Vital Access Provider (VAP) Program

January 2015

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- Approval Process and Awards
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- Process for TMRAA (Rate Adjustments)
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  (TMRAA) Documents
- Website
- Contact

VAP Program Overview

- The 2014-2015 enacted budget allocated $106 million for VAP/Safety Net Programs

	Provider Type	Total VAP/Safety Net
VAP Awards Announced September 2014		**$106.0M**
CINERGY Collaborative	Nursing Homes	$55M
Severely Financially Distressed Providers	All	$20M
Mount Sinai Hospital Groups	Hospitals	$15M
Neurodegenerative Disease Centers for Excellence	Nursing Homes	$5M
Critical Access Hospitals (CAHs)	Hospitals	$5M
South Nassau Hospital	Hospital	$3M
Maimonides Medical Center	Hospital	$2.5M

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VAP Program Overview
Purpose & Expected Outcomes

- Purpose
  - To reconfigure the operations of financially fragile vital access providers

- Expected Outcomes
  - Financially stabilize facilities
  - Improve access to services
  - Improve quality of care
  - Reduce Medicaid program costs

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Approval Process Summary

- Process Used
  - Applications scored and evaluated by OHIP staff & Strategic Planners
  - Selection made based on:
    - Facility financial condition
    - Community service needs
    - Quality care improvements
    - Health equity
- Operating costs approved
- Capital <u>not eligible</u> for VAP funding

Strategic Planner

- DOH would require some providers to involve a Strategic Planner to help develop, implement and monitor plans

- Strategic Planner role:

  - Review and work with provider to complete the TMRAA

  - Report to DOH and provide support to the provider over the VAP program duration

  - Review and analyze quarterly reports for progress towards goals

- Costs for Strategic Planners funded by DOH

CMS

Key Issues Raised by CMS

✓ Hospitals – customary charge cap limitations

- Provisions from the SSA enacted in 1970s

- Limitation on Medicaid payments to no more than expected payment from a charge paying patient

✓ FQHCs – approved payment methodology

- Can only be paid the PPS rate unless alternative payment methodology is made available to all FQHCs

✓ DOH is continuing to work with CMS staff to resolve these issues and look at several options

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Process for TMRAA

- Temporary Medicaid Rate Adjustment Agreement (TMRAA)

- Full application evaluated/processed

- Strategic Planner (if required) assigned

- CMS approval required for all adjustments

- DOB approval

- Payment processed

  - Year One

  - Quarterly Payments

Reporting Requirements (Overview)

- Submission of the TMRAA & supporting Attachments A through E

- Submission of Quarterly Reports no later than 30 days after the close of the given quarter

- Include reporting on specific benchmarks and demonstration that they have been achieved

- Transparency of all rate adjustments and reporting

  - Posted to MRT Website

Reporting Requirements (Quarterly Reporting)

- Quarterly Reports – Calendar year basis

- Filed electronically

- No later than 30 days after the close of the given quarter

- Sent to the Bureau of Vital Access Provider Reimbursement

- Email Address: BVAPR@health.ny.gov

- Certification of report (as PDF document) must be included
  - Signed by the facility's Authorized Signatory

Reporting Requirements (VAP Documents)

- Vital Access Provider Program Temporary Medicaid Rate Adjustment Agreement (TMRAA) Document

- Attachment A

    - Cover Sheet Summary – DOH completes

    - Certification – Provider completes

- Attachment B – Expenditure Plan

- Attachment C – Project Timeline

- Attachment D – Quarterly Narrative Report

- Attachment E – Metrics Report

Reporting Requirements (VAP Documents)

- How the documents relate:
  - Attachment B – Expenditure Plan – VAP Program only
  - Attachment C – Project Timeline
  - Attachment D – Quarterly Narrative Report
  - Attachment E – Metrics Report
- Expenses on Attachment B should be reported in the appropriate activity on Attachment C, supported by the narrative in Attachment D and measured by the metrics in Attachment E

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TMRAA Documents

- TMRAA Legal Document
  - Agreement between the facility and the Department of Health outlining expectations and responsibilities
- Ongoing payments to facilities will be dependent on achieving the agreed upon metrics
- The Department can terminate agreement or assign a Strategic Planner
  - Failure to comply with TMRAA
  - Failure to meet objectives
  - Failure to follow timeline
  - Misuse of funds
  - Failure to submit TMRAA reports quarterly
- Payment of awards dependent on CMS approval and appropriate authorization

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Attachment A Cover Sheet

NYS Department of Health			
Vital Access Provider (VAP) / Safety Net Award Summary			
Date Submitted:			
Legal Entity Name:			
Mailing Address:			
Authorizing Officer			
Contact Name:			
Contact Title:			
Phone:			
Email:			
VAP/Safety Net Project Name:			
Total Award Amount:			
Approved Amount per SFY*:	2013-'14		
	2014-'15		* State Fiscal Year (SFY)
	2015-'16		
Amount Budgeted per CY**:	2014		** Calendar Year (CY)
	2015		
	2016		
Payment Contingencies:	Provider must submit timely quarterly progress reports to the NYS Department of Health documenting the status of the use of VAP/Safety Net Award funding. See Attachment C, D, and E for details.		

DOH Completes :
- Contact Information
- Award amounts
  - SFY – used for DOH budgeting
  - CY – used to complete budget, timeline, etc.

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Attachment A Certification

Instructions:
1. Enter MMIS # (Payments will be made to this MMIS #)
2. Type in Signatory Name and Title
3. Print
4. Sign and date
5. Scan to PDF and email

Facility Name and Opcert number are pre-populated

AUTHORIZATION FOR SUBMISSION OF THE
VITAL ACCESS PROVIDER (VAP)/SAFETY NET PROGRAM
PROJECT EXPENDITURE PLAN (WORK PLAN BUDGET)
PROJECT TIMELINE (WORK PLAN TIMELINE)
VAP/SAFETY NET QUARTERLY NARRATIVE REPORT
METRICS QUARTERLY REPORT

Facility: _____

OpCert #: _____
MMIS #: _____

CERTIFICATION STATEMENT

I hereby certify that I have read and examined the costs, full-time equivalents (FTEs) and other statistical data contained in the Year 1 through Year 3 Expenditure Plans (as applicable) and the Note Pad Schedule included as Attachment B (tabs "B - Year 1", "B - Year 2", "B - Year 3", and "B - Note Pad") provided in support of the facility's VAP/Safety Net Project, and that to the best of my knowledge and belief, the information fairly and accurately represents the budgeted costs, FTEs and statistics necessary to implement the facility's VAP/Safety Net Project.

I hereby certify that I have read and examined the costs and planned / actual completion date data contained in the Project Timeline included as Attachment C (tab "C - Timeline") provided in support of the facility's VAP/Safety Net Project, and that to the best of my knowledge and belief, the information fairly and accurately represents the costs and completion date statistics related to implementation of the facility's VAP/Safety Net Project.

I hereby certify that I have read and examined the metric data contained in Attachment E (tabs "E - Instructions", "E - Financial", "E - Operating", and "E - Quality") provided in support of the facility's VAP/Safety Net Project, and that to the best of my knowledge and belief, the information fairly and accurately represents the Financial, Operational, and Quality Metrics related to the implementation of the facility's VAP/Safety Net Project.

I hereby affirm that the reports do NOT include costs or expenditures which are included in any HEAL Award Grants.

I hereby authorize the submission of Attachment B (tabs "B - Year 1", "B - Year 2", "B - Year 3", and "B - Note Pad"), Attachment C (tab "C - Timeline"), Attachment D (tab "D - Narrative"), and Attachment E (tabs "E - Instructions", "E - Financial", "E - Operating", and "E - Quality") to the New York State Department of Health, Office of Health Insurance Programs, as documentation of the Project's budgeted expenditures, staffing needs, planned / actual completion dates, narrative report, and metrics goals and accomplishments.

Signature Date   Authorized Signature

Print Signatory Name: _____

Print Signatory Title: _____

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Attachment B Expenditure Plan

• Costs Allowable
• Incremental costs for staffing and OTPS directly related to VAP
• Costs related to outside agencies incurred related to the VAP program, such as data collection for metric development, etc.
• Other non-capital costs needed to support the VAP program

• Costs Non-Allowable
• Related capital, including rent, depreciation, capital interest, etc.
• Past liabilities unpaid such as vendors, pensions, etc.
• Costs before the SFY awarded

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Attachment B Expenditure Plan

Page 2
Operating Expenses – Direct

Fill In

Fill In

			YEAR 1 BUDGETED EXPENDITURES				YEAR 1 ACTUAL EXPENDITURES					

Date Submitted:　　　　　　**Begin Date of First Quarter**

Operating Expenses-Direct

Line No	Description	FTE's	Salaries & Wages	Employee Benefits	OTPS Costs	Total Funding Requested	Qtr 1 Actual Expense	Qtr 2 Actual Expense	Qtr 3 Actual Expense	Qtr 4 Actual Expense	Total YEAR 1 Actual Expense	Comments
A.	**Inpatient Services:**											
1	Physicians					$0					$0	
2	Nursing:											
3	Administrator					$0					$0	
4	Nurse Practitioner					$0						
5	RN					$0						
6	LPN					$0						
7	Administration/Clerical					$0						
8	Technicians					$0						
9	Aides					$0						
10	Other *(specify in Note Pad section)*:					$0						
11	**Total Inpatient**	0.0	$0	$0	$0	$0						
B.	**Outpatient Services:**											
12	Physicians					$0						
13	Nursing:											
14	Administrator					$0						
15	Nurse Practitioner					$0						
16	RN					$0						
17	LPN					$0						
18	Administration/Clerical					$0						
19	Technicians					$0						
20	Aides					$0						
21	Other *(specify in Note Pad section)*:					$0						
22	**Total Outpatient**	0.0	$0	$0	$0	$0	$0	$0	$0	$0	$0	

- Fill in **detail** of expenses on separate tabs for each year of program.
- See "Definitions" tab
- Total is automatically calculated on "B – Budget Total" Tab

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Attachment B Expenditure Plan

Page 4: Operating Expenses - Indirect

Operating Expenses-Direct

Line No	Description	FTE's	YEAR 1 BUDGETED EXPENDITURES				YEAR 1 ACTUAL EXPENDITURES					Comments
			Salaries & Wages	Employee Benefits	OTPS Costs	Total Funding Requested	Qtr 1 Actual Expense	Qtr 2 Actual Expense	Qtr 3 Actual Expense	Qtr 4 Actual Expense	Total YEAR 1 Actual Expense	
C.	**Ancillary Services:**											
23	Laboratory Services					$0					$0	
24	Electrocardiology					$0					$0	
25	Electroencephology					$0					$0	
26	Radiology					$0					$0	
27	Inhalation Therapy					$0					$0	
28	Podiatry					$0					$0	
29	Dental					$0					$0	
30	Psychiatric					$0					$0	
31	Therapy-Physical					$0					$0	
32	Therapy-Occupational					$0					$0	
33	Therapy-Speech Language Pathology					$0					$0	
34	Pharmaceutical Services					$0					$0	
35	Central Service Supply					$0					$0	
36	Medical Staff Services					$0					$0	
37	Other *(specify in Note Pad section)*:					$0					$0	
38	**Total Ancillary**	0.0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
39	**Total Direct (Lines 11 + 22 + 38)**	0.0	$0	$0	$0	$0	$0	$0	$0	$0	$0	

Only enter data in cells that are shaded white; other cells are locked.
Total Budget automatically calculated on "B – Budget Total" tab.

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Attachment B Expenditure Plan

Page 4: Operating Expenses - Indirect

Operating Expenses-Indirect												
			YEAR 1 BUDGETED EXPENDITURES				**YEAR 1 ACTUAL EXPENDITURES**					
Line No	Description	FTE's	Salaries & Wages	Employee Benefits	OTPS Costs	Total Funding Requested	Qtr 1 Actual Expense	Qtr 2 Actual Expense	Qtr 3 Actual Expense	Qtr 4 Actual Expense	Total YEAR 1 Actual Expense	Comments
D.	**Administrative and General Services:**											
40	Fiscal Services					$0					$0	
41	Administrative Services					$0					$0	
42	Plant Operation and Maintenance					$0					$0	
43	Utilities					$0					$0	
44	Property Taxes					$0					$0	
45	Property Insurance					$0					$0	
46	Grounds					$0					$0	
47	Security					$0					$0	
48	Laundry and Linen					$0					$0	
49	Housekeeping					$0					$0	
50	Patient Food Service					$0					$0	
51	Cafeteria					$0					$0	
52	Nursing Administration					$0					$0	
53	Activities Program					$0					$0	
54	Nonphysician Education					$0					$0	
55	Medical Education					$0					$0	
56	Medical Director's Office					$0					$0	
57	Housing					$0					$0	
58	Medical Records					$0					$0	
59	Utilization Review					$0					$0	
60	Social Service					$0					$0	
61	Transportation					$0					$0	
62	Other *(specify in Note Pad section)*:					$0					$0	
63	**Total Indirect (Sum of Lines 40 - 62)**	0.0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
64	**Grand Total (Lines 39 + 63)**	0.0	$0	$0	$0	$0	$0	$0	$0	$0	$0	
65	**Provider In-kind Contributions**						Provider In-kind Contributions					
66	**Incremental Revenue To Offset (projected)**						Incremental Revenue To Offset (projected)					
67	**Total VAP/Safety Net Funding Requested**					$0	Total VAP/Safety Net Funding				$0	

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Attachment B Expenditure Plan

Notepad

Note Pad Section

Date Submitted:
First Quarter:

General Notes & Other Comments:

> If needed, provide additional miscellaneous details or comments here.

Additional Details for Sustainability:

> **Required:** Provide a short narrative of how your project will continue after VAP funding ends

Additional Details for Capital Financing:

> **Required** if your plan is related to capital costs. Provide a short narrative of how your project will obtain capital financing.

Additional Details for Year 1 Budget:

> If you have expenses in the "Other" categories, or need to make other clarifications, provide additional details related to your Year 1 Budget. There are also sections for Years 2 & 3.

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Attachment C Project Timeline

- Used to track progress towards goals

- Report steps to achieve objectives

Attachment C Instructions

- Important to follow directions.
- Parts of form will be locked once initial steps are taken.
- Data will be lost if not done correctly

Attachment C Project Timeline

Attachment C Project Timeline

2nd – Click the Make Forms button A form will be created for each activity

Vital Access Provider (VAP) Funding
Medicaid Rate Adjustment
Project Timeline Year 1

Make Forms			Set Print Area

See Instructions   **See Instructions**

1st -fill in the number of action / activity items

Example- 2 (additional staff & advertise Increased Hours

Action/Activity Item				Submission Date	
1	of				
Overall Goal / Objective				Begin Date of First Full Quarter	
Outcome					

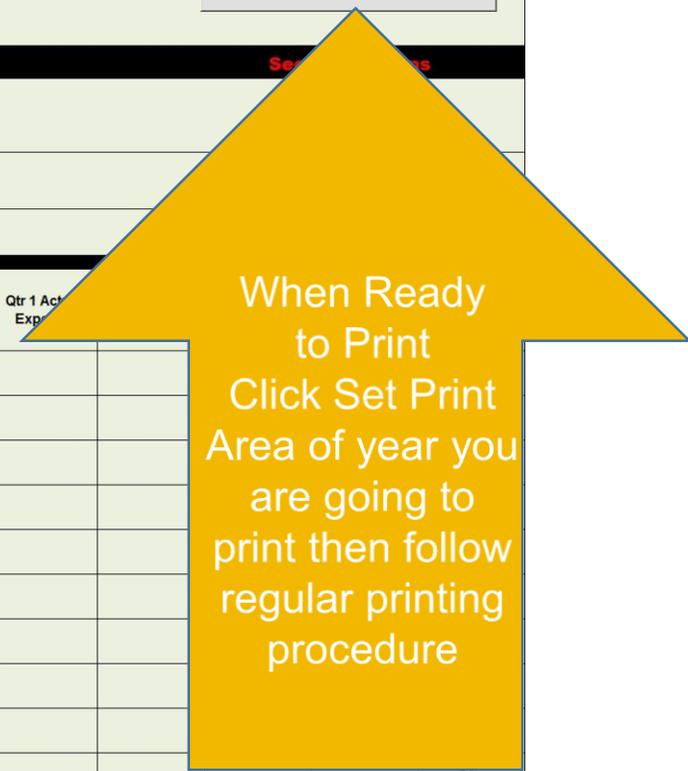| Steps for Action/Activity	Planned Completion Date	Qtr 1 Projected Expense	Qtr 2 Projected Expense	Qtr 3 Projected Expense	Qtr 4 Projected Expense	Total Year 1 Projected Expense	Actual Completion Date	Qtr 1 Actual Expense	Qtr 2 Actual Expense	Qtr 3 Actual Expense	Qtr 4 Actual Expense	Total Year 1 Actual Expense
Step 1						$0						$0
Step 2						$0						$0
Step 3						$0						$0
Step 4						$0						$0
Step 5						$0						$0
Step 6						$0						$0
Step 7						$0						$0
Step 8						$0						$0
Step 9						$0						$0
Step 10						$0						$0
Total for Activity #1		$0	$0	$0	$0	$0		$0	$0	$0	$0	$0
Year 1 Grand Total of Projected and Actual Expenses	Total Year 1 Qtr 1 VAP Projected Expense	Total Year 1 Qtr 2 VAP Projected Expense	Total Year 1 Qtr 3 VAP Projected Expense	Total Year 1 Qtr 4 VAP Projected Expense	Total Year 1 VAP Projected Expense		Total Year 1 Qtr 1 VAP Actual Expense	Total Year 1 Qtr 2 VAP Actual Expense	Total Year 1 Qtr 3 VAP Actual Expense	Total Year 1 Qtr 4 VAP Actual Expense	Total Year 1 VAP Actual Expense	

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Attachment C Project Timeline

Vital Access Provider (VAP) Funding
Medicaid Rate Adjustment
Project Timeline Year 1

Attachment C Project Timeline

When Ready to Print Click Set Print Area of year you are going to print then follow regular printing procedure

Attachment D Quarterly Narrative Report

Instructions

OUTLINE FOR VAP/SAFETY NET QUARTERLY PROGRESS REPORT
~ RESTRUCTURING PROGRAM WORK PLAN ~

This Attachment is to provide to the Department a narrative of the facility's Work Plan in the table below.

1. SUMMARY STATEMENT

This section should include a narrative describing the progress made on the Project being funded by the Agreement. This overview should be concise and to the point. Further details can be included in the section which addresses specific deliverables.

2. PROGRAM GOALS

This section should include details on the current status toward reaching the goals and objectives expected to be accomplished under the terms of the Agreement. Project goals should be quantified as much as possible. The Report on the Restructuring Program Work Plan (Work Plan) must include:

a. specific actions taken during the quarter for achieving long term financial stability, including the current status of Department approved benchmarks used to measure performance in achieving the goals;

b. address how the project is ensuring that the healthcare needs of the community are being met, including any actionable plan developed in collaboration with community and/or regional stakeholders;

c. a detailed analysis of performance measurements, as agreed to by the Facility and approved by the Department per the Work Plan, targeting improvement in the quality of care provided;

d. address disparities in health services and how the project will help to provide better care to vulnerable populations who are at greater risk for experiencing poorer health outcomes than the general population.

- Narrative of facility's Work Plan
- Description of progress made on Project
- Form prior to start of Project can be blank

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Attachment D Quarterly Narrative Report

Facility:	
VAP/Safety Net Quarterly Narrative Report - Attachment D	
Submission Date:	
Summary Statement:	
Program Goals:	

Narrative describing the progress made on the Project being funded by the Agreement
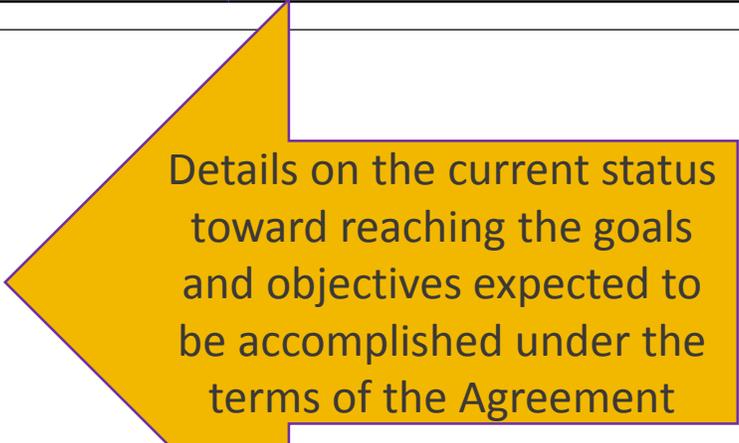
Details on the current status toward reaching the goals and objectives expected to be accomplished under the terms of the Agreement

Attachment E Metrics Report

Form to track progress towards objectives and goals using measurable metrics:

Category of Metrics	Examples
Financial	•Improve operating margin •Decrease ED costs •Reduce operating costs
Operational	•Increase primary care visits •Reduce inpatient admissions •Improve patient throughput in ED and ambulatory care •Close beds
Quality	•Reduce percentage of Medicaid PPR's and PPA's •Reduce readmissions •Increase patient satisfaction

Attachment E Metrics Report Instructions

Financial Metrics

#2 Create Forms

Read "E - Instructions" tab

#'s 7, 8, and 9 - MUST BE NUMERICAL VALUE ONLY!!

Objective #1 of #3

Start Date

#	Metric	Description	Unit of Measure	Baseline	Year 1						
					Quarter 1		Quarter 2		Quarter 3		Quarter 4
					Projected	Result	Projected	Result	Projected	Result	Projected	Result
1											
2	#4	#5	#6	#7	#8	#9					
3											
4											
5											

Instructions

Note: There are 3 separate "Metric" tabs that must be filled out, each with a different category of metrics (Financial, Operating, and Quality) These instructions are the same for each tab.   See "E - Financial", "E - Operating", and "E - Quality" tabs

Note: Use the objectives found in the Timeline to determine how many Objectives you have for each category of metrics.   See "C - Instructions" - #4

1 Enter the number of objectives in cell C5 (highlighted Yellow). Click outside of the cell.

Note: When the "Create Forms" button is selected, the number you input in cell C5 will generate the appro... You must hit Enter or click outside of cell C5, as the macro will only work if the data is properly "entered" i... appropriate number of Objectives is determined prior to selecting the "Create Forms" button, as running t... the given year will prohibit step this from being done again for that category of metrics.

2 Click the "Create Forms" button.

3 **Objectives:** Use the objectives found in the tab "C - Timeline" to fill in each objective

4 **Metrics:** List all of the metrics used to measure the success of each objective.

5 **Description of Metric:** Provide a short explanation/description of the measurement

6 **Unit of Measure:** Indicate the unit of measure used for your 'Projected' and 'Result' numbers. [For Example: increase in patients, etc.].

*7 **Baselines:** Provide a baseline measurement (what the metric measures before the program starts) If the metric is measuring part of a new initiative (with no baseline), enter "N/A"

*8 **Projected Values:** For **every** year (1-3), fill in the **each of** the quarterly projections for **all** of the metrics **(NUMERICAL VALUE ONLY).**

*9 **Actual Results:** Fill in the actual results for past quarters **(NUMERICAL VALUE ONLY).**

*Fill in ONLY numerical Baselines, Projected numbers and Results.

- Important to follow directions
- Parts of form will be locked once initial steps are taken
- Data will be lost if not done correctly

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Attachment E Metrics Report

Financial Metrics

Create Forms

2nd Click Create Forms – a form will be created for each objective

Separate Excel Tab for Financial , Operating, & Quality Metrics

Fill in rest of Attachment following directions

Objective						Start Date							
of									Year 1				
							Quarter 1		Quarter 2		Quarter 3		Quarter 4
#	Metric	Description	Unit of Measure	Baseline			Projected	Result	Projected	Result	Projected	Result	Projected	Result
1														
2														
3														
4														
5														

1st Fill in total number of objectives

Only enter quantitative data for the baseline, projections, and results.

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VAP Website

- Link: http://www.health.ny.gov/facilities/vap/

- Contains:

  - Home Page (Purpose, Program Overview and Expected Outcomes)

  - Background

  - Funding Summary (Press Releases)

  - Questions and Answers

  - ListServ (Subscribe/Unsubscribe)

VAP ListServ

- Please sign up for the VAP ListServ in regards to:
  - New information posted on the VAP Website
  - Additional information regarding any major VAP Program updates
- Subscribe to the VAP Program Mailing List:
  - To subscribe, send an email to listserv@listserv.health.state.ny.us with "subscribe vap-l" in the subject line (all lowercase ending with "-l").
  - Include your first name, last name and the words "subscribe vap-l" in the body of the e-mail.
    - *Do not* include the quotation marks.
  - Your email address will then be automatically added to the mailing list.

Contact

BVAPR e-mail:
BVAPR@health.ny.gov

Include "VAP Program" in the
subject line for any inquiries