Use Health Information Technology to Drive Value in Primary Care
Build and expand health information technology to support and inform advanced primary care.

II Transparency, Evaluation, & HIT

Integrate the State’s Health Improvement Plan Prevention Agenda 2013-2016 (PA), into NY’s health systems transformation efforts:
- Ensure delivery of clinical preventive services
- Improve linkages between the health system and community supports
- Engage the health system in community improvement efforts

IV Population Health

Develop a targeted workforce strategy to:
- Address emerging health professions needs
- Ensure sufficient primary care workforce
- Better distribute workforce to areas of need
- Train workforce for team-based care models

V Workforce

Secondary drivers

Design and implement All-Payer Database (APD):
- Implement APD by 2017 to support and inform APC.
- Develop HIT enabled APC scorecard to track progress towards Triple Aim.
- Increase percent of providers with access to APD-based scorecard to 80% by 2016.
- Consistently evaluate impact of the SHIP.

Design SHIN-NY to allow interoperability with current systems and support APC:
- Increase percent of providers with HIE capability to 80%.

- Maintain/collaborate surveillance systems to track population health measures in PA, SIM, DSRIP.
- Develop policies, systems, and supports for APC practices to deliver clinical preventive services and connect patients to community supports by 2017.
- Facilitate partnerships between local health departments, community organizations and health systems to improve community health.

- Develop and identify curriculum for new or emerging roles such as care coordinators in 2016.

Address primary care workforce shortages through rural residency and physician retention strategies:
- Reduce gap in PCPs in health care shortage areas by 26% by 2019.

1 Unless otherwise specified
### Alignment of Prevention Agenda Indicators with SIM APC Scorecard Indicators

<table>
<thead>
<tr>
<th>PA Focus Area</th>
<th>PA Population Health Indicator*</th>
<th>SIM APC Scorecard Indicator</th>
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<tr>
<td><strong>Priority: Prevent Chronic Disease</strong></td>
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<tr>
<td><strong>Reduce illness, disability and death related to tobacco use and secondhand smoke exposure</strong></td>
<td>23 - Prevalence of any tobacco use (cigarettes, cigars, smokeless tobacco) by high school age students 24 - Percentage of cigarette smoking among adults 24.1 - Percentage of cigarette smoking among adults with income less than $25,000 25 - Utilization of smoking cessation benefits among smokers who are enrolled in Medicaid Managed Care</td>
<td>6. Tobacco Use Screening and Intervention</td>
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<tr>
<td><strong>Increase access to high quality chronic disease preventive care &amp; management in both clinical and community settings (including cancer screening, asthma, diabetes and HTN)</strong></td>
<td>26 - Percentage of adults who received a colorectal cancer screening based on the most recent guidelines - Aged 50-75 years 26.1 - Percentage of adults aged 50-75 years with an income less than $25,000 who received a colorectal cancer screening 27 - Asthma emergency department visit rate per 10,000 population 28 - Asthma emergency department visit rate per 10,000 - Aged 0-4 years 29 - Percentage of health plan commercial managed care (CMC) members with hypertension, who have controlled their blood pressure - Aged 18-85 years 30 - Percentage of health plan Medicaid managed care (MMC) members with hypertension, who have controlled their blood pressure - Aged 18-85 years 30.1 - Percentage of Black health plan Medicaid managed care (MMC) members with hypertension who have controlled their blood pressure - aged 18-85 years 31 - Percentage of adult health plan commercial managed care (CMC) members with diabetes, who have blood glucose in good control 32 - Percentage of adult health plan Medicaid managed care (MMC) members with diabetes, who have blood glucose in good control 32.1 - Percentage of Black health plan MMC</td>
<td>1. Colorectal Cancer Screening 9. Medication Management for People with Asthma 7. Controlling High Blood Pressure 8. Diabetes A1C Poor Control</td>
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<tr>
<td>PA Focus Area</td>
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<td>members with diabetes, who have blood glucose in good control.</td>
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<td>33 - Age-adjusted heart attack hospitalization rate per 10,000</td>
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<td>34 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 6-17 years</td>
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<td>35 - Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years</td>
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<td>Reduce Obesity</td>
<td>18 - Percentage of adults who are obese</td>
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<td>18.1 - Percentage of adults aged 18 years and older with an annual household income less than $25,000 who are obese</td>
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<td>18.2 - Obesity among low income adults: Percentage of adults aged 18 years and older with disabilities who are obese</td>
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<td>19 - Percentage of children and adolescents who are obese in NYC</td>
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<td>20 - Percentage of children and adolescents who are obese in NYS excluding NYC</td>
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<td>21 - Percentage of children (aged 3-17 years) with an outpatient visit that includes an assessment for weight status among Commercial Managed Care (CMC) members.</td>
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<td>22 - Percentage of children (aged 3-17 years) with an outpatient visit that includes an assessment for weight status among Government Sponsored Managed Care (GSMC) members.</td>
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<td>Priority: Prevent HIV/STDs, Vaccine Preventable Diseases, Healthcare Associated Infections</td>
<td>39 - Newly diagnosed HIV case rate per 100,000</td>
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<td>39.1 - Difference in rates (Black and White) of newly diagnosed HIV cases</td>
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<td>39.2 - Difference in rates (Hispanic and White) of newly diagnosed HIV cases</td>
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<td>40 - Percentage of HIV-infected persons with a known diagnosis who are in care</td>
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<td>41 - Gonorrhea case rate per 100,000 women - Aged 15-44 years</td>
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<td>42 - Gonorrhea case rate per 100,000 men - Aged 15-44 years</td>
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<td>43 - Chlamydia case rate per 100,000 women - Aged 15-44 years</td>
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<td>44 - Primary and secondary syphilis case rate per</td>
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<td>10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults</td>
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<td>SIM APC Scorecard Indicator</td>
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<tr>
<td>Prevent Vaccine-Preventable</td>
<td>100,000 men</td>
<td>4.Childhood Immunization (status)</td>
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<td>Preventable Diseases</td>
<td>45 - Primary and secondary syphilis case rate per 100,000 women</td>
<td>3. Influenza Immunization - all ages</td>
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<tr>
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<td>37 - Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years</td>
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<td>38 - Percentage of adults with flu immunization - Aged 65+ years</td>
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<td>Prevent Healthcare</td>
<td>46 - Hospital-onset CDIs new cases per 10,000 patient days</td>
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<td>Associated Infections</td>
<td>47 - Community-onset healthcare facility-associated CDIs new cases per 10,000 patient days</td>
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<td>48 - Percentage of preterm births</td>
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<td>48.1 - Premature births: Ratio of Black non-Hispanics to White non-Hispanics</td>
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<td>Maternal and Infant Health</td>
<td>48.2 - Premature births: Ratio of Hispanics to White non-Hispanics</td>
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<td>48.3 - Premature births: Ratio of Medicaid births to non-Medicaid births</td>
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<td>49 - Percentage of infants exclusively breastfed in the hospital</td>
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<td>49.1 - Exclusively breastfed: Ratio of Black non-Hispanics to White non-Hispanics</td>
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<td>49.2 - Exclusively breastfed: Ratio of Hispanics to White non-Hispanics</td>
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<td>49.3 - Exclusively breastfed: Ratio of Medicaid births to non-Medicaid births</td>
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<td>50 - Maternal mortality rate per 100,000 births</td>
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<td>Priority: Promote Healthy</td>
<td>51 - Percentage of children who have had the recommended number of well child visits in</td>
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<td>Women, Infants and Children</td>
<td>government sponsored insurance programs</td>
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<td>51.2 - Percentage of children aged 3-6 years who have had the recommended number of well child</td>
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<td>visits in government sponsored insurance programs</td>
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<td>51.3 - Percentage of children aged 12-21 years who</td>
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<td>have had the recommended number of well child visits in government sponsored insurance programs</td>
<td>5. Fluoride Varnish Application</td>
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<td>52 - Percentage of children (aged under 19 years) with health insurance</td>
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<td>53 - Percentage of third-grade children with evidence of untreated tooth decay obese in NYS excluding NYC</td>
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<td>53.1 - Tooth decay: Ratio of low-income children to non-low income children obese in NYS excluding NYC</td>
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<td>Reproductive, Preconception and Inter-conception Health</td>
<td>54 - Adolescent pregnancy rate per 1,000 females - Aged 15-17 years</td>
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<td>54.1 - Adolescent pregnancy: Ratio of Black non-Hispanics to White non-Hispanics</td>
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<td>54.2 - Adolescent pregnancy: Ratio of Hispanics to White non-Hispanics</td>
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<td>55 - Percentage of unintended pregnancy among live births</td>
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<td>55.1 - Unintended pregnancy: Ratio of Black non-Hispanic to White non-Hispanic</td>
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<td>55.2 - Unintended pregnancy: Ratio of Hispanics to White non-Hispanics</td>
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<tr>
<td></td>
<td>55.3 - Unintended pregnancy: Ratio of Medicaid births to non-Medicaid births</td>
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<tr>
<td></td>
<td>56 - Percentage of women (aged 18-64) with health insurance</td>
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<td>57 - Percentage of live births that occur within 24 months of a previous pregnancy</td>
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<tr>
<td>Priority: Promote a Healthy and Safe Environment</td>
<td>5 - Rate of hospitalizations due to falls per 10,000 - Aged 65+ years</td>
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<td>Built Environment</td>
<td>6 - Rate of emergency department visits due to falls per 10,000 - Aged 1-4 years</td>
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<tr>
<td>Injuries Violence and Occupational Health</td>
<td>7 - Assault-related hospitalization rate per 10,000</td>
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<tr>
<td></td>
<td>7.1 - Assault-related hospitalization: Ratio of Black non-Hispanics to White non-Hispanics</td>
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<td>7.2 - Assault-related hospitalization: Ratio of Hispanics to White non-Hispanics</td>
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<td></td>
<td>7.3 - Assault-related hospitalization: Ratio of low income ZIP codes to non-low income ZIP codes</td>
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<td>8 - Rate of occupational injuries treated in ED per 10,000 adolescents - Aged 15-19 years</td>
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<td>PA Focus Area</td>
<td>PA Population Health Indicator*</td>
<td>SIM APC Scorecard Indicator</td>
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<td><strong>Priority: Promote Mental Health and Prevent Substance Abuse</strong></td>
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| Mental Health and Substance Abuse Prevention | 58 - Percentage of adolescents (youth in grades 9-12) reporting use of alcohol on at least one day for the past 30 days  
59 - Percentage of adolescents (youth aged 12-17 years) reporting non-medical use of painkillers in the past year  
60 - Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month  
61 - Age-adjusted percentage of adult binge drinking during the past month  
62 - Percentage of adolescents (youth grades 9-12) who felt sad or hopeless  
63 - Percentage of adolescents (youth grades 9-12) who attempted suicide one or more times in the past year  
64 - Age-adjusted suicide death rate per 100,000  
65 - Age-adjusted percentage of cigarette smoking among adults who report poor mental health | 12. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment  
11. Depression screening and management                                                                                                                                                   |                                                                                                                                                          |

- Objectives are from the Prevention Agenda 2013-2018 Dashboard  
d/pa_dashboard#)

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<tr>
<th>Domains</th>
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<tr>
<td>Prevention</td>
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<td>Colorectal Cancer Screening</td>
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<td>Chlamydia Screening</td>
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<td>Influenza Immunization - all ages</td>
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<td>Childhood Immunization (status)</td>
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<td>Fluoride Varnish Application</td>
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<td>Chronic Disease</td>
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<td>Tobacco Use Screening and Intervention</td>
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<td>18</td>
<td>Controlling High Blood Pressure</td>
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<td>59</td>
<td>Diabetes A1C Poor Control</td>
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<td>1799</td>
<td>Medication Management for People With Asthma</td>
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<td>24, 421</td>
<td>Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults</td>
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<td>Behavioral Health/Substance Use</td>
<td>418</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
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<td>4</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<tr>
<td>Patient-Reported</td>
<td>326</td>
<td>Advance Care Plan</td>
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<td>CAHPS Access to Care, Getting Care Quickly</td>
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<td>Appropriate Use</td>
<td>52</td>
<td>Use of Imaging Studies for Low Back Pain</td>
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<tr>
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<td>58</td>
<td>Avoidance of Antibiotic Treatment in adults with acute bronchitis</td>
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<td>Inpatient Hospital Utilization (HEDIS)</td>
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<td>Plan All-Cause Readmissions</td>
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<td>Emergency Department Utilization (HEDIS)</td>
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<tr>
<td>Cost</td>
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<td>Total Cost Per Member Per Month</td>
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References

Evaluation Services RFP Response
RFP #QPS-2016-01

Please note: References should not include HRI or NYSDOH employees.

<table>
<thead>
<tr>
<th>References for:</th>
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CMMI-SIM Reporting Schedule

SIM Grant Years: February 1 to January 31

**Year 1**
- 1st Quarter – Due May 30, 2016
- 2nd Quarter – Due August 31, 2016
- 3rd Quarter – Due November 30, 2016
- 4th Quarter – Due February 28, 2017

**Year 2**
- 1st Quarter – Due May 30, 2017
- 2nd Quarter – Due August 31, 2017
- 3rd Quarter – Due November 30, 2017
- 4th Quarter – Due February 28, 2018

**Year 3**
- 1st Quarter – Due May 30, 2018
- 2nd Quarter – Due August 31, 2018
- 3rd Quarter – Due November 30, 2018
- 4th Quarter – Due February 28, 2019