



**Quality Incentive Vital Access Provider Pool (QIVAPP) Webinar
Frequently Asked Questions (FAQs)
April 29, 2015**

This document responds to and clarifies questions raised during the April 15, 2015 Quality Incentive Vital Access Provider Pool (QIVAPP) webinar. The QIVAPP materials are posted on the DOH/MRT 61 website. In addition, please consult all previously posted materials in conjunction with the following FAQs. If you have any questions regarding this information, please email to the following address: hcworkerparity@health.ny.gov

General QIVAPP Questions

1. Q: If we submitted all requested documents, and meet all criteria, will we be receiving QIVAPP money?

A: MLTC plans are responsible for submitting the required documentation to the Department on behalf of the eligible providers, therefore, QIVAPP funds will only be disbursed to providers that have met the eligibility requirements.

2. Q: If a LHCSA offers comprehensive health benefits to its aides, but most of the aides waive it, does the LHCSA still meet the QIVAPP requirement that, "The QIPP participates in a health benefit fund for their home health care and/or personal care aides and/or provides comprehensive health insurance coverage to their employees."?

A: A minimum of 30% of an agency's total workforce, must be enrolled in the health benefit.

3. Q: If a LHCSA offers comprehensive health benefits to its aides, but does not meet all the requirements outlined in the "Sample Qualified Incentive Pool Provider Health Benefit" (Attachment Two) document, posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2014-06-13-benefits_overview_qivapp_application_attach2.pdf, can the LHCSA still be considered to meet the "comprehensive health insurance coverage" requirement?

A: See webinar slide number 11 available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/ohip_qivapp_ppt-final_04142015.pdf.

4. Q: This week, LHCSA's are receiving QIVAPP payments from plans – how was this payment calculated, i.e.: what dates of service / timeframe was used to calculate the hours provided /projected? Please advise so our plan can internally reconcile our receipt of QIVAPP funds from plans this week.

A: See webinar slide number 15 for payment calculation available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/ohip_qivapp_ppt-final_04142015.pdf.

5. Q: I just participated in your excellent Webinar re: QIVAPP. I have a question about how “LHCSAs must work with their MLTCs”. What can be done if one particular MLTC does not seem to be very cooperative? We have QIVAPP approvals from 20+ MLTCs, why should this one be different? What is our recourse?

A: The QIVAPP amounts that are determined by the Department and subsequently passed through to the plans are monitored by the Department. LHCSAs have a responsibility to work with their plans to ensure that all required materials were submitted to the plans for QIVAPP consideration. Additionally, the validation process will include a review of all materials submitted to the plans to determine if all eligible providers were considered for QIVAPP funds.

6. Q: I would like to understand if we should be reporting based on the hours paid (hours delivered to the members) including the completion factors from our actuarial? Or should we be reporting based on the authorized hours?

A: Actual hours should be reported through February 28, 2015, with projected hours for March 1, 2015 through March 31, 2015. Projected hours from the provider should be confirmed by plans and providers utilizing authorized hours.

7. Q: Our agency has submitted all the requested information to ALL MLTCs which have requested it. We are currently contracted with 90% of the MLTCs out there. However, many MLTCs have informed us that we were not on the list of qualified providers provided to them by the Department of Health. Based on the requirements provided by the Department we do qualify for QIVAPP funds. How is it possible that we were qualified only under some plans but not on others? We provided all the plans with the same info on regarding our quality program. After speaking to the plans, I became aware that this is a problem affecting many providers, not just us. Can you please provide some clarity on this issue?

A: Initial State share awards were based on original application materials submitted by plans with supporting documentation by September 2, 2014. Eligibility was determined by each plan independently. Also, additional supporting documentation submitted through December 2014 was not considered in the State share allocation. The current reconciliation process allows these providers to be considered by the plans. Also see answer #14.

8. Q: From what date should plans report hours for qualified providers if the \$18.50 rate began after April 1, 2014?

A: If rates were subsequently increased after April 1st but before September 1st, only hours paid at the qualifying level are eligible to determine QIVAPP payment.

9. Q: What time period will be used to calculate the allocation of the \$70 million QIVAPP pool?

A: The QIVAPP is a SFY15 allocation, therefore hours are determined on a SFY15 basis.

10. Q: Should hours of care provided to live-in cases be included in the reported hours for qualified providers?

A: Yes, care provided for live in cases counts toward qualifying for the QIVAPP program.

11. Q: Is the only way to exceed the in-service is by providing additional hours of In-service?

A: Yes

12. Q: Shouldn't Slide #15 should indicate 23.9 million for plan A? Is that correct?

A: Yes, the total amount was rounded.

13. Q: Since the eligibility is the same from plan to plan, why was it not accepted that if a provider qualified with one plan, they qualified with all plans?

A: Basically, we have set this up so each plan has to verify the eligibility. There may be a process for improvement down the road, but for the purpose of this program we want to make sure there is a double check with each plan that each provider is eligible.

14. Q: What were the determining factors that led to a distribution to providers in the first round of funding? Not all providers on a plan's original application received a distribution.

A: The way that the original State-shared distribution was allocated based on information received from the plans for providers with supporting documentation; in most instances it was an attestation either from the provider themselves or from a plan's attestation form that the provider met the various requirements. Any supporting eligibility documentation that was submitted by the plan, on behalf of the provider, that demonstrated all requirements were met, resulted in those hours being included in the allocation.

15. Q: According to the 1199SEIU, some agencies on our QIVAPP list do not offer health benefits; however, these agencies have provided the requisite QIVAPP attestations. Please confirm if we should continue with the pass-through of funds allocated to these agencies.

A: It is the plans responsibility to follow up with their network partners to assure whether those agencies actually meet requirements. Plans should be advised that the information they are attesting to on behalf of providers is complete and accurate.

16. Q: If an eligible provider submitted all required information and documentation to an MLTC plan but is not slated to receive QIVAPP funds from this plan, what are their options for a resolution? Who should they contact to ensure their QIVAPP information is accurate?

A: The provider should be working with their plan to try to resolve any outstanding questions or communication deficits. The first thing a provider should do is make sure the plan has all the required information and documentation.

17. Q: What is the likelihood that CMS will approve the remainder of the funding?

A: The Department is confident that there is a very high likelihood that CMS will approve this funding, they have been in the loop on the program and would alert us that they were planning on not approving it.

18. Q: Not all of our providers met the requirements. How do we return the money?

A: The Department will provide a form shortly to be completed and submitted by the plan requesting details relative to the recoupment.

19. Q: Are plans required to submit one an attestation for each provider or can plans submit one attestation for the entire group of providers?

A: An attestation is required for every provider.

20. Q: Will the Department be calculating the amount going to a specific provider or would the plan make that calculation?

A: The Department calculates it. Just as the State share was distributed, we will distribute a spreadsheet with each plans listing of providers and the allocation amount to each provider.

21. Q: Is it the intent of the Department to mandate these funds be passed on to providers in future years based on the same formula?

A: We have a commitment to this year and we are going to see how that goes before we commit to any future years.

22. Q: In regards to webinar slide # 7, Plan Attestation #2- HHA: 75 hrs. PCA: 40 hrs. "Exceed" means we have to provide 76 hr. and up/ 41 hr. and up? Providing 75/40hr. is not enough? Please clarify.

A: Correct. The requirement is for providers to offer more than the base minimum training that is required. We advise against offering just one additional hour of training, but to really think about viewing this as an opportunity to use these funds to invest in a training program which actually improves the quality of interaction in homecare. It is not just to check the box, it is really an opportunity for providers to look at your training programs and provide more than the minimum required.

23. Q: The Department asked for additional eligibility information for a portion of our providers in December. They did not receive any distribution. Will they appear in the final reconciliation?

A: See answer #1.

24. Q: If a provider was erroneously omitted from the original submission, can that provider now be eligible for the distribution on this final submission?

A: See answer #1.

25. Q: What does the \$18.50 base rate mean? Does it mean vendors are mandated to pay their aides that base rate?

A: There is no mandate, there is an eligibility requirement. Plans must offer network providers a minimum rate of \$18.50 as part of being considered as an eligible QIPP.

26. Q: Were we still supposed to be receiving the first part of the money by mid-April from the Plans?

A: Plans were expected to pass all State share allocations through to providers by April 15, 2015.

27. Q: If a plan never contacted us for QIVAPP attestation, and we met the requirements, do we have any recourse?

A: Providers should work with plans if they think they are eligible.

28. Q: Why are funds being released from the State portion if they may be recouped after the second reconciliation?

A: The intent was to get money out to the market as soon as possible.

29. Q: Should supporting documents be submitted along with QIVAPP submission on 5/1/15.

A: The supporting documentation the State needs by 5/1 is the attestation form signed by the plan for each provider and the reconciliation spreadsheet with the hours for each provider.

30. Q: How can the LHCSAs confirm the amounts they should be receiving from the MLTCs?

A: They should be talking to the MLTC plans.

31. Q: What can providers do if the plans are not working toward a resolution of QIVAPP reimbursement?

A: Communication vehicles such as email listserv are in place to voice concerns and issues. If there are particular plans that are not cooperating, Department staff are more than willing to intercede, but the first line of communication is with the plan.

32. Q: Why did DOH decide not to include providers who submitted information in August in December's initial QIVAPP calculations?

A: In order to get the funding approved and passed on to the providers, the Department had to go through the approval process prior to the request for additional documentation submitted in December. The original State share allocation was based on information collected through September. Once the approval process began, pulling back that money for the December submission was no longer an option.

33. Q: If upon validation, the documentation of the Plan is not deemed to be sufficient does the plan have any recourse to recoup from the LHCSA?

A: This all depends on what the validation indicates. If the documentation submitted to the plan is not deemed to be sufficient, then it should not be forwarded to the Department to consideration. Any recoupment activity would be between the plan and

the LHCSA in accordance with what is indicated in the contract. It would be the plan's responsibility to recoup the money from the provider.

34. Q: How can providers ensure that plans submit their homecare hour data to the Department?

A: They need to work with their plans and make sure the information is accurate and submitted by the deadline.

35. Q: The 1199 Union informed us that reimbursement for 1 hour is going to be \$ 0.43 cents, not 1 dollar for 1 hour. Is this correct?

A: Department staff are in the process of calculating those numbers to determine what the reimbursement will equate to. At this point, it is based on the reconciled hours that are submitted that is going to drive the add-on. Final value is undetermined until the reconciliation process is complete.

36. Q: If a LHCSA offers comprehensive health coverage that is in line with the QIVAPP requirements but employees decide to "opt out" of such coverage, is the LHCSA still eligible for QIVAPP funding?

A: We anticipate that most employees, if offered comprehensive coverage, will actually take that coverage. We found in previous wage parity questions submitted to the Department that there were LHCSA's were offering coverage but encouraging people to opt out of the coverage. For the purposes of QIVAPP eligibility, providers must have employees that actually take the coverage. Additionally, if the vast majority of employees decide to take the coverage, but some opt out, that would probably meet the requirement. Please see answer #2 for additional clarification.

37. Q: Will providers which receive money, once federal approval is granted, receive less money per hour for aide services than initial QIVAPP funding?

A: The pool value will be twice the amount of the State share if you are comparing it to the State share amount the provider received. The pool is doubled, so in most instances, providers should be receiving more money. It is just a matter of identifying the providers that did not meet the requirements and how that changes the hour reconciliation.

38. Q: What is a Plan's responsibility to verify/reconcile the hours that a provider verified on their attestation with what the Plan has on file? What is an acceptable variance?

A: If the plan actually paid for the hours, and the provider provided the hours, the hours should match. This questions is intimating that the hours may differ between what the plan has and what the provider has. It is the plans responsibility to attest that the hours are accurate and that the plan should have a record of the authorized hours. The first thing is to work together with the provider to make sure the information is accurate. If there is a variance, it is the plan that is attesting to it, not the provider. See answer #6 for additional clarification.

39. Q: Will the allocation spreadsheets be made public?

A: Once all of the information is reconciled, we will consider making this information public.

40. Q: Is the \$70M funding for a 9 month period or a 12 month period?

A: 12 month period.

41. Q: Actual hours provided through February 2015 and estimated hours for March 2015 must be reported. As of May 1st, not all hours have actually been billed and paid through February. How do we report estimated hours provided through February 2015?

A: See answer #6.

42. Q: Just to clarify, will the Department recoup funds from providers paid in the first \$35 million distribution to correct incorrect allocations?

A: Yes.

43. Q: For providers who do not meet all the requirements and have communicated with some of the plans who have not submitted the attestation on QIVAPP, how should this be handled and resolved?

A: All requirements must be met in order to be deemed eligible for the QIVAPP money.

44. Q: Do the amount of in-service hours that exceed the basic hours determine the amount that the provider would receive?

A: No. Providers should take the opportunity to review their training programs and improve the quality of those programs as well as the length of those programs.

45. Q: The plan requested an exception for some of the providers based on DOH instructions. For example, health benefits offered by providers do not include hearing aids or routine foot care (only medically necessary), so how will the plan know the exception request is approved?

A: We will review those exception cases and make decisions accordingly, however, the key is to offer comprehensive coverage.

46. Q: How can a LHCSA find out the amount of the distribution in any corresponding plans?

A: Providers have to work with their plans.

47. Q: Who signs the attestation form, the MLTC or the home care provider?

A: The plan signs the form, but they need to work with the provider to complete and submit on time.

48. Q: There are certain providers that the plan submitted documentation for that have met the requirements but those providers were not awarded payment. Why would that be?

A: The plan has to submit these requirements to the Department by May 1, 2015 and work with their network providers to make sure that they meet all the documentation requirements. See answers #7, #14 and #32.

49. Q: When submitting attestations for hours to the plans, should the licensed vendors account for live-in hours using 12 or 13 hours per day for the April 1, 2014 - March 31, 2015 period?

A: Live-in hours should be included in accordance with MLTC Policy 14.08: Paying for Live-In 24 Hour Care for Personal Care Services and Consumer Directed Personal Assistance Services.

50. Q: What effect, if any, will the QIVAPP federal monies have on the Medicaid cap for the 2015-2016 state fiscal year? If nothing, why?

A: Federal funds do not count in the global cap.

51. Q: What if only 20% of our employees take the offered coverage because the rest are already covered through other sources, will that make us eligible?

A: See answer #2.

52. Q: If the LHCSA offers a health plan that meets the standards, but the employees are not enrolling in the health insurance, why should the LHCSA be penalized? We cannot force employees to enroll.

A: The goal of the program is to make sure people are insured. No one can force anyone to join a health plan except the federal government under the ACA, but the goal is not to offer a plan that no one joins. The Department is not saying that providers should have to force people to join, but it is expected that the vast majority of workers would chose to enroll in a plan with comprehensive health coverage. See answer #2.

53. Q: Are there any preventative measures being taken to prevent the MLTCs from "pocketing" the funds? Who is ensuring the funds get passed through as required?

A: The plans have to attest that the requirements of the program have been met. To ensure that the QIVAPP dollars were passed through appropriately, the Department will conduct reviews and validate this process. The money should flow to the providers to invest in the home care workforce. The Department can refer questionable practices to the investigative arms of the State. This undertaking has received a considerable amount of attention, so we are confident that there are adequate preventative measures in place to make sure the money flows to where it is supposed to go.

54. Q: If the Plan requests and receives a signed attestation from a provider indicating that they have met the training and benefit requirements, will that be sufficient for the Plan to attest the provider is an eligible QIPP?

A: That is for the plan to determine. Ultimately, the plan signs the attestation. If the plan has determined that all attestations are complete and accurate, then it has to move forward those providers because they have met the requirement to qualify as a QIPP. The State will be undergoing a validation process to ensure the requirements have been

met. It is up to each plan when they sign that form to assure that their network providers who are getting QIVAPP money meet all the eligibility requirements.

55. Q: How does a home care agency get the money in April if the hour spread sheet is due by May 1st.

A: It was State share money that was put out prior May 1. The money that is being released in April is the \$35 million of the \$70 million dollar pool because the State share allocation is based on a submission from this past summer. The May 1st is the reconciliation of the \$70 million pool.

56. Q: What is the effect of having a unionized workforce on QIVAPP eligibility?

A: Having a unionized workforce does not necessarily mean all the requirements have been met.

57. Q: If a provider's rate was increased to \$18.50 on June 1 are they eligible for QIVAPP funds for hours provided effective April 1st?

A: See answer #8

58. Q: If an employee of a LCHSA works a few hours per week, must they get comprehensive insurance?

A: See answer #2.

59. Q: How long should providers wait on correspondence from the plans about the attestation and corresponding payments before reaching out to the Department? What is the scheduled timeframe for plans to obtain attestations and payments disbursed?

A: As a network provider of the plan, you should be in constant communication with your plan about the QIVAPP process and providers are encouraged to wait a reasonable amount of time before contacting the Department. If there is an issue, Department staff are available to follow up on concerns.

60. Q: We are a plan that has received questions from LHCSAs as to why they did not receive a distribution in round one while they received a distribution from other plans. Please explain how this happened.

A: There is a process to reconcile the \$70 million. In the interim, it is important to concentrate on communication between the plan and the provider and to make sure your documents are correct when you submit them on May 1. Also see answers #7, #14 and #32.

61. Q: We provided the Department with the appropriate documentation by the given deadlines. How should plans respond to inquiries from the LHCSAs?

A: See answers #7, #14 and #32.

62. Q: We have a situation where the LHCSA originally appeared qualified and so we included them on the application. After further review, we have identified that they

actually do not exceed the training requirements and are not qualified. How should we indicate this on the spreadsheet?

A: Plans should not submit an attestation or include providers on the reconciliation spreadsheet that do not meet program requirements.

63. Q: It was mentioned that there is a positive outlook that CMS will approve funds, but when does the Department expect to receive approval?

A: Our colleagues at the federal government do not have a deadline at this time. We have been working with them all along and are in constant communication with them. The Department has weekly calls on all plan amendments, but there is no actual deadline for them. We are committed to working with them to make sure that they are fully aware of the importance of this program.