13 British American Blvd. | Suite 2 | Latham, New York 12110 | P 518.867.8383 | F 518.867.8384 | www.leadingageny.org

M E M O R A N D U M

TO: LeadingAge New York Members

FROM: Dan Heim, Executive Vice President

DATE: August 18, 2014

SUBJECT: **Vital Access Provider (VAP)/Safety Net Program**

ROUTE TO: Administrator, CFO, Program Director

Abstract: Information on the Vital Access Provider (VAP)/Safety Net program.

Introduction

The Vital Access Provider/Safety Net ("VAP") program authorizes temporary Medicaid rate adjustments to financially challenged providers to reconfigure their operations in a way that promotes financial stability, improves access to services, enhances quality of care and/or reduces Medicaid costs. The Department of Health (DOH) administers the VAP program.

This memorandum provides background on the VAP program, summarizes the application process and describes other operational aspects of the program as it currently exists. Any updates to the program will be communicated to LeadingAge New York members.

Program Authorization

The final budget for State Fiscal Year (SFY) 2014-15 included legislation authorizing the VAP program in statute for all previously eligible providers (i.e., nursing homes, hospitals, certified home health agencies (CHHAs) and diagnostic and treatment centers (DTCs)). Eligibility for the program was expanded to also include licensed home care services agencies (LHCSAs) and consumer directed personal assistance program fiscal intermediaries (CDPAP FIs). The relevant legislative authority for the program [Public Health Law Section 2826] is included as Attachment A to this memorandum.

A total of $194 million was appropriated for the program in SFY 2014-15. Total VAP program funding is not sub-allocated regionally or by provider type, with the following exceptions: (1) in the statute, general hospitals defined as critical access hospitals must be allocated no less than $7.5 million annually; and (2) $30 million is supposed to be earmarked each year for awards to nursing homes; an equal amount of funding from the financially disadvantaged nursing home program was subsumed into VAP beginning in SFY 2013-14.

Program Features and Criteria

Under the VAP program, successful applicants receive a temporary Medicaid rate adjustment for a specified period of time, as approved by DOH, of up to three years. The amount of the adjustment is based on the project operating costs approved through the application process and incurred subsequent to application approval. Capital costs are **not** eligible for VAP funding.

In order to qualify for VAP funding, an eligible provider (i.e., nursing home, hospital, CHHA, DTC, LHCSA or CDPAP FI) must demonstrate that it has financial need and also meets one or more of the following baseline requirements:

- is undergoing closure;
- is impacted by the closure of other health care provider(s) in its service delivery area;
- is undergoing a merger, acquisition, consolidation or restructuring; and/or
- is impacted by the merger, acquisition, consolidation or restructuring of other health care provider(s) in its service delivery area.

Providers seeking VAP funding must demonstrate in their application that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

- protect or enhance access to care;
- protect or enhance quality of care;
- improve the cost effectiveness of the delivery of health care services; and/or
- otherwise protect or enhance the health care delivery system, as determined by DOH.

A qualifying provider's VAP application will be evaluated and scored by staff from DOH's Office of Health Insurance Programs and Office of Primary Care and Health Systems Management based on the following four criteria:

1. **Facility Financial Viability** – The VAP plans must include specific actions for achieving long term financial stability, including benchmarks to measure performance in achieving the goals outlined in these plans.

2. **Community Service Needs** – All proposals will be evaluated in context of ensuring the provider is meeting community health needs. It is anticipated that many VAP plans will include a reconfiguration of services from inpatient/institutional care to providing greater access to, and higher quality primary care/community-based care services. Moreover, favorable consideration will be given to providers in both rural and urban communities that have actively collaborated with regional stakeholders in conducting community needs assessments and in developing action plans to meet those needs, or are pursuing integration with other providers. In addition, favorable consideration will also be extended to providers that need immediate or shorter term funding to achieve defined operational goals such as a merger, integration, closure, or service reconfiguration.

3. **Quality Care Improvements** – An initial analysis of Safety Net providers indicates that some providers perform in the lower quartile on certain quality performance measures. VAP plans will target improvements in these areas.

4. **Health Equity** – A greater weight will be given to those VAP plans that address disparities in health services, or providing care to vulnerable populations who are at greater risk for experiencing poorer health outcomes than the general population.

DOH has previously provided the following written responses to questions about the VAP program, which may provide further insights to potential applicants:

- projects that do not involve downsizing, consolidation, inter-facility collaboration or other restructuring activities will not be viewed as favorably as those that do;
- a program change, without accompanying reconfiguration of physical plant, facility downsizing, inter-provider collaboration or other features of restructuring may not be viewed as a strong application relative to other submissions;
- a bed reduction project is expected to include a service reconfiguration that reflects increased patient centered care through creative community provider configurations; and
- a project proposing a feasibility study alone will lack a demonstrable favorable impact on the delivery of patient care and will not likely be scored favorably.

Prospective closures, mergers and similar transactions require Certificate of Need (CON) review. More information on the CON process is posted on the Department's Web site at: http://www.health.ny.gov/facilities/cons/.

Application Process

Providers that are interested in applying for VAP funding may submit their applications at any time. However, DOH reserves the right in the future to accept applications through formal Requests for Applications or Requests for Proposals. In any event, the application must be submitted at least 60 days prior to the requested effective date of the temporary rate adjustment.

The first step in the process is for the applicant to complete and submit the VAP Mini Application to the Bureau of Vital Access Provider Reimbursement at: BVAPR@health.state.ny.us. The Mini Application is an Excel-based form that contains six sections: (1) *applicant information* – basic information on the applying entity, contact person and any co-applicants; (2) *project description* – problem to be addressed, populations served, service area, community need and financial need; (3) *VAP proposal* – summary of proposal, objectives, general timeline, sustainability and use of a strategic planner; (4) *budget* – 3-year operating, capital and project expenditure budgets; (5) *closure plan (if applicable)* – timeline and effect on employees; and (6) *metrics* – program, financial, operational and quality objectives and how they will be measured. Oftentimes, DOH will need to ask for more detailed information in these areas, and therefore encourages applicants to supply information that is sufficiently specific to allow for an evaluation of the proposal.

Once DOH receives a Mini Application, it is evaluated by examining measures such as operating margin, Medicaid payer mix, occupancy rate, cash on hand and debt. Other criteria include the entity's financial viability, community needs, quality improvement and health equity. As previously noted, DOH periodically contacts providers that submitted Mini Applications for additional information. Applications from all provider types are evaluated, with the top scoring applications selected to receive award letters and develop full proposals.

At the point an award is made, DOH assigns one of its approved strategic planners to the provider if the provider requested one or the Department believes the provider needs assistance with developing, implementing and monitoring the project plan. The strategic planner – which is paid for by DOH – reports to the Department, provides support to the provider and reviews the quarterly reports for progress towards the project goals. DOH also reserves the right to engage a strategic planner after an award has been made.

The full application is submitted as part of the Temporary Medicaid Rate Adjustment Agreement (TMRAA) package, and includes a detailed expenditure plan, project timeline, quarterly narrative report and a metrics report. The TMRAA is a legal agreement between the provider and DOH outlining expectations and responsibilities, with ongoing payments to the applicant dependent on achieving the agreed-upon metrics. Specifically, DOH can terminate the agreement for failure to: (1) comply with the TMRAA; (2) meet the agreed-upon objectives; (3) follow the project timeline; (4) use the funds properly; and (5) submit TMRAA reports on a quarterly basis. Once DOH and the provider have worked out the final terms of the TMRAA, the provider typically has 30 days to return the completed and signed agreement to the Department.

Rate Adjustments, Reporting and Transparency

Each temporary Medicaid rate adjustment granted under the VAP program is subject to further reviews following DOH approval. When a change is made to Medicaid rates for which federal matching funding is sought (which is the case for VAP), it must be approved by the Centers for Medicare & Medicaid Services (CMS) through an amendment to New York's Medicaid State Plan. This process can take 3-6 months or longer to complete. Once CMS approval is received, the NYS Division of the Budget (DOB) reviews the rate adjustment.

Upon DOB approval, DOH will process the payments, which are made on a quarterly basis based on project expenses incurred in each quarter in connection with the approved budget. Rate adjustments continue to be paid each quarter for the duration of the award period, provided the agreement is not terminated earlier for cause as previously discussed.

VAP awardees are required to submit quarterly reports to DOH no later than 30 days after the close of the given quarter. In addition to information on project expenditures, the reports also cover progress on project-specific benchmarks and goals, including the metrics for measuring progress. As previously noted, a provider's failure to achieve satisfactory progress in accomplishing the benchmarks can result in DOH ending the provider's temporary rate adjustment prior to the end of the specified timeframe.

Information on approved projects, temporary rate adjustments and ongoing reporting is subject to posting on DOH's Medicaid Redesign Team web page.

Conclusion

All information contained in this memorandum is accurate as of the date of issuance, and any changes will be communicated to members. If you have any questions on the VAP program, please contact Dan Heim at dheim@leadingageny.org or 518-867-8383, ext. 128; or Patrick Cucinelli at pcucinelli@leadingageny.org or ext. 145.

Attachment

Public Health Law, Section 2826

§ 2826. Temporary adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system, as determined by the commissioner.

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe.

(ii) The commissioner may require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social Security act shall be allocated no less than five million dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than December first, two thousand fourteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals.