NEW YORK STATE OF OPPORTUNITY. Department of Health

LTSS Workforce and Value-Based Payment (VBP) Readiness FAQs

January 12, 2022

Eligibility Determination

Q: Are all MAP and MLTCP plans participating?

A: Only MAP and MLTCP plans that are contracted with eligible LHCSAs will participate.

Q: How did DOH decide to only consider MAP and MLTCP revenue?

A: Revenue from MAP and MLTCP plans was selected because 95% of the largest LHCSAs in each region do business with these programs. In addition, the MAP and MLTCP product lines account for the majority of the Medicaid expenditures in Long-Term Care.

Q: How did DOH develop the unique revenue thresholds for each region?

A: Revenue thresholds were set at the 66th percentile of the 2019 managed care revenue received from providers by MAP and MLTCP plans in each region. Given that there is regional variation in the spread and range of provider revenue, the 66th percentile results in a different dollar value in each region.

Q: What was the basis for establishing the threshold as the top third of managed care revenue?

A: The defined provider class received 93% of revenue from MAP and MLTCP plans in 2019.

Q: How were the regions determined?

A: Regions are consistent with the four Managed Long-Term Care rate regions, which are NYC Area, Mid-Hudson/Northern Metro, Northeast/Western, and Rest of State. LHCSAs were assigned to regions based on the service location of member claims. For example, if the LHCSA billed for a member in the NYC Area region and a member in the Mid-Hudson/Northern Metro region, the LHCSA would be assigned to both regions.

Q: Did CMS approve the definition of the provider class?

A: CMS is currently reviewing our proposal, which includes a definition of the provider class. At this time, we have not yet received CMS approval, but the provider class definition has been constructed with CMS feedback.

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Payment Structure

Q: How were the provider awards calculated?

A: Provider awards were calculated based on each agency's managed care utilization during the first six months of SFY22 (4/1/21 – 9/30/21), limited to personal care services provided to Medicaid enrollees in MLTCP and MAP plans from April 2021 through September 2021. This is a requirement of the directed payment process.

Q: How many LHCSAs are included in the provider class?

A: There are 212 unique LHCSAs included in the provider class. Some LHCSAs met the eligibility criteria in multiple regions, resulting in a total of 235 awards.

Q: What is the breakdown between the regions?

A:

Region	**# of LHCSAs in Top Third**
NYC Area	154
Mid-Hudson/Northern Metro	28
Northeast/Western	30
Rest of State	23
Total	**235**

Q: Will one payment occur between January 2022 and March 2022 or will there be several? How many payments will occur between April 2022 and March 2023?

A: Depending on when CMS approval occurs, agencies will receive payments from contracted MLTCP and MAP plans by March 2022. If an agency contracts with multiple MLTCP and MAP plans, it may receive a portion of its award from each. DOH will release payment schedules once awards are finalized. Details on payments in the 2022 - 2023 rate year will be provided at a later date.

Q: Will providers be informed of when the plan has the funds, to calculate the 30-day maximum turn around?

A: Providers will be informed of the approximate date that plans should receive the funds.

Q: Will the plans be paid an administrative fee?

A: Plans will be paid an administrative fee for their role in the directed payment process.

Q: Will DOH recoup funds from LHCSAs who fail to satisfy the requirements?

A: Agencies may be subject to audit, which could result in recoupments. Agencies must keep track of spending and clearly document all award expenditures. Agencies will not be required to provide documentation in their quarterly reports but must keep documentation available until March 31, 2028.

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Spending Options

Q: What is a state-directed program?

A: A state directed payment is a means by which CMS allows DOH to direct expenditures by MCOs for specific purposes, including rate increases or quality programs. Directed payments are authorized under federal regulations (42 C.F.R. § 438.6(c)) and have been the subject of CMS guidance through a preprint process. More information on directed payment programs may be found here: https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html.

Q: Can agencies use their awards to raise wages or incentivize recruitment?

A: Agencies can use their awards to raise wages or incentivize recruitment of direct care workers and nursing staff providing, or supervising the provision of, personal care or nursing services. DOH recognizes that one of the key elements in strengthening the workforce is increasing the number of direct care workers in the system. This will require recruiting new direct care workers to the HCBS system and retaining direct care workers who are already part of the system.

Q: Some agencies have raised the base wages of direct care workers in response to the pandemic. Can these agencies use this funding to maintain this higher base wage/increase in base pay for aides?

A: Agencies cannot use the funding to pay for current or already planned expenses. Compensation increases for direct care workers and nurses providing, or supervising the provision of, personal care are only eligible if they are *new* expenses.

Q: Are signing bonuses or reimbursement of a new employee for the completion of a PCA/HHA training program that occurs just prior to their hiring allowable?

A: Signing bonuses are allowable for new employees as long as they are not being hired from another LHCSA. Reimbursement for the completion of a PCA/HHA training program that occurs just prior to the hiring of a newly certified employee is allowable.

Q: Are transportation expenses for direct care workers allowable uses of funding?

A: Yes, funding can be used to reimburse direct care workers for transportation expenses incurred as part of their job functions. Funds can also be used to secure more reliable and accessible transportation means for direct support workers. Only new or expanded programs can be funded using this award. Funds cannot be used to lease or purchase vehicles.

Q: Can funds be used toward existing programs that fit the categories or do all funds need to go to new programs?

A: Funding cannot be used to cover existing expenses or legal requirements, even if they fall into the allowable categories. Funding must be spent on new or augmented programs, services, and/or purchases.

Q: What qualifies as a new or improved program or service?

A: A new program or service is one that is not currently being offered by the agency or required by law. For example, if an agency does not currently offer health insurance to direct care workers, providing health insurance would qualify as a new expense. An

improvement to a program or service would involve an agency augmenting, expanding, or updating a program or service that it already provides. For example, an agency might expand transportation assistance for only full-time staff to also include part-time staff. These funds must be allocated to the expansion.

Q: Is diversity focused explicitly on linguistic groups and ethnic groups, or may it include other demographics that may be relevant to an agency (e.g., gender)?

A: Diversity is not limited to linguistic and ethnic groups. It can include other demographics, such as gender.

Q: Can agencies use this funding to hire consultants to help implement new programs and strategies?

A: Funding can be used to pay for consultant fees as long as the scope of work being covered is strictly focused on one of the approved investment areas.

Q: Can agencies use this funding to pay for capital expenses that further one of the approved investment areas?

A: Capital expenses, excluding technology software investments, are not allowable uses of this funding.

Q: Can funding be used for Consumer Directed Personal Assistance Program (CDPAP) expenses?

A: Funding cannot be used for CDPAP expenses. However, you can invest in technology to improve matching between staff and service recipients for your LHCSA services.

Q: What investments require individual approval from DOH?

A: Only investments that do not fall within an area or category provided in the guidance require individual approval from DOH. To request approval for an investment that is not included in the guidance, please email DOH at LHCSA.FMAP@health.ny.gov by January 14, 2022.

Q: Does DOH have a preference for awardee spending?

A: DOH shared guidance with potentially eligible LHCSAs that provides descriptions of each spending category as well as investment examples. LHCSAs have flexibility to spend their awards in ways that are most appropriate for their agencies while staying within the bounds of the spending categories DOH has identified.

Q: Is the approximate award amount listed in the award letter the exact amount that will be awarded or will the amount change? Is the budget that agencies submit final?

A: The award amount provided in the letter is approximate. Please use this amount as the basis for your budget. Agencies will be able to adjust their budgets in quarterly reports and will need to justify any changes in their spending plans.

Q: How detailed does the spending plan narrative need to be?

A: The narrative should provide a comprehensive overview of your spending plan but does not need to include specific details such as vendor names. Narratives should be as accurate as possible, though changes can be made in subsequent quarterly reports.

Q: Agencies must implement their efforts in the regions in which they qualified for funding and may use the funding to implement efforts across their full New York service area. Does this mean that an organization can set up programs in regions where they are licensed even if they did not receive funding for that region?

A: Agencies must spend in the regions for which they were awarded funding, but do not have to spend all of the funding in those regions. Agencies may spend funding in regions where they did not receive funding. For example, an agency may offer a new training program across all their licensed counties despite only receiving funding in one region.

Metric Tracking and Survey Access

Q: Will all LHCSAs complete the survey?

A: Only eligible LHCSAs will complete the survey.

Q: What time period should the data provided in survey responses cover?

A: Unless otherwise stated, please use current, or the most recent, data to answer survey questions.

Q: My organization also provides Consumer Directed Personal Assistance Services (CDPAS). Should I include workforce data for this program in my survey responses?

A: Survey responses should only include data regarding LHCSA services. If your agency operates other programs or services, they, and relevant staff, should be excluded from your survey responses.

Q: How many hours are considered full-time?

A: The number of hours that qualify an employee as full-time is determined by individual employers.

Q: Is this survey related to any other data collection DOH currently requires?

A: This survey is separate from other data collection DOH currently requires.

Q: Who will design the spending reports LHCSAs provide to plans?

A: DOH will design this spending report and will share more information once awards have been released.

Additional Information/Resources

Q: Will DOH be holding webinars to explain this process to providers and other stakeholders?

A: DOH held a webinar for eligible LHCSAs on January 6, 2022.

Q: Is there an email to which questions can be sent?

A: Questions can be sent to LHCSA.FMAP@health.ny.gov.