State of New York Department of Health

Delivery System Reform Incentive Payment (DSRIP) Program

Vital Access Provider (VAP) Exception Form Instructions

Application due 10/14/2014
NO EXTENSIONS WILL BE GRANTED

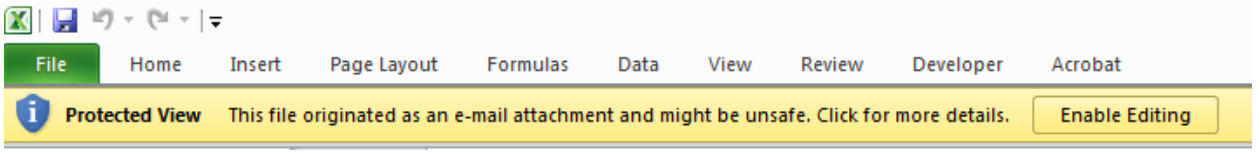
There will be no extensions for the application. Any form submitted past the due date will not be considered.

The state will consider exceptions to the safety net definition on a case-by-case basis if it is deemed in the best interest of Medicaid members and the State of NY. Any exceptions that are considered must be approved by CMS and must be posted for public comment 30 days prior to application approval.

General Instructions:

These are the instructions to the DSRIP Vital Access Provider (VAP) Exception Form. Please read all instructions. If you have further questions, please submit them to BVAPR@health.ny.gov with your facility name and "DSRIP VAP Exception Question" as the subject.

- **Health Homes** that wish to be considered for a VAP Exception should verify that they are on the draft Health Home List. This list, containing all NYS Health Homes, has been submitted to CMS for approval. If your Health Home appears on this list, you will be granted a VAP Exception after CMS approval and do not need to submit this form. If your Health Homes doesn't appear on this list but you believe that it qualifies as a Health Home, please complete this form.
- VAP Exception applicants will be evaluated by not only the criteria chosen (see Section IV), but also **in the context of the specific PPS that your organization plans on joining**. **If you intend to join more than one PPS as a VAP Exception, you must complete a separate narrative for each PPS.** It is possible for an applicant to be granted a VAP Exception for one PPS and not for another. The state will conduct attribution analysis for each PPS based on provider network data submitted on 9/29 for initial attribution. Further instructions are found in Section II below.
- Check Boxes: Keep in mind that Section I, II, IV, and VI have check boxes from where you can select your response. Please select only one check box.
- The application is formatted in Microsoft Excel 2010 (It is highly recommended that you use an updated version of Microsoft Excel). If you have any questions about this application, please submit them to BVAPR@health.ny.gov with your facility name and "DSRIP VAP Exception Question" as the subject line.
- If you see the following message (see example below) after opening the excel application form, you must click on the "Enable Editing" button to allow you to fill out and save your application.



I. Are you a Medicaid Provider

Please use the drop-down selection tool to indicate "Yes" or "No" for this question. Only Medicaid Providers are eligible for the VAP Exception. If you are not a Medicaid provider, please do not complete this form.

II. Appeal Applicant Information

Please enter the requested information in the appropriate boxes. Items with an asterisk (*) at the beginning of each bullet are **required**; *forms without these fields filled out will be rejected*.

- * **Organization Name:** Provide the **full legal name** of the VAP Exception applicant organization, as on file with the appropriate licensing agency (DOH, OMH, OASAS, etc.). If your organization is not

licensed by the State of New York please include a description of the structure of the legal entity in your narrative.

- * **Joining PPS** - Applicants appealing under qualification i or ii (see Section IV) **must** select a PPS from this list since VAP Exception appeals will be evaluated in the context of the PPS that you intend to join. A list of emerging PPSs can be found on the Design Grant Award page. Since the VAP Exception is evaluated in the context of the PPS you are joining, **you will need to fill out a separate narrative for each PPS you intend to join as a VAP Exception**. Please see Section VII below for more information.
    - "**In the context of the PPS**" – Under the VAP Exception, you must be joining a PPS that falls in line with their provider network in addition to the service area and projects that PPS is pursuing.
- *** Provider Type:** Use the drop-down menu to select the VAP Exception applicant's provider type by checking the appropriate box. This will then automatically fill out the following "Provider Type" cell. If your provider type is not listed, please select "Other" from the check box and use the text box "Provider Type – Other" to enter in your provider type.
- **Operating Certificate Number/License #:** if applicable, enter your facility's Operating Certificate Number (Opcert). This is a seven-digit number, sometimes followed by a letter. For example: Hospitals - 1234567H; Nursing Homes - 1234567N. If your facility does not have an Opcert, but does have a six digit License Number, please enter that.
- **MMIS:** The MMIS Provider Number is an eight digit number, frequently starting with 00. If your number starts with a zero (0), insert an apostrophe (') before the number or excel will not recognize the leading zeroes. For example: 12345678, or '00123456
- ***NPI**: The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique 10-position, intelligence-free numeric identifier for covered health care providers. If you don't know your NPI you may use the following website to look it up:
    - https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do
- **Agency Code:** if applicable, enter your facility's Agency Code. This is a five digit number.
- **Billing Entity ID:** if known, enter your Medicaid Billing Entity ID. This identifier begins with an "E" and is followed by seven digits. For example: E1234567
- **Address, City, State, and Zip:** Enter the address, city, state, and zip of the appeal applicant in these fields.

III. Appeal Point of Contact

All fields except for "Extension" are required.

- **Contact Person** – enter the name of the person DOH should contact if we have any questions during our review
- **Title** – enter the title of the contact person named above
- **Contact Phone** – enter the phone number of the contact person. Only enter the actual phone number; it will be automatically formatted.
- **Extension** – if applicable, enter the phone number extension of the contact person
- **Email –** enter the email address of the contact person

IV. VAP Qualification Selection

You are required to select ONE of the following choices. To select choice ii, you must be a hospital. To select choice iii, you must be a health home; only select choice iii if your Health Home does not appear on the draft Health Home List.

i. A community will not be served without granting the exception because no other eligible provider is willing or capable of serving the community.

ii. Any **hospital** is uniquely qualified to serve based on services provided, financial viability, relationships within the community, and/or clear track record of success in reducing avoidable hospital use. (In section VI, please include all that apply to your Hospital)

iii. Any state-designated health home or group of health homes

- The Department has submitted a draft list of State Designated Health Homes and Network Care Management Agencies (CMAs) that have already been approved as safety net providers as well as those that are pending CMS approval. If your Health Home appears on this list as pending approval, you will be granted a VAP Exception pending CMS approval and do not need to submit this form. If the organization operating your Health Home/CMA already appears on another safety net list, you do not need to submit this form. If your organization **does not** appear on the draft Health Home list or on another approved safety net provider list, but your organization believes that it should qualify as a Health Home, please complete this form. The draft list is available on the DSRIP website under the Safety Net Definition section.

V. Percentage of Medicaid & Uninsured

Please enter the percentage of Medicaid and Uninsured members (by volume) that your facility serves in the appropriate box. Please include both Fee For Service (FFS) and Managed Care (MC) in the percent of Medicaid. To the right, indicate the source and the most recent annual year of the data.

VI. Narrative

Use the text box on the right of the form to provide a brief statement as to HOW and WHY your facility fits the exception qualification you chose in Section IV. Please make sure that references to the supporting documentation are clear. For qualifications i and ii, **you must provide this information in the context of the PPS that you intend to join (selected in Section II and further described in the General Instructions).**

- "**In the context of the PPS**" – Under the VAP Exception, you must be joining a PPS that falls in line with their provider network in addition to the service area and projects that PPS is pursuing.

i. If you chose the qualification i, please include **all** of the following:

   a. A specific definition of the community(ies) that would otherwise not be served by the selected PPS. Be sure to include descriptions of the geographic area, the population, and

how the services in this community are insufficient without your organization's involvement given the PPS current configuration of network providers.

b. A description of the applicant's organization, the services provided, and how the services will enhance the network of services for the PPS in this community(ies).
c. Any supporting documentation to substantiate your narrative (attach as PDF in the email when submitting)

ii. If you chose qualification ii, please include **all** of the following that apply to your **hospital**:

a. A description of the applicant's particular services that would enhance the network of services for the PPS. These service can include typical clinical or support services that are vital to serving the population, for example, the only dialysis center to serve an area. These services can also incorporate administrative or operational services that will help the PPS meet its DSRIP objectives, for example, the applicant's care management system that will be deployed to the PPS system.
b. A financial viability analysis to demonstrate stability (attach as PDF in the email when submitting)

If you would like to include any supplemental data to be reviewed as part of this, please attach it as a PDF when submitting your form via email. Please limit your supplemental data to 5 pages and be sure to note the data source and year.

c. An identification of and description of how the applicant's relationships within the community that would enhance PPS's success.
d. Demonstration of past success in reducing avoidable hospital use
e. Any supporting documentation to substantiate your narrative (attach as PDF in the email when submitting)

iii. If you chose qualification iii, please include:

a. A description of your entity in specific relation to being a Health Home.
Please do not submit this form if you are already on the draft Health Home List.

This section has size limits, so please be concise in your answer. This section is limited to 3,500 characters ONLY. There is a character count located at the top of this section for your reference (you must click outside the narrative cell for the count to refresh).

You may copy and paste your narrative from a word document if you wish. To do this, highlight your text within the word document, make sure that it is less than 3500 characters (with spaces), copy the text, **double click** on the narrative cell (the large grey-shaded box), and paste. If you do not double click the cell (so that you can see the flashing line cursor), you will receive an error message when trying to paste.

VII. Additional PPSs

If you intend to join more than one PPS as a VAP Exception, you must fill out a separate unique narrative for each PPS. Please do this on the "VII_Additional PPSs" tab. Use the drop down menus to select which additional PPS you are joining as well as the VAP Exception qualification that you are applying under. Fill

out each narrative as detailed above in Section VI. Be sure that each narrative you provide is customized for that PPS. In the unlikely event that you are joining more than 2 PPSs as a VAP Exception, you should scroll down and provide a narrative for each PPS in the space provided.

VIII. Certification

Please select "Yes" or "No" from the check box provided and in the space provided, input the name of and title of the person making this certification. The person certifying the form must be the CEO, CFO or comparable level personnel. Electronic signatures are sufficient; please do not save as a PDF.

Instructions to submit:

- Save and complete the form in Excel format. Please include your facility's name in the filename when saving.
- Send an **unsecured** email to BVAPR@health.ny.gov including the form as an attachment as well as any other supplemental documentation. Include your facility's name as well as "DSRIP VAP Exception Form" in the subject line of the email.