Massachusetts eHealth Institute

eHealth eQuality Incentive Program Grants Solicitation

RFP No. 2015-MeHI-03

ADDENDUM #1

ISSUED:
April 1, 2015

Massachusetts Technology Collaborative
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Westborough, MA 01581-3340
http://www.masstech.org

Solicitation Issued:	**February 17 2015**
Team Leader:	**Judith Iwanski**
Applications Due:	**April 16, 2015**

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Addendum #1

Application Due Date

The application deadline has been extended. The new deadline is 3:00 p.m. on April 16, 2015.

Eligibility Criteria #2 in Section 2.3.2 is amended as follows:

	Eligibility Criteria	**Detail**	**Method of Substantiation**
2	Organization has no financial relationship/affiliation to an acute care hospital system	Organization is not a subsidiary in an affiliated or parent-subsidiary group or otherwise have access to financial or health IT resources through corporate or contractual affiliations	Organization must provide a full corporate organizational chart showing the ownership, governance and operational structure of the provider organization, including any parent entities, and corporate affiliates
	➢ Organizations that have a relationship/affiliation to an acute care hospital system meet this criterion *IF*:	(1) the acute care hospital system or a component thereof holds a minority ownership interest in the organization; (2) the acute care hospital system or a component thereof does not exercise governance or management control over the organization; and (3) such organization's financial statements are not consolidated with the financial statements of the hospital system or component thereof under generally accepted accounting principles. A "component of an acute care hospital system" means the parent organization of such system or any entity that is controlled by, under common control with, or that controls such "parent" entity.	Organization must provide: (1) a full corporate organizational chart showing the ownership, governance and operational structure of the provider organization, including any parent entities, and corporate affiliates; and (2) s copy of relevant agreement(s) between the organization and the hospital system or component thereof. Confidential provisions in such agreements should be redacted prior to submission to MeHI. In lieu of submitting the entire agreement(s), the organization may extract and submit to MeHI the portions of such agreement(s) that describe the management relationship between the entities and the nature of the ownership interest in the organization.

Updates to Attachments A-1 and A-3

If the Applicant has a relationship with an acute care hospital system that satisfies the revised eligibility criteria set forth above, the Applicant should utilize the revised and updated Attachment A-1 (Substantiation Form) and Attachment A-3 (Officer's Certification Form/Signature) that follow. All other Applicants should use the versions of Attachments A-1 and A-3 that are included in the RFP.

Addenda to RFP No. 2015-MeHI-03 are posted to the Massachusetts Technology Collaborative's website at http://www.masstech.org/ehealth-equality-incentive-program-grants-solicitation-0 and the COMMBUYS website at https://www.commbuys.com/bso/.

Attachment A-1

Substantiation Form

Applicant must submit, in tabbed and labeled format, the Eligibility Substantiation Documentation as is required by this Solicitation, including:

	Documentation	Included
1	Copy of currently valid license(s) to provide LTPAC direct inpatient care services in a Level I or Level II licensed long-term care facility granted by the Massachusetts Department of Public Health (MA DPH) (http://www.mass.gov/eohhs/docs/dph/regs/105cmr150.pdf • The LTPAC profile (Attachment A-1-a) must be included with the Application	Yes☐ No ☐ N/A☐
2	A statement documenting: (1) Total Patient Service Revenue (PSR) for inpatient LTPAC services[1] for the last State FY for all MA DPH licensed facilities or units (Level I, II, III, or IV) (2) The amount and percent of PSR for inpatient LTPAC services for MA DPH-licensed Level I or Level II LTC facilities only), and (3) The source, amount and percent for all such LTPAC services revenue, e.g., private payer(s), Medicaid, Medicare, etc. • The PSR chart (Attachment A-1-b) must be included with the Application • PSR calculations must be supported by documentation from Uniform Financial Statements and Independent Auditor's Report (UFR) or similar audited report (most recent FY available) that is **attached as supporting documentation**.	Yes☐ No ☐ N/A☐
3	A full corporate organizational chart showing the ownership, governance and operational structure of the provider organization, including any parent entities, and corporate affiliates	Yes☐ No ☐ N/A☐
—	If the organization has a relationship with an acute care hospital, provide a copy of relevant agreement(s) between the organization and the hospital system or component thereof. Confidential provisions in such agreements should be redacted prior to submission. In lieu of submitting the entire agreement(s), the organization may extract and submit the portions of such agreement(s) that describe the management relationship between the entities and the nature of the ownership interest in the organization.	Yes☐ No ☐ N/A☐
4	Documentation that it is not an EH under the HITECH Act AND that its providers are not EPs under the definitions of the Act OR	Yes☐ No ☐ N/A☐
—	if have providers who are EPs, submit documentation verifying: (1) the number and percent of the organization's clinical care providers that are EPs (2) how each of those EPs assign/will assign their EHR Incentive Program revenue, AND (3) that the number of the EPs that assign their EHR Incentive Program revenue to the Organization is less than 30% of the organization's clinical staff	Yes☐ No ☐ N/A☐

[1] PSR is revenue from post-acute care services, and does not include revenue from outpatient, assisted living, hospice or other services that may be performed at these licensed facilities

Attachment A-3

Officer's Certification Form / Signature

1. ___________ [*Organization name*] attests that it currently holds a valid license(s) to provide LTPAC direct patient care services in a Level I or Level II licensed long-term care facility granted by the MA DPH (http://www.mass.gov/eohhs/docs/dph/regs/105cmr150.pdf)

   Yes☐ No☐

2. ___________ [*Organization name*] attests that [*Organization name*] or its providers are not excluded from participation in Federal or state healthcare programs or listed on the Office of Inspector General (OIG) Medicare Exclusion Database (MED) and General Services Administration (GSA) Excluded Parties List System (EPLS) exclusion lists, and that it will promptly notify MeHI if [*Organization name*] or its providers become so excluded.

   Yes☐ No☐

3. ___________ [*Organization name*] attests that it has no financial relationship/affiliation to an acute care hospital system, is not in an affiliated or parent-subsidiary group, or otherwise has access to financial/IT resources through corporate or contractual affiliations.

   Yes☐ No☐ (If NO, proceed to 4)

4. ___________ [*Organization name*] attests that it meets the requirements for eligibility under Criterion #2 in that (1) the acute care hospital system or a component thereof holds a minority ownership interest in the organization; (2) the acute care hospital system or a component thereof does not exercise governance or management control over the organization; and (3) such organization's financial statements are not consolidated with the financial statements of the hospital system or component thereof under generally accepted accounting principles.

   Yes☐ No☐

5. ___________ [*Organization name*] attests that more than 50 percent of the organization's Patient Services Revenue, defined herein, is public payer.

   Yes☐ No☐

6. __________ [*Organization name*] attests that it is not an Eligible Hospital (EH), Federally Qualified Health Center (FQHC), or Community Health Center, and that its providers are not Eligible Professionals (EPs) under the Medicare or Medicaid EHR Incentive Programs.

   Yes☐ No☐ (If No, proceed to 7.)

7. [*Organization name*] attests that the number of EPs who assign/will assign their EHR Incentive Payment to the organization total less than 30% of its total clinical staff.

   Yes☐ No☐

8. __________ [*Organization name*] attests that the information provided in Attachment A-1 (<u>Substantiation Form</u>) and accompanying documentation is true and complete.

   Yes☐ No☐

9. __________ [*Organization name*] attests that the information provided in Attachment A-1-a (<u>Organizational LTPAC Profile</u>) is true and complete.

   Yes☐ No☐

10. __________ [*Organization name*] attests that the information provided in Attachment A-1-b (<u>Organizational Patient Service Revenue</u>) is true and complete.

    Yes☐ No☐

11. __________ [*Organization name*] attests that the information provided in Attachment A-2 (Current Use of Health IT) is true and complete.

    Yes☐ No☐

If you have answered 'No' to any questions, please explain. Attach additional sheets if necessary.

Attachment A-3 (page 2)

Certification

The undersigned, ____, hereby certifies
(Name and Title)
that I am a duly authorized representative of ____
(Organization Name)
and that all of the foregoing answers and all statements contained in any explanation are complete, true and correct. Providing false or misleading information or failure to provide all required information will be considered grounds for disqualification. I attest to the accuracy of all information contained in this application and verify that the information submitted is in fact complete, accurate and true.

Signed and sworn under the penalties of perjury

Dated at:_____________________________________
(location)

This _________ day of ____________________, 2015

By:____
(Signature)

Name:____
(Printed or Typed)

Title/Position:_________________________________