HEAL NY – PHASE 11
Capital Restructuring Initiatives #3
Request for Grant Applications #0904211132

Questions and Answers

Eligible Applicant

1. Based on definitions contained in the Health 11 materials Section 1.4 "Eligible Applicant" it appears Residential Health Care Facilities are exempt from Heal 11. If I understand correctly, RHCF's fall under PHL Section 2801(2) and this grant covers 2810 (10).

   Nursing homes are not eligible to apply. They are eligible to apply under HEAL Phase 12, which is for the support of alternative long-term care initiatives.

2. Section 1.4: The application appears to preclude a proposed, to-be-established entity from being an applicant. Can the Department confirm that, in an application whose central component will be a proposed joint venture entity to be formed (after CON establishment) by two hospitals to operate a shared service, one of the two hospitals should be the lead applicant and proposed contracting entity?

   Yes. An entity that is not yet established would not be eligible to apply. Therefore one of the two hospitals should be the lead applicant and proposed contracting entity.

3. I understand that HEAL 11 grants are available for alignments of hospitals under a common corporate parent with "active powers" which is approved under Article 28 of the PHL. If one of the two hospitals aligning under a common corporate parent is located just across the stateline in Pennsylvania, the other hospital is a New York hospital, and the parent is a to be formed New York corporation, is the New York hospital an "eligible applicant" under section 1.4 of the RGA? The CON application for establishment approval of the corporate parent has been submitted to DOH. Thank you for your consideration.

   Yes, the New York hospital would an eligible applicant. Note, however, that only costs and restructuring activities that directly improve the health care system in New York State are eligible for funding. In the example given, activities that would in any way benefit the corporate parent in Pennsylvania would not be eligible for consideration under this RGA.

   You are also reminded that HEAL funds may not be used to supplant existing sources of funding. Therefore, any costs associated with the CON application for establishment approval, for which your submission of a CON application indicates that you have already demonstrated that the establishment project is financially feasible, would not be eligible for funding under this RGA.

Eligible Project

4. Is a requirement of the restructuring program the closure of inpatient beds? Is an eligible project one that will increase efficiency and increase access to outpatient care through capital restructuring without closing inpatient beds?

   As with previous HEAL solicitations for capital restructuring, downsizing of inpatient care is a priority of Phase 11. Nevertheless, bed reduction is not an absolute requirement for eligibility for funding. Some hospitals may, for example, be able to make a case that capital improvements or collaborative arrangements with other facilities which do not involve bed reductions would result in fewer people going outside the service area for hospital care, which may have favorable effects on costs, access and efficiency in the area overall. Facilities with strong connections to the community may also be able to demonstrate that proposed capital projects to reconfigure services or to undertake collaborative activities with other providers may strengthen their community-oriented ambulatory care programs, without bed reduction. Applicants should bear in mind, however, that HEAL solicitations are highly competitive, and that projects that do not propose to reduce beds may face strong competition within their regions from those that do.

5. We are an established Article 28 network which includes a not-for-profit 15-bed critical access hospital and a not-for-profit 84-bed long term care facility. We are considering making application to HEAL NY 11. We are considering downsizing by closing beds, but not in the hospital – in the 84 bed nursing home. On page 7 of the RFP under the "expenditures eligible for funding…" section, #4 clearly states "…to implement a closure or downsizing plan to either decommission or downsize *hospital* buildings…" Because the closure plan applies to nursing home beds, not hospital beds or buildings, we are unsure as to whether this project qualifies for funding. In addition, we are seeking to possibly convert those long-term beds and the section of the building which houses them to assisted living, and possibly utilize funds for badly need renovations to the hospital's Emergency Department. Mr. Schmidt, is this a project which would be considered for funding under Heal NY 11?

   Because it deals with nursing home beds and alternative long-term care services, this project would not be eligible under this RGA. It would be more appropriately considered under HEAL Phase 12.

6. Goal # 3 mentions promotion of outpatient and ambulatory care. Are there any restrictions on the type of care – mental health, dental care, medical and surgical specialty, etc?

   The four categories listed would be eligible for consideration under this RGA. However, you are reminded that any mental health services would be subject to approval by the Office of Mental Health and would have to meet all applicable OMH requirements. Similarly, any services for chemical dependence overseen by the Office of Alcoholism and Substance Abuse Services (OASAS) would have to meet the requirements of that agency.

7. RGA Section 1.5a - Under the "Shared Services, Consolidation" category, you note that facilities can combine one or more clinical services to eliminate duplicate capacity and to gain operational efficiency - would consolidation of operational and/or administrative functions also qualify under this category?

   The main purpose of consolidation and other collaborative activities is to improve the efficiency and accessibility of care rendered to patients. Savings in administrative functions should not be the focus of a Phase 11 application and, if included, should have a demonstrable favorable impact on the delivery of patient care.

8. Would there be interest in an outpatient program addressed to chronic disease patients with a goal of reducing inpatient hospitalizations?

   Downsizing and/or collaborative activities eligible for funding under this RGA that enhanced outpatient services to patients with chronic diseases would be eligible for funding under this RGA.

9. In the applicant conference, the Department appeared to indicate that the HEAL 11 grant funding is not meant to support primary care expansion, yet the RGA states that one purpose of this RGA is "to assist hospitals in reducing excess inpatient capacity in favor of outpatient and ambulatory services." May HEAL 11 funds be used to support primary care expansion (with concurrent inpatient capacity reduction), or must the outpatient service expansion be in non-primary care areas? Clarification of the Department's comments will be appreciated.

   Primary care is eligible for funding under this RGA. The statement made at the conference explained that this HEAL Phase 11 RGA was aimed at hospitals (and Phase 12 at long-term care providers) but that an RGA for providers of primary care (as HEAL Phase 6 was in 2008) may be issued sometime later this year.

10. Is inpatient bed reduction a requirement to be eligible for funding?

    See answer #4.

11. Section 1.5a Eligible Activities, specifically the passive parent issue. If one Article 28 hospital under a passive parent and a second Article 28 hospital, which is willing to be a subsidiary under the same passive parent, agree to put together a shared service collaboration, would these activities qualify for funding?

    A collaborative arrangement for shared services under a strong, legally binding agreement would be eligible for funding under this RGA. However, any costs associated with making the second Article 28 hospital a subsidiary under the existing passive parent (or any other passive parent arrangement) would not be eligible.

12. I would like to submit the following questions concerning the submission of several potential HEAL 11 Projects our hospital is considering. These questions primarily pertain to who is an eligible to be a "significant collaborator" for a HEAL 11 project. There are also several questions on the permissible use of HEAL funds that are not clearly identified in any specific section of the HEAL 11 RGA:

    a. Can HEAL 11 be used to reduce and/or consolidate the operations from several facilities of the operation of inpatient psychiatric beds, achieved in part through the expansion of outpatient behavioral health and psychiatric emergency services?

       Yes. See also answer #6.

    b. Can HEAL 11 be used to reduce and/or consolidate the operations from several facilities of the operation of inpatient alcohol and/or drug detoxification (chemical dependency treatment) beds?

       Yes. See also answer #6.

    c. Can Health 11 funds be used for projects that include funding for the renovation or construction of facilities owned/or operated under the auspices of the State of New York, including SUNY Hospitals and OMH facilities?

       Phase 11 funds may be used for the renovation or construction of facilities owned/operated by SUNY Hospitals, but not for those owned/operated by OMH or other State agencies.

    d. Can HEAL 11 projects be used for a collaborative project between an acute care hospital and a New York State Certified Home Health Agency (CHHA), where inpatient beds and hospital based outpatient care is replaced with home based care?

       Because this project would result in an expansion of home-based care, it may be better suited for submission as a HEAL Phase 12 application.

    e. Can HEAL 11 be used to support collaborations with Acute Care Hospitals and Skilled Nursing Facilities to reduce and/or consolidate the operations of both Acute Care Rehabilitation Medicine Beds and SNF beds, achieved in part through the expansion of outpatient rehabilitation medicine services?

       In considering projects that involve hospitals and nursing homes, applicants should determine whether the bulk of funded activities would occur under the hospital's or the nursing home's auspices, and whether the resultant services would serve primarily hospital patients or long-term care clients. If the latter, the project would be more suitable for submission under the HEAL Phase 12 RGA.

    f. If part of a HEAL 11 project involves a reduction in beds of an inpatient unit, can HEAL funding be used to renovate the remaining beds in the unit? For example, if a

40 bed unit consisting of triple and double bedded rooms is reduced to a 20 bed unit, can HEAL funds be used to renovate the remaining 20 beds into single bedded rooms? Also for example, if an inpatient unit is downsized (beds reduced) can HEAL funds be used to relocate the unit within the Hospital? Can HEAL funds be used to renovate a downsized (reduced bed) inpatient unit to meet current facility code requirements?

Renovation of vacated inpatient space would be acceptable. However, bringing other space up to code, which the hospital would have to do anyway, would not be eligible.

13. The stated goals of the HEAL NY program focus on downsizing capacity (Section 1.2), will you accept and rate a proposal that creates a legal relationship between two hospitals (e.g., merger) and expands ambulatory services but does not decertify beds and can demonstrate that a decertification of beds is not warranted in the interests of the community needs?

    See answer #4.

14. Can HEAL 11 funds be used to eliminate liabilities of one hospital so that it can enter into a legal relationship with another hospital (e.g., merger)? if yes, would this go on the Acquisition - Other line or Fees - Legal line on Attachment 12 of the Financial Application?

    Yes, funds can be used to eliminate liabilities that would hamper a merger or other substantive collaborative relationship. Such costs would probably best be presented on the Acquisition-Other line, supported by narrative under the Justification section.

15. Example: 2 hospitals create a legal relationship (e.g. merge), and some of hospital A services are combined with hospital B services & hospital A increases outpatient services. Can HEAL 11 funds be used for hospital B to accommodate hospital A services & hospital A to expand outpatient?

    HEAL Phase 11 funds can in general be used to support the costs associated with the consolidation, reorganization or redistribution of services between two or more facilities to achieve the goals of the RGA.

16. In the example above, the result would be part of hospital A would downsize its services, can HEAL 11 funds be used for the portion related downsizing, for example, employee expenses, medical records storage, med mal...?

    Yes, the costs of downsizing are generally acceptable under this RGA.

17. At the applicant conference it was stated that an acceptable Article 28 network applicant was one with its name on hospital operating certificates. There are Established (PHC approved) Article 28 networks that do not have its name on hospital operating certificates, can the Article 28 network be a HEAL 11 applicant?

    Any applicant must appear on an operating certificate as operator or co-operator of an eligible Article 28 entity. As stated at the conference, applicants are strongly cautioned to make certain that their “network” or other applicant organization is so listed.

18. Section 3.4 Review Process - it is indicated that there is a scoring process for each application section (technical and financial), can you provide the max points for each criteria/component that is scored?

    The Department and DASNY do not make scoring or weighting criteria public.

19. Would DOH consider an application whereby a hospital in an over-bedded county (Hospital A) decertifies beds and transfers these beds to an unrelated hospital in an under-bedded county (Hospital B)? The result of which prevents Hospital B submitting a CON for additional beds. Would the arrangement be deemed as meeting the goals of HEAL 11?

    In general, bed transfers are not allowed between hospitals (except within an established Article 28 network). An addition of beds to hospital B would have to be evaluated on its own merits in the normal CON process, with hospital B as the CON applicant.

20. Same scenario as described above but Hospital A and B also enter into a sponsorship or other binding governance agreement?

    The governance agreement would have to be for an Article 28 network arrangement or merger, which would permit the evaluation of bed need based on the combined service area of the two hospitals and with reference to the existing bed capacity at each hospital site. Any less collaborative governance arrangement would require the treatment of facility B as a separate entity, as described in answer #19.

21. Again, assuming the bed transfer arrangement is allowable, would it also be allowable to use HEAL funds to compensate Hospital A for decertifying its beds and to compensate Hospital B for construction-related activities needed to put in place the to-be-certified beds?

    See answers #19 and #20.

22. Same scenario as 1 above but transfer is between Hospital A which is a general med/surg provider and Hospital B which is a specialty hospital (e.g. Children's Hospital) and both Hospital A and B are in the same service area and Hospital B can demonstrate a need for expanding its specialty inpatient capacity and it is likely to submit a CON for additional beds.

    See answer #19.

Miscellaneous

23. Our system is in the midst of the due diligence process to merge 3 entities. All 3 will have merger related expenses (legal, accounting analysis, etc). One entity will have significant capital needs due to consolidation / closure of beds. Should everything be combined in a single application (which could total 2/3 of our region's allocation) or should these be separated?

    Because of the highly competitive nature of the HEAL procurement process, no individual application should be dependent upon the approval of one or more other applications. If this

project would truly be a three-hospital collaborative endeavor, it would likely be better to submit it as one application, with one hospital designated as the lead applicant.

Whether requesting an amount equal to two-thirds of the regional allocation would reduce the chances of funding would depend on how well the application scored relative to other proposals in the region, on how many applications were received from that region, and on the individual amounts of those proposals.

Financial

24. My (smaller) facility is working with another larger facility in affiliation discussions that would make them our active parent. What kinds of debt can be retired through HEAL 11 to facilitate the merger? We have a significant (>$1,000,000) line of credit which is an impediment to the merger progressing.

    Lines of credit and debts to vendors are generally eligible for consideration under this RGA.

25. Will these grants only be approved in total, or, if there are distinct components, will there be grant awards covering one component, but perhaps not all?

    Applications will be evaluated in their entirety. The Department and DASNY will not fund segments or individual components of proposed projects.

26. Can you tell me how the allocation of available funds was determined?

    The allocation of funds by region is based on population, using U. S. Census intercensal population data for 2008.

27. Under the "Hospital Closure" category, would the costs of technically closing a hospital, but then transitioning the facility to an ambulatory care or other non-inpatient type site be considered for funding?

    Yes, both the closing expenditures and the costs of conversion to non-inpatient care would be eligible for funding.

28. What is the maximum funding award for an individual facility; or how can an applicant know what the maximum award would be for HEAL Phase 11, in order not to exceed the maximum amount?

    As stated on page 9 of the RGA, individual grant requests under this solicitation may not exceed $25 million.

29. "If IT investments are needed as part of a full clinical integration of services between 2 hospitals, can those IT costs be included in the HEAL 11 request?"

    IT costs are eligible under this RGA, but IT should not be the principal focus of an application. Such projects would be better submitted under the current HEAL Phase 10 RGA for HIT, or under subsequent HEAL HIT solicitations.

30. Do proposed initiatives that seek to enhance community access to and viability of ambulatory care services through changed governance structure (e.g. transitioning outpatient clinics to FQHC or FQHC/LA status) have to demonstrate, at a minimum, budget neutrality to be considered eligible for funding?

    Applicants should demonstrate that the proposed project will result in a financially viable endeavor following the end of HEAL funding. Projects that project a deficit or questionable long-term sustainability will not be scored favorably.

31. Would funds be awarded and be able to be utilized to provide care to patients who are not underinsured or in an underserved community?

    HEAL Phase 11 funds are for capital projects and not to cover direct care costs, except in very specific, limited circumstances (e. g., start-up costs, etc.).

    As stated in the RGA, applicants should show that proposed projects are responsive to identified community need. Therefore, applications for capital projects that propose to increase capacity to serve the underserved/uninsured will be scored more favorably (and would be more consistent with Berger Commission recommendations and the HEAL legislation) than those which do not.

32. Section 1.11: In regions of the State with allocations of less than $25 million, may an applicant propose funding up to the single-applicant limit of $25 million, or must the applicant constrain its request to a maximum of the regional allocation?

    Because proposed projects are evaluated for funding in their entirety and ranked by score relative to other projects in the applicable region, an application that exceeds the assigned regional total risks being unfundable, even if it scores highly.

    For all applicants, any application that exceeds $25 million will be deemed ineligible for funding, regardless of the total funding allocation for the applicant's region.

33. How much of the $175 million will be available from the DASNY bond proceeds and how much from State capital appropriations? (Section 1.7)

    The mix of bondable and non-bondable funds to be awarded will vary and cannot be predicted with precision. Funds available under the Federal-State Health Reform Partnership (F-SHRP) will also allow the Department flexibility in awarding funds to projects that best

meet the goals and objectives of the RGA, whether proposed costs are bondable or non-bondable, or a combination of the two.

34. Which types of debt restructuring costs are eligible?

    Payment of principal and of costs reasonable and necessary for restructuring of debt are eligible under this RGA.

35. Does a proportional amount of long term debt on the closure of beds qualify as eligible costs?

    Yes. Any such restructuring approved as part of a HEAL application would then also be subject to regular DOH financial approval; for example, by the Division of Health Care Financing and/or the Division of Health Facility Planning.

36. If a hospital qualifies under PHL 2818 for funds outside the usual HEAL application process should a specific application be filed or should reference be made in a multi provider application or hospital application?

    This HEAL Phase 11 RGA pertains only to this allocation of $175 million in HEAL funds, to be awarded on a competitive procurement basis. This RGA is not announcing the availability of any other HEAL allocation, nor will any application submitted in response to this RGA be considered for any HEAL funding other than that available under this HEAL Phase 11 solicitation.

Application Format

37. Can you clarify what it is you want submitted from vendors or contractors regarding an applicant's business practices?

    Examples might include statements from vendors and contractors regarding your facility's timeliness in making payments; and attestations from local groups and organizations regarding the reliability of your services, quality of your marketing practices, and overall soundness of your transactions with business entities in the community.

38. How exhaustive a list do you want as far as grants applied for/received in the past 3 years. A large health systems' inventory could be immense - is there a parameter to what types of grants you want information on?

    The list should include any grants applied for or received with regard to health care or clinical services, including research. Grants for nonclinical endeavors (e. g., construction of a parking garage) would not have to be listed.

39. Section 2: The description of the Technical and Financial Applications seems to preclude the provision of proposed legal documents for a joint venture as an attachment. Can the

Department confirm that the provision of proposed legal documents for a joint venture as an attachment is either not allowed? If the provision of proposed legal documents relative to a proposed joint venture is allowed, would providing the documents result in a higher score than not providing the documents, by demonstrating more advanced planning?

Proposed legal documents may be included as an attachment. The Department does not comment on scoring criteria or on how/whether any particular component of an application may affect a score.

40. Section 2: The description of the Technical and Financial Applications seems to preclude the provision of community letters of support. Yet, projects are supposed to be responsive to community needs. If an applicant believes that community letters of support help it to demonstrate responsiveness to community needs, may the applicant attach community letters of support? If so, will the Department consider those letters of support in its scoring?

    Letters of support would not be deemed sufficient to document community need. As stated at the applicant conference, community need should be demonstrated through quantified, verifiable information, such as Census data, SPARCS data, vital statistics, PQI's, data tabulated from the applicant's records (without patient identifiers), or data gathered from statistically valid surveys.

41. We are still in the very early stages of an affiliation agreement, how much detail is required in the Financial Application? (Section 2)

    The application should describe the nature and scope of the affiliation, the services or other activities to be covered, the nature of the contemplated legally binding agreement, and the anticipated financial impact of the agreement (revenues, etc.) for each facility.

42. Technical Application Format Part A Eligible Applicant /Attachment 7. At the Applicant Conference, a suggestion may have been made by DOH that co-applicants in a multi-provider application should submit with the application an MOU or other "strong evidence of intent" to collaborate. Is this correct? If so, please advise if this evidence should be attached to Attachment 7 (which requires the co-applicant's acknowledgment and consent only) or attached elsewhere to support the Eligible Applicant's "preparation to proceed with the Project."

    Yes, the applicant should submit an MOU or other strong documentation of intent to collaborate (for example, board resolutions). This documentation would fit best with the main part of the Technical Application rather than Attachment 7.

43. Financial Application, Parts D, E, and F. If a lead applicant (Art.28 hospital) files a multi-provider application with another Art.28 hospital, is the financial information required in these sections for the lead applicant only, or should the application include financial information about each collaborating partner, since the financial viability impact, financial stability, etc. may be different for the lead and co-applicants?

It would be advisable to include as much detail as possible regarding material financial impact on all parties to the project.

44. If some of the projects included in an application are joint projects between two hospitals and other projects are hospital specific, should a multi provider application be submitted or should each hospital submit their own application and refer to the joint projects in each of their applications?

    See answer #23.

45. How detailed and firm do MOUs need to be?

    See answer #39, #41 and #42.

46. How granular should community need statistics be?

    Statistics should be by Zip code, census tract or other conventionally defined delineation. Ill-defined categories such as “neighborhood,” or “market area” are not sufficiently rigorous and should not be used.

Anti-Trust

47. Please further clarify the "anti-trust concerns" slide addressed at the applicants' conference.

    See Mr. Bienstock’s remarks on pages 21 through 27 and 38-39 of the transcript of the May 15 applicant conference.

Public Work

48. Would you please explain how Public Work requirements, Section 1.8 on page 8, apply to in-kind project contributions by Applicants?

    In the opinion of Department of Health counsel, the Public Work definition applies only to the HEAL-funded activities of a project.

Review Process

49. Section 3.4 Review Process. Are the 5 components listed under the Technical Application point allocation equally weighted and, if not, will DOH share the relative scoring weights within the 75 points? Same question for the 6 components under the Financial Application. For example, is the “overall cost” component weighted the same as the “reasonableness” or “completeness” component? (Presumably, a relatively low cost proposal scores higher than a more costly proposal, however this component is weighted.)

    The Department and DASNY do not make scoring or weighting criteria public.