Q&A DSRIP Design Grant App. Webinar (5/6/14)

Contents

General

Q: Has the application changed since originally posted?
A: Yes, there have been some updates; two updated versions (for excel 2007 and 2010/13) were posted on the morning of 5/6/14 as well as an updated Section 10 posted 5/13/14. The instructions have also been updated to reflect these changes. Please use the most recent application materials available on the DSRIP Project Design Grant website (hyperlink).

Q: What time are the LOIs and the Project Design Grant applications due to be submitted?
A: The LOI and the application are due by 5:00 pm on May 15th and June 26th respectively.

Q: Would you entertain multiple DSRIP Applications for systems providing different menu of projects for the region? In other words more than one PPS for same region?
A: No, the application should be one application for a specific PPS. Providers can be in multiple PPSs. However, the state reserves the right to possibly combine multiple PPSs over the same geographic region. This will depend on the specific applications and/or projects. While selecting partner organizations for your emerging PPS, keep in mind that the theme of DSRIP is **collaboration.**

Q: How do smaller agencies find a large Coalition to join?
A: The letters of intent have been published on the DSRIP website by region. This will allow unaffiliated organizations to identify existing emerging Performing Provider Systems within their service area.

Q: What happens if a participant is included in the planning grant and then decides not to participate? What if new providers want to join a PPS after December 16th or later in the five year term?
A: The design grant award is made to the PPS as a whole, so it is not an issue if a partner organization decides to not participate. No more than once a year, Performing Provider Systems may submit proposed modifications to an approved DSRIP Project Plan for state and CMS review. This may include the removal or addition of partner organizations to the PPS. Removal of any Performing Provider System member organization requires a proposed modification and removal of any such lower performing member must follow the required governance procedures including progressive sanction requirements.

Funding

Q: If there are four safety net facilities developing a collaborative for DSRIP, can two of the entities apply for a grant and the other two apply for another? Or is it one grant award for one DSRIP collaborative for planning purposes?
A: The whole PPS is applying for the design grant. The lead is just the contract and overall lead of the PPS. Only one grant application per PPS.

Q: Can PPS participating hospitals (who are not the lead hospital) still apply for planning grant funds? If not, how do participating non-lead organizations gain access to the planning dollars to cover significant expenditures that accompany the planning process?
A: The emerging PPS, through the lead applicant, is applying for the grant. The emerging PPS is responsible for establishing a payment mechanism to allocate and distribute the funds to the partner organizations.

Q: What is the total planning dollars available state wide to develop project plans?
A: This amount is left to the State's discretion and will be determined based upon the submitted design grant applications.

Q: Will DSRIP incentive payment be determined through another application process?
A: That will be based upon the full DSRIP application.

Q: Please clarify how much of the funds will be passed on to the CHHAs and to the SNFs.
A: It is the responsibility of the PPS to allocate and distribute both the design grant and project plan award funds.

Letter of Intent

Q: If we are **not** going to be the lead on a DSRIP application, do we still have to send in a letter of intent by May 15th?
A: No, you should not submit a letter of intent. Only the lead applicant will submit a letter of intent; this letter will include a list of all proposed partner organizations.

Q: Can we file for an extension on the letter of intent?
A: No extension will be provided.

Q: How will the Letters of Intent be used to inform application development? Will we receive feedback on these letters?
A: DOH will be reviewing the LOI and will be reaching out to the lead applicants to further discuss the contents of these LOIs to further assist the emerging PPS. Lists based upon submitted LOIs have been posted on the DSRIP webpage.

Q: As the lead organization, our letter of intent must have providers we are planning to include in our PPS. Can we add partners in the Project Plan Application?
A: The partner organization list in the Letter of Intent (LOI) is preliminary and not binding. Providers may be added or deleted in the final DSRIP Project Plan application.

Eligibility

Q: If between now and June 26th, we determine that there is an organization that we want to partner with but didn't include them on our May 15th Letter of Intent, is it too late to add those organizations on our June 26th design grant submission?
A: It is not too late; please include these "extra" providers within your Design Grant Application. Also, it should be noted that you may further adjust the list of participating providers when you

submit your DSRIP Project Plan Application (due December 17th 2014).

Q: Can an organization participate in more than one PPS? If an organization is on more than one application, what is the likelihood that the State will limit or assign who that group can work with?
A: Yes. An organization may participate in more than one PPS, but the community population served must not be the same.

Q: If the lead provider is a safety net provider as an Article 28, and the other members of the PPS are not Art. 28, but do serve 35% or more Medicaid population, does this qualify? How do we document that the other providers serve more than 35% Medicaid? Must we have providers designated as vital access provider?
A: The other providers would need to demonstrate that they meet the definition through auditable documentation. Such organization might include a physician group practice, individual physicians, etc.

Q: Can hospitals who have been awarded IAAF funds be the lead applicant in the planning grant?
A: Yes.

Q: Can MLTCPs (Managed Long Term Care Plan) participate in DSRIP?
A: All managed care plans are encouraged to participate in DSRIP because they often have the population-based data and health management tools to help the emerging PPS develop and implement their DSRIP Project Plan. It should be noted that since they are not qualifying providers, MLTCPs and other non-qualifying providers are limited to 5% of the award as described in the Special Terms and Conditions.

Q: Are assisted living residences (AH, EH, ALR, EALR, SNALR, ALP) defined as supportive housing (there was no definition of supportive housing in the glossary)? If not, where do they fit in a PPS?
A: Assisted living residents are not defined as supportive housing, but are allowable safety net providers.

Q: If a hospital is a sole community hospital, is their hospital-based SNF, LTHHC automatically considered safety net, too?
A: Yes.

Q: Can for-profit entities be collaborative partners?
A: Yes.

Q: Would local health departments be considered safety net providers? If not, are they limited to receiving 5% of any given project award?
A: Yes, local health departments can be considered safety net providers if they run a clinic that files an AHCF or similar report with another State agency containing visit information. LHDs would need to demonstrate they were eligible as a safety net provider. If not, they would be

limited to 5%.

Q: Integrated organizations with large faculty practice and community practice plans operating outside of the hospital but under the larger corporate umbrella. Do they qualify with the hospital or are they considered non-qualifying providers with the 5% limitation? Many centers service the Medicaid and indigent populations in their private practices rather than hospital clinics.
A: Large facility practice plans who serve 35% of Medicaid dual and uninsured population are eligible to participate. If the data is already reported as part of the hospitals data then they are qualified if the hospitals meets the safety net definition.

Q: Many skilled nursing facilities have not been invited to participate by hospitals in the NYC area. Since it is unlikely that an SNF would be selected as a lead in the region, how will the potential programs for the SNF be considered?
A: Hospitals or any eligible safety net provider can be a lead. However the PPS should look to include all types of providers since the purpose is to serve the overall continuum of health care needs of the community served overall by the PPS. Applicants will be scored on comprehensiveness of providers and projects in relation to the community's needs. Hence, provider diversity is important if Providers are to not only serve the holistic needs of its patients, but also hope to receive a high application valuation.

Q: What role do community based organizations play in DSRIP?
A: Community based organizations will play an integral part in the DSRIP Program. Community based organizations add value to emerging PPSs as they are capable of community outreach work; they can be engaged by emerging PPSs in the planning process, as a stakeholder, as partner organizations, or as a consultant. Community based organizations are limited to the non-qualifying 5% of the award unless they can demonstrate that they are qualified. Applicants will be scored on comprehensiveness of providers and projects in relation to the community's needs. Hence, provider diversity is important if Providers are to not only serve the holistic needs of its patients, but also hope to receive a high application valuation.

Q: Can an individual physician be a safety-net provider? How would you measure Medicaid percentages?
A: Yes. There will be a separate attestation process for physicians and physician groups. More information to come…

Safety Net Definition

Q: Is Self-Pay or Charity Care included?
A: Yes, since they are included as part of uninsured.

Q: Could you explain more how charity care for the insured will count towards safety net eligibility?
A: Charity care for the insured will not be counted since they are insured. Only free uninsured were included.

Q: Will managed Medicaid patients be allowed in the calculation?

A: Yes, Medicaid managed care data was included in the development of the safety net list.
Q: How will Medicaid and dual eligible patients of private practitioners be attributed?
A: They will be the same as the other providers however this data will need to be provided by the private practitioners and exceed 35% to be full PPS participants; the data provided must be auditable. There will be a separate application process for physicians and physician groups.

Q: How is number of patients defined? Does it include inpatient, outpatient, those seen through academic medical centers, etc.?
A: Discharges or visits, as submitted, by provider type are used to determine if the provider is eligible as a safety net provider.

Q: If NYS Hospitals serve out of state Medicaid recipients from New Jersey will they be counted?
A: The data used to determine the safety net criteria for hospitals for inpatient or outpatient criteria included all Medicaid fee for service utilization as reported on their 2012 ICR. Providers will not include out of state covered lives in their performance measures over the 5 year program duration.

Q: Please explain how the data was analyzed for CHHAs as it relates to the safety net definition. There is a surprisingly low number of CHHAs that meet that definition, which doesn't seem to make sense.
A: There was an error in the original calculations posted for CHHAs. This error has been fixed and an updated list of eligible CHHAs can be found here. Data came from their annual reports adjusted for dual eligible information as developed using analytical data file from CMS.

Q: Does the 5% apply to each non-qualifying provider or is it 5% total (for example, if you have two non-qualifying, does that mean a total of up to 10%)?
A: The 5% applies to non-qualifying providers as a whole. For example: If there are 10 non-qualifying providers in an emerging Performing Provider System, then they will all split the 5% between the 10 organizations.

Q: How will the state determine that a provider in the PPS is getting less than 5% of the money given the fact that the DSRIP grant money is paid out on a PMPM basis to the entire PPS? Or is the PMPM paid out to each member of the PPS based on how Medicaid beneficiaries were attributed (this, however, will lead to a lot of overlap since multiple providers will serve the same beneficiary)
A: As part of the DSRIP Project Plan application due in December, emerging PPS will be required to identify a payment structure that will be used to disburse the funds to the partner organizations.

VAP Exception

Q: For those organizations that believe they meet the non-hospital based "safety net provider" definition, for which the Department has not developed an eligible provider list, how can this eligibility be verified with the state?
A: The State has posted various safety net lists for all providers who report data that could be used to develop the eligibility list. However, there is an appeal process that an organization can use to provide the data. This data must be auditable by the State and/or CMS. In addition, there is a VAP exception process that could be used to allow an organization to fully participate; however, the VAP Exception only applies to certain providers who meet the strict criteria. This VAP Exception form is being developed and will be separate from the safety net appeal process. An MRT list-serv notice will notify providers when the form has been posted.

Q: What is the process for requesting an exception as a Vital Access Provider?
A: Further information will be posted in the near future on the process that will be used for the VAP Exception process.

Q: To qualify as a Vital Access Provider, does an organization have to fit all 3 of the allowed reasons or can an organization fit 1 or 2 of the allowed reasons?
A: This will be described in the documentation to be posted in the near future.

Q: Can we qualify as a vital access provider exception for a specific population such as Pediatrics within a county?
A: Further information will be forthcoming on the VAP exception process.

Technical Questions

Q: When do you anticipate having the problems with the Excel application file resolved (or alternatives provided)?
A: All known problems have been resolved. Keep in mind that if you are using a version of Excel prior to 2007, you will have issues with the drop down menus and will have to follow the instructions in Appendix D of the application instructions in order to fill out the those sections. For this reason, we **highly recommend** that you upgrade your software to Excel 2007, 2010 or 2013 in order for the drop down menus to work. Version 1 works with Excel 2010 - 2013 and Version 2 works with Excel 2007.

Q: Should it matter whether you are completing the application on a Mac or a PC?
A: A PC should be used and is highly recommended as the application is written using that version of software. (However if a Mac is used, Version 1 of the application (2010-13) works with the 2011 Mac only and Version 2 of the application (Excel 2007) works with the 2008 Mac only).

Q: Do we download the application to our computers so we can work on it and save the work or is it an online submission?
A: For this application, you can simply download the file from the DSRIP website and save it on your PC. Once downloaded, you can work on completing the application and submit the excel file as an email attachment.

Q: Will this webinar be recorded and available for review later?
A: The webinar slides and recording for the DSRIP Project Design Grant Application were posted on 05/9/14. Please keep in mind when reviewing the PowerPoint and recording, that Section 10 (Project Advisory Committee Form) has been updated and made as a separate document.

Q: We are having problems unzipping and opening the application document. Can you provide directions on how to do this? When we click on the document it doesn't open like you just demonstrated. It says it is zipped and when you open zip file there are tons of files.
A: The files are not zipped. There should be no issues opening the documents from the website and it should be as easy as shown in the webinar. Please contact your IT department if you are having these issues. The web browser you are using probably needs to be updated OR you should be using another web browser (Google Chrome, Firefox).

Q: Does the number of character restrictions include spaces or not?
A: Spaces are included in the character count restrictions. You can use the provided character count next to the text boxes to see how many characters you have used (note: you must click outside of the cell for the character count to refresh). Alternatively, you can copy and paste your answers from a Word document.

Section 2: Partner Organizations – Contact Information

Q: You mention the maximum number of partners, what is the minimum or average number you are looking for in each application?
A: There is no minimum or maximum number of partners, but the partners should provide coverage for the community being served.

Q: Must all PPS partners be Art. 28 D&TCs?
A: No. PPS partners can be all types of providers (hospitals, D&TC's, NH's CHHA) and should be a mix of providers to provide all community needs.

Q: If a partner organization is not included in the Project Design Grant, what does that entail? Does that preclude them from receiving future funding? Do they need to be in both?
A: If a partner organization is not included in the Project Design Grant application, you may still add additional partners later with the DSRIP Project Plan Application. The planning grant (aka Project Design Grant) is to assist the PPS in getting to a comprehensive DSRIP plan.

Q: Are multiple agencies (e.g. CHHA, DTCs) associated with the same health system applying for DSRIP funding together considered a collaboration?

A: Yes, but a collaboration also includes other health care providers, not part of your health system, but serving your community.

Q: Just to be clear, can a PPS applicant sub-contract with another (non-safety net) provider entity for the design grant? And if so, does the 5% cap apply to the design grant as well?
A: Both qualified and unqualified safety net providers can be part of a PPS and it will not affect the planning grant awards. The 5% only applies to the actual DSRIP funding.

Q: We have an Article 31 and a Pros program under our umbrella. Two different operating certificates, two separate applications?
A: They will be considered separate partners and each must meet the 35% safety net criteria. A list has been recently posted to the DSRIP page.

Q: If a hospital has a hospital-based SNF and LTHHC program, should these two programs be listed along with the hospital as partners on the list of 100 partners since they have separate op cert?
A: Yes, but the corporate structure should be described in the text sections where applicable.

Q: Do we report separate sites of a given organization as individual partners? For example, if an FQHC has 4 sites - should each be listed as separate partners?
A: Should file as one entity unless they have a different operating certificate. For example: if an FQHC has four sites, the FQHC would be listed as one partner organization, noting two of the four NPI's. On the other hand, if a hospital and its hospital based nursing home are participating in an emerging PPS, they would be listed as two separate organizations since they have two distinct operating certificate numbers. Please refer to the instructions to determine the operating certificates for Article 16, 31 and 32 facilities.

Q: A partner organization has multiple OMH operating licenses - are you saying to use only one license and not indicate all licenses (even if services from more than one service line will be part of the whole)?
A: There is a list of OMH providers on the DSRIP web page and that list is based upon how CFR reports are filed with OMH.

Q: For the partner organization information, how should you account for multiple NPIs (more than 2) or MMIS? For example, a physician group.
A: Assuming they have the same operating certificate number, fill in the group as one partner organization. It does not matter if the facility has multiple MMIS and NPI numbers; any will suffice. A separate template will be made available for physicians, physicians groups and pharmacies.

Q: For independent physician associations, can you list the entire IPA as 1 entity or do you need to enter each physician separately?
A: There will be a separate attestation process for physicians' practices and groups.

Q: What does the datum "MMIS" refer to? How is this different from the Medicaid Provider number? Where would I find our MMIS number?
A: It is not different and refers to Medicaid Management Information System (MMIS).

Section 3: Partner Organizations and Service Area

Q: Will the Department seek to change, and seek exceptions to rules and regulations for the industry as a whole to enable PPSs to be effective?
A: In Section 3.1, we are asking if any regulations need to be waived to accomplish a DSRIP partnership within the emerging PPS, along with an explanation. Information will be used to determine what regulations, on a case by case basis need to be waived or altered to make the emerging PPS successful in achieving its transformative goals.

Q: Does service area need to be unique i.e. could one community or zip code be included in service area of two PPSs? Does service area have to be contiguous?
A: The service area does not need to be unique. If multiple PPSs have selected the same geographic region, the members will be attributed following the attribution rules; please see slides 58-62 of the powerpoint on the DSRIP website for further details. Service area does not have to be contiguous.

Q: How must a community be defined? I.e., could a large performing provider system include health centers spread out over the entire NYC area? Or is that too broad?
A: The PPS is initially being defined by the provider community. However the state reserves the right to merge or work various PPS to better serve a community health needs. We are using counties to ID the service area for the Planning Design grant application.

Q: Can whole Boroughs be the defined service areas?
A: You may choose to use Boroughs to describe your proposed service area in section 3.2, however, in section 3.3, you must indicate each county that will be included within the service area of your emerging PPS.

Q: As a safety net hospital we know how many Medicaid lives we care for but we don't know if they will be attributed to a different PPS due to care management claims or duplicate primary care claims. Are there any tools available to PPS applicants to better estimate their attributed lives?
A: Tool Kits and Data Books have been provided to date with additional data to be provided over the next several months. If specific data is needed, please include it in Section 8 (Data Request) of the Design Grant Application.

Section 4: Project Program Overview and Description

Q: Are there any examples of the type of project that would qualify for these awards that we can review/read?
A: A list of CMS approved projects is located in Attachment J; the DSRIP Project Toolkit lists

and describes these projects.

Q: Is there still the ability to submit a DSRIP project that is not in the approved CMS list, if it can be shown the project meets DSRIP goals?
A: No.

Q: Section 4 (Project Program Overview and Description) asks applicants to identify specific projects, which are supposed to be driven by community needs assessments. But Section 5 (Community Needs Assessment) makes it seem like the community needs assessments do not have to have taken place before submission of the Design Grant. How can we select projects if we haven't done all data collection and community needs assessment yet?
A: Your responses in this section should be based upon information known to date but can be altered in the final DSRIP proposal to be filed in December.

Section 5: Community Needs Assessment and Stakeholder Engagement

Q: Jason indicated that further guidance will be provided on the community health assessment. When will this guidance be released?
A: The DSRIP team has been working on creating a variety of resources to help emerging PPS in their undertaking of a comprehensive CNA. Expect further guidance in early June.

Q: Would the NYC DOHMH (not the clinics they operate) be a partner or stakeholder?
A: Yes, emerging PPSs may want to consider including local health departments when engaging stakeholders.

Section 6: List of Vendors

Q: What is the definition of a "vendor" as required in section 6?
A: A vendor is defined as a business such as a consulting firm that is or will be employed to assist the emerging PPS in the development or implementation of their DSRIP plan.

Q: Could a local health dept. be contracted as a vendor? Possibly to run data for CNA?
A: Yes, as long as they are providing needed services for the emerging PPS.

Q: What happens if the vendors to be used for assistance are not known at the time the application is filed?
A: Mention this issue in Section 4.6 (specific challenges). An updated list of proposed vendor organizations may be required as a future deliverable.

Q: Are all vendor agreements to be used by applicants for the design grant phase required to be in place by the July 17th deadline or can these vendors be amended prior to the December application phase?
A: These are the vendors known to date but can change in the final Project Plan application.

Section 7: Design Grant Timeline

Q: What level of granularity is expected for the timeline? Do you want us to include subtasks related to generating deliverables?
A: Include relatively high levels with major actions, decisions, milestones, and enough detail so it is clear that the timeline makes sense.

Q: What is the "end point" of the design grant timeline? Is it the submission of the December DSRIP application?
A: The end date should be March 31, 2015, since the DSRIP program is slated to begin April 1, 2015. Further details can be found in the instructions.

Section 8: Data Request

Q: On the section for identifying additional data needed, is this data that the proposed PPS will need to gather or data that it needs from the State?
A: This section is referring to data that the emerging PPS needs that the State might be able to provide directly or gather through sources to support the emerging PPS's planning activities.

Q: In regards to the Data Request, what are examples of information the state can provide?
A: Please see the DSRIP Performance Data on the DSRIP website to get a better understanding.

Q: If our organization was not included in the Salient Medicaid data spreadsheet posted on the NYSDOH DSRIP webpage, who should we contact and what information should we include?
A: The Salient data workbooks are not a complete list of all the providers in a given region. Each of the regional workbooks is built from a list of the top 50 providers in each county for each of the included service types. The DSRIP team is working very hard to create a data portal to provide more information to help with planning and eventually DSRIP reporting. In the meantime, please include any data requests for useful performance information as part of Section 8 of the DSRIP Design Grant Application.

Section 9: Design Grant Budget & Capital Needs

Design Grant Budget

Q: Will the Planning grant awards be based on the identified non-capital costs or will they all be $500,000?
A: Project design grant awards will generally be for $500,000; however, the amount will be dependent on the proposed service area and the identified planning expenses provided in the Design Grant Budget. Applicants should provide **all** projected planning expenses (regardless of amount) related to developing their DSRIP Project Plan Application in Section 9.1 of the Design Grant Application. Larger emerging Performing Provider Systems may be eligible for additional

planning funding; applicants that do not provide a sufficient and reasonable budget may be awarded less.

Q: Can project budgets include funds for program evaluation (i.e. systematic outcome monitoring, etc.)?
A: No. The project budget is only budget related to the planning process, not the full DSRIP applicant to be filed later this year.

Capital Needs

Q: Where the need for capital is referenced in the application, will those funds come from DSRIP funds or from other DOH sources?
A: Capital funds **will not** come from other DSRIP funds and will not necessarily come from other DOH sources. We are just asking for the capital needs of the emerging PPS. Sources will be further defined – there are state funds that may be used, but other sources should be explored by the PPS.

Q: For the Planning grant, is capital defined as working capital or renovations? For example if an FQHC needs to hire startup staff or consultants for planning is that an allowable expense and where does it go on the budget?
A: Yes, capital is real capital not working capital. This would be an allowable expense; if there is not an existing category for it, make one by following the instructions.

Q: How do you define capital? Bricks and mortar, and/or equipment? HIT? What qualifies as capital?
A: Capital consists of things like Bricks & Mortar as well as equipment and other similar items, generally defined under GAAP as capital.

Q: If capital is not funded under DSRIP, why are you asking about it?
A: This is asked to obtain information about capital needs directly required to make all emerging PPSs successful.

Section 10: Project Advisory Committee

Q: Are the required Project Advisory Committees for DSRIP planning only, or are they expected to be in place and working over the five years of the DSRIP program?
A: They are expected to be in place over the five years; more information can be found in the FAQs.

Q: Could you elaborate on what the State sees as the minimum "scope of work" for the PAC? Does NYS have specific expectations or requirements for what PAC responsibilities are? For example, does PAC need to approve anything or prepare a report?
A: Please refer to the recently amended Section 10, revised instructions on PAC and the FAQs.

Q: For the Project Advisory Committee - does EVERY partner need to have a management and a worker/union representative?
A: Please refer to the recently amended Section 10, revised instructions on PAC and the FAQs.

Q: What is the recommended size of the PAC -- is there a minimum or maximum?
A: Please refer to the recently amended Section 10, revised instructions on PAC and the FAQs.

Q: Could a stakeholder, such as an association, be permitted on the Project Advisory Committee?
A: Yes. Please see Section 10 of the updated instructions regarding this.

Q: Would DOH consider requiring Local Health Department (LHD) representation on PACs?
A: Larger emerging PPSs may choose to form an alternate PAC structure as described in the updated instructions and FAQs. If not proposing an alternate structure and the LHD is a partner organization within the PPS, they should be included in the PAC. If the LHD is not part of the PAC, the PPS can invite them to join or consult with them; the more successful PPSs are incorporating community partners in their planning and discussion, the greater impact it will have on their Project Plan application.