March 12, 2015

Jessica Woodard
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: New York State DSRIP Vital Access Provider Exception Determination

Dear Ms. Woodard:

On behalf of LeadingAge New York, I am writing to ask you to reconsider your recent disapproval of certain applications for the Vital Access Provider (VAP) exception, as they relate to our State's Delivery System Reform Incentive Payment (DSRIP) program. This exception would have granted Safety Net status for several providers who didn't otherwise meet the criteria.

By way of background, LeadingAge NY represents over 400 not-for-profit and public providers of Long-Term and Post-acute Care (LTPAC) and senior services throughout the State. Many of our members are engaged in DSRIP, and recognize that the initiative has the potential to fundamentally change the way services are delivered and paid for in the future. LeadingAge NY has been working closely with our members in conjunction with our colleagues from across the continuum to ensure the provider community's understanding and engagement in DSRIP.

Among the many issues we have worked with our members on is the Safety Net application process and subsequent VAP exemption process. We were disappointed at the determinations made by the Centers for Medicare and Medicaid (CMS), and had several questions regarding the CMS approval letter and rationale. It would be helpful to understand more about the process, and why the State's recommendations were not accepted.

We see VAP Safety Net designation for those qualified providers recommended by the New York State Department of Health (DOH) to be in the best interest of New York's Medicaid members, as supported by the agreed upon criteria set forth in the DSRIP Special Terms and Conditions. Due to the unique factors and evolving Medicaid landscape in New York, as discussed more fully below, we urge CMS to reconsider the recent disapprovals of providers identified by DOH as "vital" to the communities they serve. CMS reconsideration and approval of VAP Safety-Net status will afford those approved providers with the opportunity to receive the full amount of DSRIP incentive payments necessary to promote interconnectivity, care coordination and full participation in emerging PPSs in their region. Without such designation, these critical providers are unfairly disadvantaged and will be placed on a unlevel playing field throughout the five year DSRIP waiver period, and beyond.

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Set forth below are specific areas of requested clarification, as well as proposed bases for reconsideration.

Certified Home Health Agencies (CHHAs):

CMS did not recommend any of the CHHAs for approval. Among the reasons in the documentation include:

- *Provider is considered safety net under another category*.
- *Provider's statistics for Medicaid volume are different from the State's statistics.*
- *The application is not clear how a provider can or will contribute to DSRIP or its PPS' efforts.*

***Provider is considered safety net under another category*.** We were confused by this statement. Does having one part of your organization designated as Safety Net result in such a designation for all of its related parties? This certainly has not been the approach for the Safety Net provider designation process thus far.

Or, conversely, does having a part of your organization designated as a safety net provider preclude the organization from having another part designated? Again, this is not consistent with the Safety Net provider designation process. We contend that Safety Net designation in one arm of the organization should not preclude Safety Net designation for another component of the organization.

Does the determination mean that VAP applicant is indeed a Safety Net provider; in other words, CMS dismissed the application because they were otherwise deemed a Safety Net provider? Applicants are still unclear about the meaning of the determinations and their status.

Our not-for-profit members are often organized as separately licensed entities under a common parent along the LTPAC continuum. Sometimes the populations are overlapping, and sometimes distinct. In addition, in New York, we have multiple types of home care providers. Because of the expansion of manadatory mangaged care for Medicaid beneficiaires requiring long term care services, the State has been reconfiguring the home care landscape by allowing an expansion in the number of CHHAs, while encouraging the winding down of the Long Term Home Health Care Program (LTHHCP). Within some organizations, home care patients are being transitioned from one regulated entity to another within the same corporate umbrella as a result. Patients move back and forth between regulated entities depending on their need for skilled services.

Additionally, Licensed Home Care Services Agencies (LHCSAs) are home care agencies that are not Medicare certified, but may provide personal care and related services to Medicaid eligible and dual-eligible populations.

Given these complexities, an individualized assessment of the organization structure and the clients they serve is needed, rather than wholesale exclusions. With more information about the factors that influenced your decisions, we could be helpful in making these structures clearer, and identify the vital role that these providers play in the communities.

Provider's statistics for Medicaid volume are different from the state's statistics.

As noted above, the provider landscape is changing in New York, and the State opened up the opportunity for entities to apply to become a CHHA, a few years ago. These newer CHHAs, which in

and of themselves were approved by the State because of the need in the community in the context of Medicaid managed care, simply didn't have enough data at the time of the Safety Net application to meet the criteria to be a Safety Net Provider. At the time of the VAP application, the provider had more experience to project the its level of service to the Medicaid and dual-eligible populations. This may be why the providers' statistics differ from the State's statistics; they are likely to be more recent. Some new CHHAs developed in order to absorb the dual eligible population that were being served by LTHCPs that are being phasesd out.

The application is not clear how a provider can or will contribute to DSRIP or its PPS' efforts. While this is obviously a key aspect of the VAP process, we note that the consecutive Safety Net application and VAP application processes have been confusing for applicants. It is has been unclear what exactly is being asked for, and what data is most helpful to submit. For these reasons, a dialogue with such applicants might have been illustrative.

"Other" Category

According to the documents, none of the "other" categories were recommended for approval. This category was extremely broad, and included a variety of different types of providers. This determination seems to have excluded 13 hospice organizations forwarded by the State for the VAP exception. Hospice is already underutilized in New York. The absence of hopsice providers as full PPS participants will further marginalize hospice programs and impede access for Medicaid beneficiaries. We urge that the hospice determinations be reviewed, because Hospices are uniquely capable of providing that specific service in their communities, and the regions' hospice and palliative care needs would not be well served without their inclusion.

Reasons stated for CMS disapproval of the VAP exception include:

- *Full provider VAP application was not forwarded to CMS for consideration*.
- *Source for provider's Medicaid volume is unclear.*

***Full provider VAP application was not forwarded to CMS for consideration*.** We are confused about why portions of the applications were witheld, and whether or not it can be rectified.

Source for provider's Medicaid volume is unclear. We question why this was not clarified, and recommend an opportunity to provide additional information.

Lastly, among the CMS materials regarding these determinations are a list of "Administrative Considerations", which included the following bullets:

- *New York's State-level appeal process rejected providers that did not have creditable narratives in their application. If a provider expressed that the surrounding community will not be served if the provider is not approved for an exception and didn't give an accurate description/depiction of the community, the appeal was rejected. Other appeals simply did not have enough information in the narrative to make a determination.*
- *New York received additional materials from providers that were not provided to CMS.*
- *A provider approved for a safety net exception is not guaranteed more of the 95 percent project value than what would have been expected as part of the 5 percent project value. For example, if as a non-qualified provider, Dr. Jones would have received $.10 of the $5.00 shared between*

non-qualified providers, the PPS may still only give Dr. Jones $.10 for his participation in the overall $100 project.

New York's State-level appeal process rejected providers that did not have creditable narratives in their application… As noted above, this process has been somewhat confusing and it has been hard to discern exactly what information is needed. We suggest that compelling applicants be given the opportunity to provide additional information where CMS had questions.

New York received additional materials from providers that were not provided to CMS. We are unsure why this would be, but urge again that there be the opportunity to provide the additional information so that CMS can have more complete data to make an accurate and fair determination.

A provider approved for a safety net exception is not guaranteed more of the 95 percent project value than what would have been expected as part of the 5 percent project value… We understand that even a Safety Net designation does not guarantee a certain amount of the project value; there are many factors that go into that calculation. We maintain that a Safety Net designation provides a PPS participant with recognition by the PPS as a vital provider in the community as well as eligibility for critically needed DSRIP payments. Thus, we see the Safety Net designation as very valuable.

We have appreciated CMS's commitment to ensuring transparency and stakeholder involvement in this complex initiative, and respectfully request more information in this spirit. We are concerned that some decisions were made without necessarily having enough information or context to make a fair determination. Thank you for your consideration of our concerns. We look forward to your response. You can reach me at 518.867.8828.

Sincerely,

Diane Darbyshire

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