GENERAL INSTRUCTIONS

This application form should be used by Managed Long Term Care (MLTC) plans in the New York City area seeking consideration, on behalf of Personal Care and Home Health Aide providers, to participate in the Quality Incentive / Vital Access Provider Pool (QIVAPP) Program.

Reference Material

The following reference materials may be of assistance when completing this application:

- Dear Administrator Letter - Quality Incentive / Vital Access Provider Pool Program 4/23/2014 available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-04-23_dal_qual_incent_vap_pool.pdf

Instructions to Attachments

In addition to these general instructions, instructions for the completion of specific portions of the application also are included within the application itself on page 3.

Submission Requirements

Submit one copy of the application and related attachments to:

Hcworkerparity@health.state.ny.us

Subject line: QIVAPP Application

The application must contain either an electronic signature or the original signature authorizing the application by the Health Plan President or CEO.

Acknowledgement/Completeness Review

The Office of Health Insurance Programs will acknowledge receipt of the application in a letter to the applicant. If the application is determined to be incomplete it will be returned for revision and resubmission. All applications, to be considered, must be fully completed and submitted by **September 2, 2014**. Applications that do not meet this criteria will not be considered for QIVAPP pool payments.

As part of the review process, applicants should be aware that additional information may be requested.

Whom to Contact for Assistance

Any questions concerning the application process should be directed to the Office of Health Insurance Programs, New York State Department of Health by e-mail at Hcworkerparity@health.state.ny.us

I. IDENTIFYING DATA

Instructions

Enter the name and address of the MLTC plan as it appears on the Certificate of Authority (COA).

Enter the name of the person who is assigned to provide additional information regarding the application.

The authorizing signature can only be the President and/or CEO for the MLTC plan.

THE INDIVIDUAL DELEGATED AUTHORITY BY THE APPLICANT TO SUBMIT THE APPLICATION MUST SIGN THIS PAGE.

Name of MLTC: ______________________________

Address: ______________________________
STREET

______________________ ________ ________
CITY STATE ZIP

Telephone: ______________ MLTC Plan MMIS ID: ______________

Name of Person to Contact for Additional Information: ______________________________

Address: ______________________________
STREET

______________________ ________ ________
CITY STATE ZIP

Telephone: ______________ Fax #: ______________ E-mail: ______________

Authorizing Signature

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto, is accurate, true and complete in all material aspects.

Name (print or type): ______________________ Date: ______________

Signature: ______________________ Title: ______________

II. PROJECT NARRATIVE

In the space provided below, briefly describe how you intend to disperse the QIVAPP funds.

Description:

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III. PROGRAM ANALYSIS

Indicate in the attached Excel document (Attachment 1), the providers your MLTC contracts with for the provision of Home Health Aide and Personal Care Aide services. Only include providers that operate in at least one of the Five Boroughs (New York City) and meet the criteria in accordance with the April 23, 2014 Dear Administrator Letter - Quality Incentive / Vital Access Provider Pool (QIVAPP) Program. Additionally, plans can only consider those providers that meet the following:

1. Are offering a training program beyond the current Department of Health minimum requirement.
2. Have negotiated an hourly rate of at least $18.50 **prior to the application deadline**, as this is the minimum standard for providers to qualify as a QIPP.

Attach all required documents as directed in the April 23, 2014 QIVAPP Letter. Plans are encouraged to share these documents with their providers as they see fit.

In addition, we are requesting that you collect the following information on your contracted providers and submit it on Attachment 1:

1. What hourly rate was established with this provider as of 4/1/2014?
2. What are the actual hours provided to plan enrollees from 4/1/2014 to 5/31/2014?
3. What are projected hours to be provided to plan enrollees from 6/1/2014 to 3/31/2015?
4. Indicate the total number of current and projected hours by provider from 4/1/2014 to 3/31/2015, that meet the criteria for QIVAPP participation

This information is necessary to determine which entities meet the qualifications for the QIVAPP dollars.

Please note, for all non-union providers, you must meet or exceed what is offered in the attached sample benefit package to qualify (Attachment 2).