

24. Community Health Care Conversion Demonstration Project (CHCCDP)

Pursuant to the original, approved New York Partnership Plan Terms and Conditions (1997), this chapter describes the State's plan for operating and monitoring the CHCCDP. On September 30, 2006, the Community Health Care Conversion Demonstration Project was completed.

Overview

In order to expand primary care capacity in New York and to accommodate the restructuring in health facilities serving the poor under a mandatory Medicaid managed care system, federal funding pursuant to the waiver included an additional \$250 million annually for the periods October 1, 1997, through September 30, 2002, and April 1, 2003, through March 31, 2004, and \$100 million for the period April 1, 2004, through March 31, 2005, to strengthen New York State's health care safety net infrastructure. Pursuant to the 1997 waiver Terms and Conditions, funds for Years 1 - 5 of the demonstration were allocated to eligible hospitals based upon a formula which measured each hospital's relative historical role in providing services to the State's Medicaid and uninsured populations. Hospitals were required to use such funds for health service delivery and workforce restructuring activities. Pursuant to the 1997 waiver Terms and Conditions, funds for years after Year 5 of the demonstration were allocated to eligible hospitals based on State established formulas and application procedures which addressed non-reimbursed hospital funding needs for graduate medical education, health facility restructuring, and health workforce retraining, and recruitment and retention.

All funds for CHCCDP programs awarded as part of demonstration years 1-5 were to follow the formulas for demonstration years 1-5. Unused funds for specific hospitals were allowed to be rolled over for use in subsequent years provided that funds rolled over from demonstration years 1-5 followed the formula for years 1-5, not the formula applicable for years 6 and 7. The only funds that were subject to the requirements and formula of years 6 and 7 were the \$350 million in federal funding awarded as part of the extension to the demonstration, not any of the funds that made up the \$1.25 billion in federal funding awarded as part of the original demonstration.

In order to receive such funds, each eligible hospital had to submit an application in each year funding was available, to the Commissioner of Health describing how funds would be used. Such applications were not required for formula based awards granted in Years 6 and 7 of the demonstration period.

Administration of CHCCDP

The CHCCDP was administered by the State Department of Health. ¹ The Division of Health Care Financing was responsible for administration of formulas specified in the 1997 waiver Terms and Conditions which established annually the list of eligible hospitals and award levels pursuant to such formulas. As of January 2007, the Division of Planning, Policy and Resource Development was responsible for any grant award determinations, and project applications, implementation, monitoring and evaluation processes required pursuant to the 1997 waiver

June 2007

Terms and Conditions. Such activities included: the development and distribution of required project application forms; administering the review and approval of such submitted applications; project contracting and monitoring; and overseeing project audit requirements.

Funding

The 1997 waiver Terms and Conditions identified State program expenditures for which CMS agreed to provide a Title XIX match to generate funds to be used annually by the State to support the CHCCDP. Such claims were not allowed to exceed \$250 million in federal funds during the first two waiver years (claims for subsequent waiver years were subject to the conditions specified below), or \$1.6 billion in federal funds over the seven year demonstration period. Such State program expenditures that exceeded the amount needed to fully fund CHCCDP in any given demonstration year were allowed to be claimed to fund CHCCDP in subsequent years. This claim was to be initiated by the State following routine Title XIX claiming procedures as specified in the State Medicaid Manual published by CMS.

All expenditures made on a cash basis for such specified programs from July 15, 1997, to the end of the waiver period were eligible for federal matching. Pursuant to the aforementioned paragraph, the State was allowed to claim such program expenditures either in whole or in part and could adjust such claims between such programs or among facilities (where applicable) to ensure that such claims were within all established federal limits and to avoid any reductions in a hospital's Medicaid disproportionate share (*i.e.*, DSH) payments which might result from including Professional Education Pool payments as a Medicaid revenue in a hospital's annual facility-specific DSH cap calculation. As specified in the 1997 waiver Terms and Conditions, to the extent that Child Health Plus (*i.e.*, CHP) expenditures were used to support the federal match for the CHCCDP, the without-waiver baseline specified in the Terms and Conditions had to include the total cost net of premium cost sharing of servicing CHP eligibles, per Attachment B of the Terms and Conditions.

The State reported expenditures that were claimed under the CHCCDP project as a separate MEG on the CMS 64. Expenditures for the CHP program appeared on line 17E and expenditures for all other programs appeared on line 25. The Fiscal Management Group within the Department's Division of Administration broke out the expenditures reported on line 25 separately in the narrative. In addition, expenditures were reported on a date of payment basis and not a date of service basis.

For the third through sixth demonstration years, the State's claim to fund the CHCCDP could exceed \$250 million per year and for the seventh demonstration year the State's claim to fund the CHCCDP could exceed \$100 million, solely to ensure that the DSH payments made within the OBRA 1993 facility-specific payment limits were not affected by claims for Federal matching funds for the Professional Education Pool. In order to ensure that the claiming of each hospital's Professional Education Pool (PEP) distribution would not diminish each hospital's receipt of otherwise allowable Medicaid DSH payments, it might be necessary, upon facility-specific DSH cap reconciliation, to make an adjustment to a previous year's submitted PEP claim across all

June 2007

facilities, inclusive of reductions to facility claims, elimination of facility claims, increases to facility claims, and new claims for facilities. This adjustment of PEP claims might make it necessary to adjust claims to fund the CHCCDP, as specified in the 1997 waiver Terms and Conditions, after DSH reconciliation. The State might make adjustments to their claim to fund the CHCCDP subject to the following conditions:

- 1) The State could adjust expenditures claimed to finance the CHCCDP at the time of DSH reconciliation for a previous period. Such adjustments were allowed to be made up to 30 months after the end of the DSH year for which the reconciliation was being made. Since our DSH periods were on a calendar year basis, for the final year of the demonstration (SFY 04-05), this means that adjustments had to be made by June 30, 2008 (i.e., 30 months after the end of the 2005 DSH year).
- 2) For the fourth years through sixth of the demonstration, Federal matching funds for the CHCCDP should not exceed \$275 million in each demonstration year for the final year of the demonstration; federal matching funds for the CHCCDP should not exceed \$110 million.
- 3) In no year could federal matching funds for the PEP exceed \$250 million.
- 4) New York State was allowed to submit claims for Federal matching funds only for expenditures that occurred during the demonstration period.
- 5) This agreement in no way affected the requirement in the 1997 Partnership Plan Terms and Conditions that, solely from Federal funds available, total payments for the CHCCDP should be equal to \$250 million in each of the first six years of the demonstration and \$100 million in the final year of the demonstration.

Appendices 24.1 (a) and (b) provide a copy of the statutory authority enacted by New York State to authorize the use of the aforementioned federal matching funds for the CHCCDP consistent with the provisions delineated in the 1997 New York Partnership Plan Terms and Conditions. The statutory authorization delineated in Appendix 24.1 (a) fully appropriated funds for the first five-year demonstration period and would be continued in each subsequently affected State fiscal year through a State reappropriation process. Appendix 24.1 (b) provides statutory authorization to appropriate funds for the last two years of the demonstration, which would also be re-enacted in each subsequent year, as needed, through the State reappropriation process.

For demonstration Years 1 - 5, hospital eligibility for a CHCCDP award was annually determined pursuant to the 1997 waiver Terms and Conditions based upon statistical data reported by hospitals through the New York State Institutional Cost Report, (i.e., ICR). The 1995 ICR was used to establish eligibility and potential awards for the first year of the demonstration. The 1996 through 1999 ICR data would be used respectively for each subsequent demonstration period. Allocation amounts were announced on or about October 1 of each demonstration year. Only those hospitals that had contracts with or were Partnership Plan

contractors would have been eligible for these funds in Years 2 through 5. Those hospitals that become ineligible for CHCCDP funding in a given year, were allowed to roll over any unused funds from a prior award for uses provided for in this chapter.

Consistent with the formula described in the 1997 waiver Terms and Conditions, each eligible hospital's first year annual award level was based upon specified inpatient reported discharges. Appendix 24.2 provides a list of eligible hospitals and award amounts for the demonstration's first year.

For subsequent years through Year 5, the 1997 waiver Terms and Conditions required that the allocation formula be modified to incorporate Medicaid and uninsured outpatient visits. The details of this revised allocation formula were to be submitted under separate cover for HCFA(CMS) review and approval prior to award determinations for the second demonstration year.

For the last two years of the demonstration period, payments under CHCCDP were to be provided to hospitals which qualified for formula-based or grant awards authorized through State law which were targeted to subsidize non-reimbursed hospital expenses for graduate medical education, health facility restructuring, and health workforce retraining, recruitment, and retention. Procedures for identifying eligible hospitals and applicable award levels were prescribed through authorizing State law or Requests for Proposals issued to solicit any required grant applications.

Only those public and voluntary hospitals which possessed a New York State Article 28 General Hospital Operating Certificate during the applicable demonstration year were eligible for receipt of CHCCDP awards. Eligibility for and calculated award amounts attributable to those general hospitals which possessed a hospital operating certificate during any cost report year used to establish eligibility, and who have since lost or forfeited such certificate, might have been made available to another hospital. However, their previously licensed services must have been transferred through merger/ acquisition/ corporate affiliation, to that existing hospital. Calculated award amounts attributable to those general hospitals which possessed an operating certificate during any applicable cost report year used to establish eligibility, and who have since lost or forfeited such certificate but have not transferred licensed services through merger/acquisition/corporate affiliation, should have been reallocated to all of the remaining applicable eligible hospitals.

Use of Funds During Demonstration Years 1 - 5

As stated above, among the goals of this demonstration program were: to support worker retraining, expand primary care capacity and increase provider readiness for managed care. Funds were allocated such that hospitals getting over \$1 million had to spend at least 25% of their award on worker retraining and the remainder on primary care capacity development and improving readiness for managed care. Hospitals with awards less than \$1 million had to spend at least 10% on worker retraining and the remainder for primary care capacity development and

June 2007

readiness for managed care. Lesser percentages of the award were to be allocated to worker retraining in the event that the hospital's ability to expend the full allocation for worker retraining in any given award year/cycle was jeopardized by the 25/10% thresholds. For every year the 25/10% thresholds could be met by the hospital, the hospital could seek labor union support for a reduced worker retraining percentage allocation. To effectuate a reduced percentage, the hospital and labor unions had to agree on a new percentage allocation, subject to State final review and approval. To satisfy the requirement for obtaining labor union agreement, the following conditions had to be met. The hospital had to obtain a written statement from the labor unions outlining labor union agreement to the lower percentage allocation for worker retraining. The hospital had to retain this written statement in its records. Further, this written statement had to be submitted by the hospital to the State along with a proposal outlining the proposed reduction in the worker retraining percentage, the new percentage to be spent on worker retraining, and how unspent funds would have been re-allocated and spent to support the expansion of primary care capacity or increased managed care readiness. The State retained the final authority to approve or deny any such proposed change to worker retraining allocations. The application guidelines established a 10 percent cap on administrative costs; however, hospitals were allowed the flexibility to include such costs as either a separate component or as part of the individual program areas.

The specific requirements in each of these areas are discussed below:

I. Support Worker Retraining

This component of the program was intended to support training that would lead to a system wide shift in jobs of the health care workforce. This program retrained workers at risk of job-loss due to downsizing for jobs in growth occupations, e.g. primary care. Priority for retraining was to be given to workers in non-managerial jobs.

New York believes that training can best be accomplished on a large scale with experienced entities rather than on a hospital by hospital basis. Applicants were required to work through experienced training entities. Examples of experienced training entities are training funds sponsored by unions, trade associations, the Consortia for Worker Education, and universities. These training entities could submit an application on behalf of the hospitals provided the hospitals included a letter in the application stating their partnership with the training entity. Exceptions could be made in cases where there was no available experienced training entity in an area or for unique programs worthy of testing on a small scale. In addition, applicants had to demonstrate, through letters of support, that their worker retraining proposal had the support of labor and management.

II. Expand Primary Care Capacity

This component of the program was intended to expand primary care capacity to meet the needs of Medicaid managed care. In many areas of the state, the delivery system had excess inpatient capacity and a lack of integration among inpatient and outpatient providers. To expand primary

care capacity, New York intended to build on the existing infrastructure and to promote integration and networking among providers.

Applicants were required to fully utilize the existing infrastructure to expand primary care capacity. This might include redesigning hospital outpatient departments/clinics, converting inpatient space to primary care and partnering with existing community based providers (*e.g.* FQHCs, school-based health clinics, and local health departments).

Applications for new construction would be considered only in those areas that could demonstrate a lack of existing infrastructure that could be renovated or converted and the lack of existing community based providers to include in the network. The State might consult with outside experts to make these determinations.

III. Increase Provider Readiness for Managed Care

This component of the program was intended to increase provider readiness for managed care. Activities supported could include (1) educating providers and consumers about managed care; (2) improving internal systems, such as information systems, patient intake, and quality assurance; and (3) working with community based organizations on outreach, health education and other health promotion efforts.

IV. Application Process

The Department of Health developed a streamlined application process. Each qualifying hospital was notified in writing of the amount of its first year award and was required to complete an application (attached, Appendix 24.3) which guided the hospital through the priority objectives of the demonstration program and which required a detailed line item budget. Applications had to be accompanied by a certification form signed by the Chief Executive Officer or the Chief Operating Officer of the hospital. During each year of the demonstration, sample hospital applications had to be forwarded to HCFA (CMS) for review.

Hospitals were required to complete applications for each year they were eligible for funding. The year 2 applications were distributed to hospitals in November 1998 with subsequent years' applications provided each November for the duration of the demonstration. The application was due to the DOH within eight weeks. Applications were reviewed as they were submitted and could be submitted before the eight-week deadline. Late applications were not considered. Funding in years 2-5 was dependent on the hospitals achieving year 1 objectives. The year 2-5 applications were modified to include measures of success in meeting the prior years' objectives. The types of information on past year achievements that were required are:

- Information on the number and type of workers being retrained and those who successfully completed retraining.
- Documentation of how facilities improved access to primary care for Medicaid and uninsured patients.

- Documentation of improved readiness for managed care (e.g., information systems, provider and consumer education).

V. Review Process

A streamlined application review process was also planned. Since the demonstration program was non-competitive, hospitals were encouraged to consult with their neighboring applicants, community-based providers and DOH staff as they developed their plans. Applications were reviewed by a DOH team consisting of representatives of the Office of Managed Care (now known as the Division of Managed Care and Program Evaluation), the Office of Medicaid Management (now known as the Office of Health Insurance Programs), the Division of Health Care Financing and the Division of Planning, Policy and Resource Development.

The review process would judge the consistency of the application with the goals of the demonstration and the applicant's plan to accomplish the project objectives. Any issues arising from the review would be addressed directly with the applicant institution and DOH staff would work with the applicant to modify the proposal if necessary. Contract awards would be made which incorporated the applicant's budget and work plan into the contract document.

VI. Audit Process

The DOH has a well-established contract monitoring process which was applied to the projects funded under this demonstration. Projects were monitored from both a fiscal and programmatic perspective. Hospitals claimed reimbursement on a quarterly basis for expenditures consistent with their budgets. These quarterly vouchers had to be accompanied by quarterly project status reports. Both the expenditure information and project report had to be reviewed and approved by DOH staff before payment was authorized. In addition, contract hospitals could be site visited which would include a review of documentation to support vouchered expenditures and reported program activities. The monitoring activities would be used to determine whether the hospital continued to receive funding in subsequent years. Program and fiscal monitoring were conducted by the DOH central office in Albany.

Use of Funds during Demonstration Years 6 and 7

Through the adoption of the Health Care Reform Act, New York State authorized a number of programs which were carefully structured to address special funding needs of hospitals during the proliferation of a more competitive managed care environment. Such programs provided both formulaic and grant funding for critical initiatives undertaken by hospitals which were not reimbursed in rates negotiated or established by third-party payors under current State law. Recognition of these costs is integral for preserving critical services rendered by many "safety-net hospitals" throughout the State.

CHCCDP funding approved for Demonstration Years 6 and 7 was used to help support these

June 2007

program initiatives. Funding objectives included: 1) subsidizing hospital graduate medical education expenses, which included payments for innovative medical education models, to help improve the competitiveness of teaching hospitals in obtaining contracts and negotiating rates with non-public third-party payors; 2) supporting the restructuring of service delivery systems, network arrangements, and other business strategies for hospitals experiencing financial difficulties in an effort to improve the long-term stability of needed institutions; 3) issuing grants to hospitals to support worker retraining initiatives which were necessary to respond to systematic changes in service delivery needs and associated health care business practices; and, 4) subsidizing unreimbursed salary expenses incurred by certain “safety-net hospitals” which were necessary to recruit and retain non-supervisory health care workers in our constrained health care labor market. The following provides a more detailed description of procedures employed by the State for administering these programs. In January, 2007, the Division of Health Facility Planning in the Office of Health Systems Management took over the application/contract process.

Graduate Medical Education

State law authorizes \$493 million of annual formulaic payments to teaching hospitals to help subsidize graduate medical education expenses which are otherwise not reimbursed by third-party payors. Within this amount, \$462 million are disbursed directly to teaching hospitals to subsidize graduate medical education costs which are not reimbursed by third-party payors. The purpose for this subsidy is to ensure the competitiveness of teaching hospitals in negotiating contracts and rates with non-public third-party payors as we transitioned from a regulated to de-regulated ratesetting system. The formula used to establish each teaching hospital’s share of this aggregate annual award is specified in Section 2807-m of the NYS Public Health Law. Distributions are made monthly up to the annual total of \$462 million.

The remaining balance of \$31 million is annually allocated through a regulatory formula to teaching hospitals, or their consortia, to foster reductions in graduate medical education programs and/or residents, increase the number of residents training in underserved areas and ambulatory care facilities, increase training of minority residents, and improve the quality of such training programs. Distributions are made each year to eligible teaching hospitals or consortia following consultation with a Statewide Graduate Medical Education Council and adoption of regulations necessary to implement Council formulaic recommendations for the applicable annual award period.

Health Facility Restructuring

Section 2815 of the NYS Public Health Law authorizes the establishment of a \$20 million annual Restructuring Pool which provides loans and grants to not-for-profit hospitals to assist them in the development and implementation of business plans for addressing service delivery strategies, long-term debt obligations, and other facility planning endeavors targeted at improving the long-term financial stability of the institution.

June 2007

The Restructuring Pool is administered by the Dormitory Authority of the State of New York pursuant to a Memorandum of Understanding entered into with the Department of Health. Project funding determinations are based upon the filing of an application by a hospital which is reviewed and evaluated by both State agencies pursuant to the aforementioned agreement. Upon approval of such application, project scope, objectives and payment terms are delineated in a contract administered by the Dormitory Authority.

Health Workforce Retraining

Section 2807-g of the New York State Public Health Law authorizes the Department of Health to make grants to health care facilities, their trade associations, health worker unions, and labor management committees to support training and retraining of health care employees to respond to systemic changes in health workforce demands. Grant applications are competitively filed and evaluated on a regional basis in response to Requests for Proposals issued by the Department.

Funded projects can include: 1) assessments to help determine training needs; 2) remediation instructions in basic reading and math; 3) completion of requirements for a general equivalency diploma; 4) basic skills development; 5) reorientation; and, 6) skills and educational enhancements. Projects are initiated and funded following execution of a contract administered by the Department of Health. State law authorizes approximately \$41 million annually to fund such grant applications.

Health Workforce Recruitment and Retention

Section 2807-c of the New York State Public Health Law authorizes formula-based awards to major public general hospitals to help them recruit and retain non-supervisory and direct patient care employees. Such eligible hospitals must submit a certification attesting that these funds will solely be used for this stated purpose as a condition of receipt.

An aggregate amount of \$82.5 million was made available to support this program.

**24. COMMUNITY HEALTH CARE CONVERSION DEMONSTRATION PROJECT
(FHP)**

Same.

June 2007