



State of New York Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Safety Net Appeal Form Instructions

Application due 8/27/2014

There will be no extensions for the application. Any form submitted past the due date will not be considered. Also, Only MEDICAID providers will be considered.

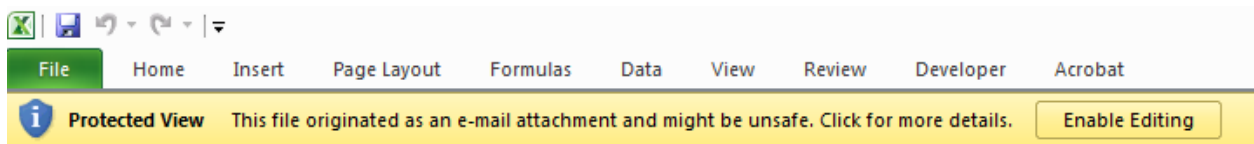
These are the instructions for the DSRIP Safety Net Provider appeal process. Please review the DSRIP Safety Net Provider lists on the [DSRIP Website](#). If your organization is not included on the safety-net list pertaining to its provider type, or your organization believes that the eligibility determination on the list is inaccurate, please use this process to submit an appeal.

This appeal form is NOT for entities who are looking to pursue the DSRIP Vital Access Provider (VAP) Exception. If your organization is interested in pursuing the Vital Access Provider Exception, information on that process will be forthcoming.

Please see the DSRIP website for provider listings and additional information on the Safety Net Definition: http://www.health.ny.gov/health_care/medicaid/redesign/dsrp_safety_net_definition.htm

General Instructions: These are the instructions to the DSRIP Safety Net Appeal Form. Please read all instructions. If you have further questions, please submit them to BVAPR@health.state.ny.us with “Appeal Facility Name – DSRIP Safety Net Appeal” as the subject.

- Please complete the form in Microsoft Excel format and submit it with an e-mail to BVAPR@health.state.ny.us by 5 pm on **August 27, 2014**. Please use “Appeal Facility Name – DSRIP Safety Net Appeal” as the subject line.
- There will be no extensions for this application. **Any application submitted past the due date will not be considered.**
- Only enter information in the shaded grey cells; if information has been entered, the cell will turn white.
- The narrative section has size limits, so please be concise in your answers. This section is limited to 2,500 characters. Additional information may be also attached to the email in PDF format only. If there is a need to refile or file a cost report, please follow the normal procedures for filing that report with the respective agency (DOH, OMH, OASAS, or OPWDD). The report must be submitted by August 27, 2014 to be considered for the safety net definition.
- The application is formatted to be compatible with Excel 2007 and higher versions. If you use an older version of Microsoft Excel, the drop down menus may not work. If you have issues with this format, please submit your concerns to BVAPR@health.state.ny.us.
- 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 your application.



Safety Net Definition: Below are the criteria for the various provider types to determine if they qualify as a Safety Net Provider. There are separate definitions for Hospitals and Non Hospital Based Providers:

Hospitals

A hospital must meet one of the following three criteria to participate in a performing provider system:

1. The first criterion is if the facility is designated as a public hospital, Critical Access Hospital or Sole Community Hospital.

OR

2. For the second criterion, hospitals must pass both tests A and B.
 - A. At least 35 percent of all patient volume in their outpatient lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.

AND

 - B. At least 30 percent of inpatient treatment must be associated with Medicaid, uninsured and Dual Eligible individuals.

OR

3. Must serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. The state will use Medicaid claims and encounter data as well as other sources to verify this claim. The state reserves the right to increase this percentage on a case by case basis so as to ensure that the needs of each community's Medicaid members are met.

Non Hospital Based Providers

1. Non-hospital based providers must meet one criteria. Non-hospital based providers, not participating as part of a state-designated health home, must have at least 35 percent of all patient volume (utilization or units of service) in their primary lines of business must be associated with Medicaid, uninsured and Dual Eligible individuals.

Section I: Medicaid Provider Verification: Please enter yes or no based upon the services you provide. **Only Medicaid Providers will be considered as safety net providers.**

Section II: Appeal Applicant Information: Please enter the requested information in the appropriate boxes.

- The **Organization Name** should be the **full legal name** of the appeal applicant as on file with the licensing agency (DOH, OMH, OASAS, etc.)
- **Provider Type:** Select the lead applicant's provider type from the drop-down menu. If your provider type is not available from the drop-down, please select "Other" in the drop down and use the text box "Provider Type – Other" to enter in your provider type.

- **Entity ID:** Enter your organizations Entity ID.
- **OPCERT:** Enter a certain identifying code depending on your designation:
 - OPCERT Providers: Enter the Operating Certificate Number. This is a seven-digit number, sometimes followed by a letter. For example: Hospitals - 1234567H; Nursing Homes - 1234567N. Please complete one form for each operating certificate number.
 - OASAS: Enter the five-digit Program Reporting Unit (PRU) number. Exception: use 99999 if no PRU has been assigned to a program (for example, Special Legislative Grant (MIs)).
 - OMH: Enter the Operating Certificate Number for certified programs and the Facility-Unit code for noncertified programs.
 - OPWDD: Enter the Operating Certificate Number for certified programs. For noncertified programs, use the first four digits of the agency code and the last three digits from the program code. When more than one program/site is assigned to the same program/site identifier, increase the number of the last digit by one. For NYS OPTS (Program Code 0234) use the contract number replacing the starting letter of the contract number with "0" in order to create a seven-digit number.
 - LHCSA: Please enter the license (ex XXXXLXXX) number. Kindly submit one form for each license number.
- **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:** Enter your NPI number (National Provider Identifier number)
- **County:** From the drop down menu select the county in which the provider's main site is located.
- **Address, City, State, Zip:** Enter the address, city, state, zip of the appeal applicant in these fields.

Section III: Appeal Point of Contact: Based on the appeal applicant's Information in section I, please complete all the contact information requested in this section. For the phone number field, please input only the ten digits; this will be auto-formatted to (XXX)XXX-XXXX. The extension, if applicable, should be entered in the cell to the right.

Section IV: Revised Data: Please provide the required data below that will be used to determine eligibility. The data must be based upon the same reporting period that was required to be filed with the Department of Health (DOH), The Office of Mental Hygiene (OMH), the Office of Alcohol and Substance Abuse (OASAS), or the Office for People with Developmental Disabilities (OPWDD). Generally this will be for the 2012 reporting period, either calendar or fiscal year. Please fill out the data Source and year below the data.

Utilization Column:

Listed are the various units of service (Visits/Days/Hours/Discharges/Encounters) that may apply to your facility that were used to determine your provider's eligibility as a safety net provider. Please only complete the appropriate areas for your facility. Please write the unit used on each line. If you are a hospital, please use the provided blank lines for inpatient and outpatient.

HOSPITAL ONLY-County Recipients Check Box:

Please select yes or no that you serve at least 30 percent of all Medicaid, uninsured and Dual Eligible members in the proposed county or multi-county community. Only hospitals need to complete this field.

Lines of Business Columns:

- **Medicaid FFS (Non-dual):** Report the total Medicaid utilization on the appropriate statistical category for only fee for service (FFS) patients only
- **Medicaid FFS (Dual):** Report in the appropriate statistical category the units of service where the patient was eligible for Medicare and/or another insurance for the services rendered and Medicaid may or may not have had a financial liability (co-pay or deductible) related to the service rendered.
- **Medicaid Managed Care:** Report the utilization in the appropriate statistical category for all patients that were Medicaid Managed Care
- **Uninsured:** Report the utilization in the appropriate statistical category for all patients that were uninsured.
- **Medicare:** Report the utilization in the appropriate statistical category for all patients that were Medicare.
- **All Others:** Report the utilization in the appropriate statistical category for all patients that were not included in the above categories. These would include Commercial and other 3rd party insurers.

Cost Report Filing Check Box:

Please select yes or no that you filed your 2012 respective report with the appropriate agency listed. If you did not, please contact the appropriate agency to discuss your filing requirements by August 27, 2014.

Section V: Safety Net Appeal Narrative: In the text box to the right, please provide a brief statement as to why your facility meets the safety net definition as described above. The current lists on the DSRIP webpage is based upon the latest information available to the DOH at the time these list were created. This appeal process is to allow providers to request reconsideration of that determination. This section has size limits, so please be concise in your answers. This section is limited to 2,500 characters. There is a character count located at the bottom of this section for your reference.

Data Source and Year:

Please indicate the source (ex. census data, cost report) and year used to compile the data above in section IV.

Certification: Please select yes or no in the box provided and in the space provided 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.