NEW YORK STATE | Department of Health

CAPITAL RESTRUCTURING FINANCING PROGRAM (CRFP)

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Office of Primary Care and Health Systems Management

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Capital Restructuring Financing Program(CRFP)

- $1.2 billion for capital projects to enhance the quality, financial viability and efficiency of the health care delivery system in New York State embracing the goals of DSRIP.
- Fiscal Year 2014-15 appropriation. Program sunsets year 2020.
- DASNY Bond Financing.
- DOH and DASNY in consultation with OMH, OPWDD, OASAS.
- Regional Balance: Statute required funds be awarded regionally in proportion to applications received; implemented as two separate award pools, 54% NYC, 46% ROS.
- Awards Announced – March 2016; OSC approved the procurement – June 7,2016
- CRFP Contract Term – October 1, 2015 to March 31, 2021; no cost time extensions allowed.

NYS Contract Requirements

All Contracts Subject To:

- Prequalification in Grants Gateway
- Adherence to MWBE 30% Goal
- No debarment in OSC Vendor Responsibility
- Current Workers Compensation and Disability Insurance

Capital Project Contracts Subject To:

- State Environment Quality Review Approval (SEQR)

NYS Contract Requirements

All State Bond Funded Contracts Subject To:

- DASNY (or other bonding authority) Bond Counsel Review
  - Obtain real property appraisal, prior bond certificate, if applicable
  - Verify expected useful life of equipment
  - Determine if non-bondable cost can be “swapped out” against match
  - Review relocations and scope changes
- Public Authorities Control Board (PACB) Approval

DOH CRFP Contracts Subject To:

- Approved Certificate of Need (CON) for Project

Contract Status, Statistics

Of 135 CRFP Awards:

- 94 Completed Bond Counsel Review
  - Remaining 41 to be completed by end of month
- 59 Cleared fully by DASNY
- 102 SEQR approvals
- 66 Participated in Kick Off meetings
- Certificate of Need (CON) submission

Challenges

- AWARDED PROJECT MODIFICATIONS
  - To date: 20 of 135 Awardees notified DOH of project modifications:
  - 14 are relocations primarily due either to:
    - Previously identified site no longer available for lease
    - Small modification to build-out plans
    - DASNY is reviewing these 11 for need for new SEQR, other issues
  - 3 awardees have affiliated and new organizations proposed either architectural or service changes
  - 4 notifications of project expansion/cost increase, with match or offset new revenue to be verified
- **AWARDEE DELAYS IN SUBMITTING REQUESTED DOCUMENTS/INFORMATION**

New CON policies

- 115 projects traditionally would have needed to file CON application
  - 24 out of the 115 are for IT projects. We are implementing new policy to waive CON application for IT projects provided applicant submits a notice and IT checklist on NYSE-CON.
  - 23 already submitted CONs, of those 10 contingently approved.
  - 68 still need to file a CON application
    - Awardees were supposed to file a CON by 8/31, or request an extension.
    - 47 already submitted CON extension requests and have been approved to be extended no later than 12/31/16.
    - 9 have submitted CON extension request beyond 12/31/16 and decision is pending.
    - 12 have not yet submitted a CON extension request.
- **If CON not received by due date, another extension request must be submitted and signed by PPS lead and awardee.**
- **The extension request must state the impact that the delay will have on the DSRIP project and the PPS' ability to meet its performance metrics. The letter must include the anticipated date that the CON will be filed and the revised project completion date.**

PPS Responsibilities

- Engaged in, and aware of, CRFP awardee project status
- Signatory on member's request for CON extension exceeding 12/31/16
- Understand the potential impact of the need for capital project extensions, on the completion of DSRIP projects and achievement of DSRIP outcomes.
- Approve member's request for CRFP project scope and/or location change
- Complete the Regulatory Waiver & Project Tracking Tool to list the providers that will be submitting DSRIP projects that will require a CON and /or PAR application, as well as the providers that you would like linked to each approved regulatory waiver. The Regulatory Waiver & Project Tracking Tool can be found on the Digital Library and are due back from the PPS by **November 8th, 2016**.

Single vs Separate & Distinct Providers

- Integrated Services Provider
  - A single provider billing 2 Evaluation & Management Codes on the same date of service

- Co-location and Shared Space
  - Two distinct/separate provider organizations (separate corporate structures)

- The specific model for each situation need to be known to respond with accuracy.

Integration Models and Approaches for Different Providers

- Co-Location
- Shared Space

Co-Location

- Co-location - Arrangement where two or more providers are located at the same physical address, but are not sharing any physical space.

- Co-located providers :
  - may share public space within a building that is accessible to patients of all providers. These spaces include entrances, exits, atria, elevators and staircases.
  - may not share or commingle staff. Individuals may be employees of both providers, but their schedules must not overlap.
  - CMS has indicated that FQHCs that share waiting rooms with other co-located providers may be approvable on a case by case basis

Co-Location

- Examples of co-located arrangements include:
  - a office building with a common atrium and elevator bank that houses multiple providers, each in their own suites.
  - The “medical village” concept as a model for an integrated delivery system.
  - a general hospital leasing a floor of the hospital to an FQHC 24 x 7
  - an FQHC co-located with an Article 31 Mental Health Clinic, each with its own distinct physical space

Shared Space

- Shared Space- Arrangement where two or more providers work together to deliver care by sharing physical space
- Federally designated providers such as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) or Ambulatory Surgical Center (ASCs) may:
  - lease or share space from another provider as long as use is temporally distinct.
  - may share clinical space such as exam rooms and non-clinical space such as bathrooms, or reception areas, as long as use is temporally distinct.
- Hospital and Hospital Extension clinics may not share space with another entity. They may co-locate with another provider by leasing space to that provider who uses space “24/7”.
- State-only licensed or certified Article 28, 31 and 32 provider may share space as long as patient safety is protected, patient is aware of which provider they are seeing, and are in compliance applicable State/Federal law.

Shared Space

- Examples of shared space arrangements include:
  - An FQHC that is open Monday, Wednesday and Friday and leases their space to a private practice on Tuesdays and Thursdays.
  - State licensed Article 28 (D&TC) and Article 31 clinic sharing a common waiting room and receptionist.
  - A private practice and an Article 32 sharing an examination room.

Co-Location and Shared Space

Provider Type	Co-Location Arrangement	Shared Space Arrangement
Ambulatory Surgical Centers	Providers may lease/share space with an entity provided that the physical and clinical space are separate. Public spaces within the building may be accessible to patients of all providers (i.e. shared entrances, atria, elevators, and staircases). Patients may not travel through the clinical space of one provider to get to another.	Providers may lease/share space with an entity as long as the space is not used by both at the same time. Shared space use must be "temporally distinct".
Federally Qualified Health Centers & Rural Health Clinics		
Hospital & Extension Clinics		Hospitals & CAHs may not share space in general, but federal policy allows for leased space that is under the control of the lessee "24/7" and is accessible without passing through the clinical space of another provider.
Article 28, 31 & 32 State Only Provider (non-federally designated)	Non federally-designated providers may co-locate in a setting and may share waiting rooms provided patient safety is protected, signage is clear, and all local, State and Federal laws are followed.	Non federally-designated providers may share both physical space, including clinical and non-clinical space.

Shared Space Medical Records

- Providers in a shared space arrangement may share or integrate medical records and treatment information with each other to the extent permissible under State and Federal law.

- Providers should only be able to access protected health information of their own patients.
  - Each provider patient records should be secured (e.g., locked file cabinet, password protected).
  - Providers may use a shared electronic health record platform, however, paper records may not be stored together.

Shared Space Reimbursement

- Different providers rendering care at a shared location will be responsible for their own claims submission to cover care delivered on that date of service.

- Payments will be processed separately for each provider through the APG grouper/pricer and paid in accordance with the APG pricing rules associated with services normally billed under that rate code.

- Beginning with the second year of implementation, value based payments are eligible to be made to providers that achieve integrated medical records for their shared patients.

Who to contact with questions

- Both DOH and DASNY are committed to providing clarification where needed or to answering questions. If you are in need of assistance or have questions, please contact your DOH Contract Manager at CRFPGRANTS@health.ny.gov.
- Please identify your project and provide specific details regarding your project and question. We will respond as quickly as possible.

QUESTIONS??