

**Application for Article 44 Certified Health Plans to Participate in
Medicaid Advantage Plus and/or Managed Long Term Care
Partial Capitation Plans**

NYS Department of Health

June, 2011

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NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Bureau of Continuing Care Initiatives

MANAGED LONG TERM CARE PLAN
APPLICATION
NEW YORK STATE

FOR NYS DOH USE ONLY

DATE RECEIVED

APPLICANT

STREET ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE NUMBER (AREA CODE)

EXECUTIVE DIRECTOR OF APPLICANT MLTCP

STREET ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE NUMBER (AREA CODE)

CHAIRMAN OF THE BOARD OF APPLICANT

STREET ADDRESS

CITY

STATE

ZIP CODE

TELEPHONE NUMBER (AREA CODE)

APPLICATION TYPE: Managed Long Term Care Plan

MODEL:

PACE

Medicaid Advantage Plus

MLTC Partial Capitation

FEDERAL Employer ID# _____

TAX STATUS:

Privately Held

Not-for-Profit

Publicly Traded for Profit

Signature of Executive Director of APPLICANT

Date:

Signature of Board Chairman of APPLICANT

Date:

Signature and Title of Individual Executing Application
(If different from Executive Director)

Date:

Name of Contact Person and Phone Number

DOH-793A-MLTC

This application represents the MLTC program as it is currently structured. As the part of the Medicaid Redesign Team process, a work group has been established to evaluate the Managed Long Term Care program and recent laws that have been passed to expand enrollment. Please be aware that the program requirements may be modified as a result of this evaluation.

Section I. Overview of Medicaid Advantage Plus and Managed Long Term Care Partial Capitation

This application is used for Article 44 certified health plans who want to participate in Medicaid Advantage Plus (MAP) and/or MLTC partial capitation plan. Article 44 certified health plans wishing to participate in the Program of All Inclusive Care for the Elderly (PACE) can find the application and more information on the CMS website at: http://www.cms.gov/PACE/01_Overview.asp#TopOfPage.

A. General Description

Medicaid Advantage Plus

Medicaid Advantage Plus is a Medicaid managed care program designed for individuals who are eligible for Medicare and Medicaid and also meet the criteria for enrolling in New York State's Managed Long Term Care Program. The program allows dual eligibles who meet eligibility criteria to enroll in the same health plan for most of their Medicare and Medicaid benefits. Enrollment is voluntary.

Plans that participate in the program offer dually eligible persons who meet the enrollment criteria a combined Medicare and Medicaid benefit package. The Medicaid Advantage Plus Product covers certain benefits not covered by Medicare and beneficiary cost sharing (co-pays/deductibles, and Part C premiums, if any) associated with the Medicare Advantage benefit product. Health plans receive two monthly premiums: a Medicare Advantage premium from the Centers for Medicare and Medicaid Services (CMS), and a payment from NYS that covers any Medicare supplemental premium and the premium for the Medicaid Advantage Plus services.

Some Medicaid services will continue to be available to Medicaid Advantage Plus enrollees on a fee-for-service basis. The Medicaid Advantage Plus participation standards, including the combined Medicare and Medicaid Advantage Plus benefit packages, are found in the Medicaid Advantage Plus model contract which is available on the NYS DOH website.

Managed Long Term Care Partial Capitation

A partially-capitated Managed Long-Term Care (MLTC) plan provides long-term care services, and ancillary and some ambulatory services through Medicaid capitation. Enrollees access primary, specialty, hospital and some other services on a fee-for-service basis.

Most enrollees are dually-eligible for Medicaid and Medicare. Enrollment is voluntary. Although not all Medicaid reimbursed services are covered, the MLTCs are responsible for coordinating all services, whether they are covered by the plan or available to enrollees on a fee-for-service basis through Medicaid and/or Medicare.

Acute and primary care services are reimbursed on a fee-for-service basis by Medicare and/or Medicaid. These services include: physician services; inpatient and outpatient hospital services; radiology/laboratory; mental health and substance abuse services; and emergency transportation. Since physician services are reimbursed on a fee-for-service basis, enrollees of partially-capitated MLTCPs do not need to change their existing primary care providers when they join a plan, although the physicians must agree to collaborate and coordinate services with the MLTCP. In addition, care managers are responsible for arranging and/or coordinating non-covered services with the services covered by the plan.

B. Health Plan Participation Requirements

To use this application for Managed Long Term Care, a health plan must:

- Be eligible to apply as a Managed Long Term Care plan pursuant to Article 4403-f of the Public Health Law and certified under Article 44 of the Public Health Law as a Managed Care Organization (MCO).
- In addition, to offer a Medicaid Advantage Plus the health plan must:
 - Be approved by CMS as a Medicare Advantage Plan in the service area proposed for Medicaid Advantage Plus, and
 - Offer the combined Medicare and Medicaid benefit package for the Medicaid Advantage Plus program as specified by SDOH.

Section II. Application Process

In order to qualify, health plans must complete and submit an application to the SDOH for review and approval. **This application is designed for entities that are already licensed under Article 44 of the Public Health Law as a managed care organization in New York State.** It consists of three parts: a program application; finance requirements; and, a transmittal letter.

A. Program Application

The program application consists of a number of questions contained in Attachment I of this document.

Additional participation standards are contained in the Medicaid Advantage Plus and/or MLTC partial capitation (herein will be referred to as MLTCP) model contracts which can be found on the NYS DOH website.

B. Financial Requirements

Financial Projections

A revenue and expense statement by month for the first 36 months of operation or break even, whichever is longer; and, a pro-forma balance sheet as of the date of opening and year-end for each of the projected three years. The format for the balance

sheet and revenue expense statements will be provided by SDOH via the contact information below.

Initial Rates

Please contact the Bureau of Managed Care Financing at (518) 474-5050 for information regarding initial plan rates.

C. Transmittal Letter

All applications must be accompanied by a Transmittal Letter. The Transmittal Letter must be signed by the Chief Executive Officer (CEO) or Chief Operating Officer (COO) or an individual who has been delegated the authority to sign for the CEO or COO and is authorized to make commitments on the organizations' behalf. The Transmittal Letter must contain the following:

- A statement attesting to the accuracy and truthfulness of all information contained in the proposal.
- A statement that the applicant has read, understands, and is able and willing to comply with all standards and participation requirements contained in the applicable MLTC contract.
- A statement the applicant acknowledges that, once certified, the MLTCP will provide written notice to DOH immediately upon (A) the departure, resignation or termination of any officer, member of the board, member or manager of a limited liability company or the medical director, together with the identity of the individual; and (B) the hiring of an individual to replace an individual concerning whom notice is required under (A), together with the identity of the individual hired.
- For MAP, a statement that the applicant is or is applying to become an entity determined to be an eligible Medicare Advantage Organization under Section 422.503 of Title 42 of the Code of Federal Regulations (CFR) in the service area for which it is requesting qualification to participate in Medicaid Advantage Plus; and that the applicant intends to offer the combined Medicare and Medicaid Advantage Product as described in Appendix K of the Medicaid Advantage Plus contract to Medicaid Advantage Plus enrollees.

Applications must be submitted in the following format:

- Submit application in a 3 ring binder.
- Organize application with tab dividers indentifying each section.
- Clearly number all pages of the application, including attachments, with each section of the application separately numbered and identified in the Table of Contents.
- Submit a completed DOH-793A-MLTC form and include the signatures of the individuals who are authorized to submit an application on behalf of the proposed MLTCP. An original form is required. The application must be signed by the CEO and, when applicable, the general partner (partnerships), owner (proprietorship), or chairman/CEO (public applicant). Provide the name, title and

telephone number of a contact person for matters related to the application.

- Submit 1 original and 3 copies of the application and 1 additional copy of the application in a word document format on CD or flash drive to:

**Bureau of Continuing Care Initiatives
Division of Managed Care
New York State Department of Health
Empire State Plaza
Corning Tower Building --- Room 2084
Albany, New York 12237**

Section III. Additional Information Regarding Provider Networks and Subcontracts

A. Provider Networks

Networks for certain Medicaid services covered by the plan’s Medicaid Advantage Plus and MLTC partial capitation product must be approved by the SDOH. The SDOH will defer to Medicare approved networks for Medicare covered services for MAP and will only review provider networks for the delivery of Medicaid covered services. Some services, such as Skilled Nursing Facility, Home Health Care and DME, overlap between Medicare and Medicaid and the provider network must be submitted to SDOH. The benefit package for MAP and partially capitated plans includes:

Provider Type	Provider Type
Home Health Care*	Audiology/Hearing Aides
Medical Social Services	Respiratory Therapy
Adult Day Health Care	Private Duty Nursing
Personal Care	Nutritionist
Durable Medical Equipment (DME)**	Skilled Nursing Facilities
Non-emergent Transportation	Social Day Care
Podiatry	Home Delivered/Congregate Meals
Dentist	Social and Environmental Supports
Optometry/Eyeglasses	Personal Emergency Response Service (PERS)
Outpatient Rehabilitation PT, OT, SP	

***Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)**

****DME including Medical/Surgical supplies, Hearing Aid Batteries, Prosthetic, Orthotics, and Orthopedic Footwear**

Plans that participate in Medicaid Advantage Plus or MLTC partial capitation will be required to report providers of the above covered services to the SDOH on a quarterly basis in the format determined by the SDOH.

B. Provider Agreements

If new or amended provider agreements or management contracts are required in relation to the Medicaid Advantage Plus or the MLTC partial capitation program, they must be submitted to SDOH for review and approval.

- Provider agreements for Medicaid only services must be in accordance with the Department’s Provider Contracting Guidelines for Medicaid managed care. These guidelines can be found at http://www.health.state.ny.us/nysdoh/mancare/hmoipa/hmo_ipa.htm.

- Provider contracts which transfer financial risk to providers may also be subject to review by the NYS Insurance Department under state regulation.
- Management contracts not previously approved by the SDOH must be submitted in accordance with SubPart 98-1 of Title 10 of the New York Compilation of Codes, Rules and Regulations (10 NYCRR) and guidelines issued by the Department.

Section IV. Pre-Operational Requirements

Successful applicants will be required to complete the following activities:

A. Marketing Plans, Marketing and other Enrollment Materials

Plans must have a SDOH approved Medicaid Advantage Plus or MLTC partial capitation marketing plan. In addition, marketing and enrollment materials including brochures, advertising, sales scripts, websites, enrollment/disenrollment forms, member handbooks and member notices must be approved by SDOH's Bureau of Continuing Care Initiatives.

B. Encounter Data

Participating health plans must submit monthly encounter data through the State's Fiscal Agent, Computer Sciences Corporation (CSC). Plans must establish a Provider Transmission Supplier Number and an active eMedNY exchange, File Transfer Protocol (FTP) or VPN account with CSC.

Participating plans are expected to develop processes for capturing, storing and reconciling Medicaid Encounter Data System (MEDS II) encounter data response reports. Plans also must establish access to the MEDS Home Page on the Health Provider Network (HPN) and join the MEDS II Listserve discussion forum (MEDS_L).

C. Provider ID

Health plans must complete an application to obtain eMedNY Provider Identification (ID) to offer the Medicaid Advantage Plus or MLTC partial capitation product. This application may be obtained from the Bureau of Managed Care Financing at (518) 474-5050. This requirement applies to all plans including those that already have a provider ID for other Medicaid managed care programs.

D. Provider Electronic Transmissions

After receiving a new Provider ID, health plans must establish the capacity to engage in electronic transmissions with CSC using their new ID. Plans may download the provider electronic transmission forms they need to establish appropriate access. Provider electronic transmission forms may also be downloaded from the CSC website at: <http://www.emedny.org>.

E. Plan Code and Benefit Package Code

Participating plans must be assigned a new Medicaid Advantage Plus/MLTC partial capitation Plan Code and Benefit Package Code by SDOH. Plans also may wish to request a new HPN Account Identification for staff to access Medicaid Advantage Plus and/or MLTC partial capitation rosters and daily reports.

F. Contract Execution

Participating plans must have an executed contract with the SDOH. Executed contracts must be approved by CMS before they are effective and must also be approved by the New York State Office of the State Comptroller.

**MEDICAID ADVANTAGE PLUS and/or MLTC PARTIAL CAPITATION
PLAN PROPOSAL**

Applicant Name _____

Date of Application _____

1. Service Area

List the counties and New York City boroughs in which the applicant proposes to offer Medicaid Advantage Plus and/or MLTC partial capitation and the time frame for participation in each county or group of counties.

2. Organization

- a) Identify the legal entity that will be responsible for Medicaid Advantage Plus or the MLTC partial capitation product. For MAP, state whether this is the same legal entity that contracts with CMS for Medicare Advantage. If not, explain the relationship between the two entities.
- b) Identify all entities that will be involved in the administration of Medicaid Advantage Plus or the MLTC partial capitation, including management contractors. Briefly describe the roles of each entity.
- c) Provide a list of current board members and term of office.

3. Staffing

- a) Identify by title and job description any new staff positions to be added to enable the applicant to satisfy the requirements of the Medicaid Advantage Plus or MLTC partial capitation program. If you are not proposing to add new staff, please provide an explanation of how existing staff will administer this new product line.
- b) Identify individuals and/or departments/units that will have lead responsibility for administering Medicaid Advantage Plus or MLTC partial capitation including at minimum the medical director, and those responsible for utilization management, finance, marketing, management information systems and regulatory compliance and quality improvement.

4. Implementation Schedule

Provide an implementation schedule with target dates outlining the major steps that the applicant will take to prepare its organization for participation in Medicaid Advantage Plus or MLTC partial capitation.

5. Network Development and Subcontracting

Consumers must be offered a choice for each type of provider. Plans must have a network of providers that have specialized expertise serving the target population including any special populations. Consideration will be given to development of networks based upon the availability of providers in the proposed service area.

- a) If applicant is proposing to use its existing contracted provider network to provide Medicaid Advantage Plus or MLTC partial capitation members the services in Section III A., check here _____ and complete the network attestation in Attachment II.

Provide a copy of the proposed notice to providers informing them about their obligation under their existing contract to provide services to Medicaid Advantage Plus and/or MLTC partial capitation members.

- b) If applicant is proposing to enter into any new contracts with providers for any of the services in Section III A., check here _____, and provide the following:
- a copy of the contract(s) for SDOH review and approval. See Provider Contract guidelines at www.health.state.ny.us/nysdoh/manicare/hmoipa/hmo_ipa.htm.
 - a list showing the name, address, telephone number, type of service and county of participation for each new provider; and
 - a completed attestation in Attachment III.

Note: If applicant is proposing to use its already contracted network and add new providers, check both 5(a) and (b) above and complete and submit both attestations.

- c) Identify any new management contracts the applicant proposes to implement in relation to the new product. Submit any new contracts to the SDOH for review and approval. Refer to Section 98-1.11, paragraphs (h) through (s), of 10 NYCRR.
- d) Explain how the applicant will monitor and maintain networks to ensure adequate access and availability of covered services for the enrolled population. Identify the access standards that the applicant proposes to use.

6. Ability to Identify Changes in Member's Eligibility Status

The applicant must report to the appropriate Local Social Services District any change in status of its enrollees which may impact the enrollee's eligibility for Medicaid, Medicaid Advantage Plus or MLTC partial capitation within 5 business days of knowledge of such a change including a change in their Medicare Advantage enrollment status. Describe the mechanism the applicant will use to monitor any change in status of its enrollees in order to meet this operational requirement. State the type of data that will be reviewed and the periodicity of the reviews.

7. Enrollment and Disenrollment

Describe the enrollment process. Include in the description the following:

- Eligibility criteria
- Process for identifying ineligible applicants
- Process for denial of enrollment
- Steps to be taken if application is withdrawn by the applicant
- Identify how the plan will ensure the enrollment is an informed process for the applicant
- Provide a proposed enrollment agreement
- The timeframe for completing the assessment after the referral is made
- The qualifications of the staff performing the assessments
- The criteria or other guidance provided to staff for developing the care plan
- The process for ensuring the completeness and accuracy of the assessment forms and the appropriateness of the treatment plan
- The instruments that will be used (in addition to the Semi-Annual Assessment of Members (SAAM) required by SDOH) to assess needs and risk level.

Provide a description of the disenrollment process from the plan. Include in the policy reasons for disenrollment and the procedure for voluntary, involuntary disenrollments and a spenddown/surplus policy to include disenrollment criteria for non-payment of spenddown/surplus.

Enrollment/Disenrollment policy and procedures and the forms and notices the applicant intends to use to inform members of plan actions must be submitted and approved prior to the readiness review. A general list of forms and notices is included in Attachment 2.

Applicants that are currently operating a Medicaid Advantage Plus or MLTC partial capitation program and intend to use the same processes and procedures for the new plan as approved may so indicate.

8. Care Management

Care management is a critical component of the MLTCP. Provide a detailed description of the care management model and of how the applicant will provide care management to its members. Include the following specific information:

- The plan's approach to providing care management to its members that assures that needs are identified, linkages are made to needed services, members and relevant informal supports have input and feedback, services are monitored and care plans amended if goals are met or needs change. The overall approach should address health and long term care needs, behavioral health needs, as well as social and environmental needs. Include specific approaches for special populations.
- A functional and organizational description of care management. Indicate whether care management will be performed by the applicant's employees or under a contract

agreement. If under a contract, identify the name of the contractor and describe the experience of the contractor in performing similar care management programs and how the plan will monitor the contractor;

- What type of personnel will provide care management for the plan? What are the qualifications of the care management staff and what are the proposed ratios of care managers to members?
- How will the plan assure that all necessary disciplines are involved in the assessment, care planning and monitoring? How will communication regarding members take place between care management staff? Between plan staff and network providers? Between plan staff and non-network providers?
- Will the plan employ varying levels of care management dependent on specific health conditions or other member characteristics? If so, describe the levels and how members will be evaluated and monitored for each level.
- Describe how care managers will work with the enrollee's physician(s), informal supports and others to arrange for and monitor the provision of both covered and non-covered services, including health and long term care services, and social and environmental supports;
- The care manager's role in the development and implementation of a care management plan. Include in the description the approach to ensure that the enrollee and/or informal caregiver(s) are involved in the development of the care plan;
- The proposed process for matching care managers to specific enrollees, including policies surrounding the enrollee's choice of care manager and requesting a change in care manager;
- The proposed process to allow members access to care management 24 hours a day, 7 days a week;
- A description of the proposed care management record and
- A description of how the care management function relates to other health plan functions, including but not limited to quality assurance, utilization review and complaints and grievances; and
- Proposed process for handling service authorization requests from members and providers.
- How the plan will maximize reimbursement of and coordinate services reimbursed by Medicare and all other applicable benefits.
- How the plan will arrange and manage Medicaid covered services and coordinate non-covered services which could include primary, specialty, and acute care services

Applicants that are currently operating a Medicaid Advantage Plus or MLTC partial capitation program and intend to use the same processes and procedures for the new plan as approved may so indicate.

9. Family Planning Services (MAP Only)

Describe how the Medicaid Advantage Plus applicant will permit its enrollees to exercise their right to obtain family planning and reproductive health services from either the Contractor, if Family Planning and Reproductive Health Services are provided by the Contractor, or from any appropriate Medicaid enrolled non-participating family planning provider, without a referral from the Enrollee's primary care provider or without approval by the applicant, as defined in Appendix C of the Medicaid Advantage Plus Contract. How will the applicant notify its enrollees, staff and network providers of these policies?

10. Target Population

Submit a market analysis of the proposed service area and a plan that includes the following information:

- Describe in detail the size and characteristics of the proposed target population to be enrolled in the Managed Long Term Care product. Describe special populations to be served by the plan identifying the unique needs of the populations that will need to be addressed. Include an analysis of current operational plans and the applicants anticipated role in the market over a three year period.
- Describe the approaches that the applicant will use to market to the eligible populations consistent with §98-1.19 of 10 NYCRR, Marketing Guidelines in Appendix D of the Medicaid Advantage Plus Contract or in Article V.G. of the MLTC partial capitation model contract.
- Describe the training that will be conducted for marketing staff. Describe how the applicant will monitor the activities of its marketing staff.

11. Medicare and Medicaid Integration (MAP only)

Medicaid Advantage Plus integrates Medicare and Medicaid covered services through one health plan.

- Describe how the applicant will operationalize and integrate Medicare and Medicaid services for Medicaid Advantage Plus within your organization.
- How will services be authorized and transitioned between Medicare and Medicaid (i.e. home health, nursing home etc.).
- What actions will be taken to make the program appear as seamless as possible to the enrollee?
- Describe the applicant's plan for issuing member identification cards (i.e., will enrollees use a single health plan card for both Medicare and Medicaid covered services)

- Describe how the applicant's member services department will interact with Medicaid Advantage Plus members on issues related to both Medicare and Medicaid.
- Provide a copy of the Model of Care submitted to CMS if the Medicare product is a Medicare Advantage Dual Eligible Special Needs Plan.

12. Member Materials and Member Rights

Describe in detail your member services program including:

- how staff will be trained on the member rights and responsibilities outlined in Article 4408 of the PHL
- educational materials to be provided
- ratio of member services representatives to members
- hours of operation
- language translation services
- the establishment of a 1-800 number for members
- how the plan will address the needs of persons with visual, hearing, speech, physical or developmental disabilities.

13. Organization Determinations, Actions and Grievance System

- a) Explain the applicant's grievance system procedures and how they will be available to enrollees, including the processes and procedures that the applicant will implement to comply with requirements for organization determinations, action appeals, complaints and complaint appeals, as defined in Section 14 and Appendix F of the Medicaid Advantage Plus contract or as defined in Article V and Appendix K of the MLTC partial capitation contract.
- b) Provide a flow chart of the applicant's grievance system procedures.
- c) Before the readiness review, applicant must submit the forms and notices it intends to use to inform members of organization determinations and enrollee complaint appeals, action appeals and grievance rights as part of the qualification application. (See Attachment VI for listing of required notices).

14. Fair Hearings

- a) Discuss the process and the procedures that the applicant will implement to ensure that Medicaid members are afforded the opportunity to request a fair hearing regarding a final adverse determination for a denial, termination, suspension or reduction of a covered service.

15. Quality Management

- a) Describe the applicant's quality assessment and improvement program. Include a description of the structure of the quality program and process of evaluation.

- b) Describe how the applicant's quality assessment and improvement program will integrate information from clinical and administrative functions such as complaints/grievances/appeals, medical /utilization management, provider relations, etc. to identify problems and implement appropriate corrective actions as needed.

16. Operational Data Reporting

- a) Describe the applicant's plan for collecting and reporting operational data pursuant to Medicaid Advantage Plus program reporting requirements as defined in Section 18 of the Medicaid Advantage Plus contract or Article VIII E. of the MLTC partial capitation contract (financial, networks, complaints, encounter, quality data, etc.)
- b) How will the applicant verify the accuracy of data reported by its providers? Discuss any data validation activities the applicant performs including medical record audits.

17. ADA Compliance

Applicants are required to comply with Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for program accessibility. Applicants shall review their current compliance activities and provide the SDOH with the current ADA compliance plan and the completed checklist found in Attachment IV. Guidelines can be found in the Model Contract. The ADA Compliance Plan must be approved by and filed with the SDOH. If already approved by SDOH, attach a copy of the plan and indicate date of SDOH approval.

PROVIDER NETWORK ATTESTATION AGREEMENT

I, _____, the Chief Executive Officer of _____ hereby attest, under penalty of perjury, that the current provider network for the counties of _____ as submitted to the Department of Health will be used for the provision of Medicaid covered services to enrolled members, if the plan has contracted to provide the benefit in the county. The network includes a choice of providers who are obligated by contract to provide services to the enrolled population for the following services:

- _____ **Dental Services**
- _____ **Non-emergent transportation**
- _____ **Home Health Care**
- _____ **Personal Care**
- _____ **Private Duty Nursing**
- _____ **Durable Medical Equipment (DME)**
- _____ **Nutrition Services**
- _____ **Medical Social Services**
- _____ **Respiratory Therapy**
- _____ **Social and Environmental Support Services**
- _____ **Home-delivered or Congregate Meals**
- _____ **Adult Day Health Care**
- _____ **Social Day Care**
- _____ **Personal Emergency Response Systems (PERS)**
- _____ **Optometry/Eyeglasses**
- _____ **Audiology/Hearing Aids**
- _____ **Skilled Nursing Facility**

Chief Executive Officer

Date

Notary Signature and Seal

NEW PROVIDER ATTESTATION AGREEMENT

I, _____, the Chief Executive Officer of _____ hereby attest, under penalty of perjury, that _____ has executed a contract with each of the providers listed in response to Question 5(b) of the application submitted to the Department of Health on (date) and that such providers are obligated to provide the services indicated to the enrolled population.

Chief Executive Officer

Date

Notary Signature and Seal

Medicaid Advantage Plus/MLTC Partial Capitation Qualification
ADA Compliance Activities Update

In accordance with the Medicaid managed care contract, all participating Medicaid managed care organizations must comply with Title II of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 for program accessibility.

I, or my designee, have reviewed (health plan name) current ADA compliance activities

I certify that the checklist below is correct.

(Signature CEO or Designee)

(Printed Name and Title)

Name of person with primary responsibility for ADA compliance:

Title:

Telephone number:

E-mail address:

Insert the Section and Page number and place an **X** in the column to indicate that your health plan currently has a satisfactory ADA compliance plan in effect.

ADA Compliance Activities	Section & Page #	Current Satisfactory Compliance is in Effect
<p>Pre-enrollment Marketing and Education: MCO has made pre-enrollment marketing and education staff, activities and material available to persons with disabilities.</p>		
<p>Members Services Department: MCO has member services functions that are accessible to and usable by people with disabilities.</p>		
<p>Identification of Individuals with Disabilities: MCO has satisfactory methods/guidelines for identifying members with disabilities and determining their needs. These guidelines do not discriminate against potential or current members.</p>		
<p>New Enrollee Orientation: MCO gives members information sufficient to ensure they understand how to access medical care through the plan. This information is made accessible to and usable by people with disabilities.</p>		
<p>Complaints and Appeals: MCO makes all information regarding complaint process available to and usable by people with disabilities and assures that people with disabilities have access to sites where members typically file complaints and requests for appeals.</p>		
<p>Care Management: MCO has adequate care management systems to identify service needs of all members including those with disabilities and ensures that medically necessary covered benefits are delivered on a timely basis.</p> <p>Care management systems include procedures for standing referrals, specialists as PCPs and referrals to specialty centers, out of plan referrals and continuation of existing treatment relationships without plan providers during transition period.</p>		
<p>Participating Providers: MCO networks include all provider types necessary to furnish the benefit package, to assure appropriate and timely health care to all enrollees including those with disabilities.</p> <p>Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site; e.g., exam tables and medical equipment.</p>		
<p>Populations with Special Health Care Needs: MCO has satisfactory methods for identifying persons at risk of, or having chronic disabilities or diseases and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. MCO has satisfactory systems for coordinating service delivery.</p>		

ATTACHMENT VI

For applicants that meet the initial MLTC qualification, additional materials and notices to members will be required. Notices must be submitted and approved prior to the readiness review.

This list is for informational purposes and may not be all inclusive. Refer to the model contract for additional reference to notice requirements.

Partial and MAP Notices

Enrollment

Enrollment Ineligibility notice
Proposed Denial of Enrollment notice to applicants
Denial of Enrollment notice
Notice to referral sources indicating plan action on a specific referral
Acknowledgement of application withdrawal to applicant
Enrollment Agreement
Member ID card
Spendedown/Surplus Notice

Disenrollment

Confirmation of Voluntary Disenrollment Request
Voluntary disenrollment form for member signature
Notice of Voluntary Disenrollment
Notice of Intent to involuntary disenrollment
Notice of involuntary disenrollment

Service Authorization

Notification to member of authorized service plan
Notice of Service Authorization request
Denial of Expedited Service Authorization request

Grievance/ Grievance Appeal

Acknowledgement Notice
Denial of Expedited Request for Grievance and Grievance Appeal
Notice of Extension for Grievance and Grievance Appeal
Grievance Decision
Non consideration of grievance appeal (late filing)
Grievance Appeal Decision

Action/ Notice of Action

Non-consideration of appeal (late filing)
Acknowledgement Notice
Denial of Expedited review request
Notice of Plan Initiated Extension Taken
Appeal Decision