

## CHAPTER 1: INTRODUCTION

### 1.1 Program Overview

The State of New York qualifies managed care organizations (MCOs) for participation in the managed care program for its Title XIX population. This document provides the guidelines for the participation of full risk MCOs in the Partnership Plan, a Medicaid managed care program. In order to serve the Medicaid population in New York, an MCO must be qualified by demonstrating its ability to comply with these guidelines.

The State has defined a number of important objectives for its managed care program. Specifically:

- ! Improve the overall quality of care furnished to Title XIX beneficiaries by enhancing their access to primary, preventive, and other medically necessary services, and by integrating their care with that received by the privately insured population.
- ! Reorient service delivery away from institutionally-based delivery systems and or to promote the delivery of primary and preventive care.
- ! Foster the development of managed care systems willing and able to serve high cost, high need persons and reduce the potential of these persons systematically being denied the benefits of managed care over time.
- ! Contain costs over the long term at a level that can be supported by the State's tax base.
- ! Move toward establishment of a more uniform Title XIX managed care program throughout the State, while preserving the ability of counties to address issues of highest priority within their jurisdictions.

To further these goals the State submitted to the Health Care Financing Administration (HCFA) and received approval of an 1115(a) waiver to implement a mandatory program. The waiver is being implemented in phases, and there are counties that will not participate in the mandatory program because they have requested an exemption. Consequently, MCOs may have slightly different contracts for some of the counties in which the MCO proposes to serve. The voluntary and mandatory programs are essentially the same, with differences in policies related to marketing, enrollment and disenrollment.

This document describes the participation standards for organizations interested in serving as an MCO in the New York State Medicaid Managed Care program. It also describes the steps that must be followed by organizations choosing to submit proposals. Applicants are cautioned to review carefully all participation standards and proposal submission requirements. The State reserves the right to reject as unresponsive the proposals of any organization that does not demonstrate a willingness to comply fully with all participation standards or which otherwise does not conform fully with proposal submission instructions.

## 1.2

### **MCO Qualification Process**

This document outlines the participation guidelines for all MCOs interested in serving Medicaid beneficiaries in New York State, with a focus on 1) MCOs not currently doing business in New York, and 2) existing MCOs that wish to expand their service area. This qualification process is open to all certified MCOs (Health Maintenance Organizations (HMOs), Prepaid Health Services Plans (PHSPs), and Integrated Delivery Systems (IDSs)) in the State or any of those entities seeking certification. MCOs may apply to participate in any county.

The New York State Department of Health (SDOH) will accept MCO applications on a continuous basis; contracts will be negotiated once the review process is complete and a decision for approval has been reached. SDOH will evaluate an MCO on the basis of information contained in the application and on any additional information obtained through on-site visits and other requests for information. Please see section 1.4, MCO Qualification Schedule, for additional information.

#### **New MCOs**

Any MCO that is interested in serving Medicaid beneficiaries and did not participate or was not qualified in previous qualification cycles must successfully pass all evaluations. For MCOs new to the Partnership Program the qualification process consists of two primary components: a written application consisting of a General Technical Proposal, a Network Composition submittal, and a Business Proposal, and then an on-site Readiness Review evaluation. For MCOs wishing to participate in New York City, there is also a New York City addendum.

The written application and New York City addendum, if appropriate, will be evaluated to determine if the MCO has demonstrated the ability to provide services to Medicaid recipients in accordance with the guidelines identified in this document. Premiums will be developed based either on legislation, where applicable, or on an analysis of each MCO's own prior experience (when available) and the experience of other MCOs. In all cases, premiums must be approved by HCFA and be adjudged by SDOH to be cost effective.

For example, SDOH will use the MCOs' actual cost and utilization experience to develop utilization and price norms. These norms will be shared with the industry and used as benchmarks for evaluating MCO specific premium proposals. Standard premium proposal formats will be distributed to all MCOs. The submission of a complete Business proposal will be the basis for the MCO-specific rate negotiation process.

#### **Existing Partnership Plan MCOs/Service Area Expansions**

MCOs that were qualified during the initial 1995 or 1997 Partnership Plan program cycles and that wish to expand their service areas may submit a Network Composition proposal and Business Proposal for each county in which the MCO wishes to operate (and a New York City addendum, if appropriate). Existing Partnership Plan MCOs are not required to submit a

General Technical Proposal, nor a New York City addendum if the MCO is already qualified to operate in New York City.

### **1.3 General Information for Applicants**

#### **1.3.1 Program Administration**

The Single State Medicaid Agency for New York is the State Department of Health (SDOH). Many of the functions of the Medicaid program in New York are carried-out on SDOH's behalf by local Departments of Social Services (LDSS) in each borough/county of the State. The LDSS in New York City is the Human Resources Administration (HRA) and the New York City Department of Health, Division of Health Care Access (CDOH-HCA). The term LDSS as used in this document includes HRA and CDOH-HCA.

The SDOH Office of Managed Care (OMC), in collaboration with its LDSS partners, will be responsible for day-to-day oversight of the managed care program described in this document. The Bureau of Managed Care Program Planning will serve as the primary point of contact for MCOs with respect to this qualification process. The Office's qualification contact person and address are as follows:

Elizabeth Macfarlane  
New York State Department of Health  
Office of Managed Care  
Empire State Plaza  
Corning Tower Building---Room #2001  
Albany, New York 12237

518/473-0122 (telephone)  
518/474-5886 (fax)

#### **1.3.2 Contract Period**

It is the State's intent to have contracts awarded through this qualification process take effect on or after July 1, 1999. Regardless of the starting date with a particular county, all contracts resulting from this qualification will include the same expiration date of June 30, 2001.

#### **1.3.3 Covered and Excluded Populations**

The Partnership Plan will encompass most of the non-elderly, non-institutionalized Medicaid population in the State, as well as the expanded Title XIX population who were previously eligible for state-only medical assistance through the Home Relief program. The following populations are required to enroll in an MCO on a mandatory basis, as described in the remaining sections of this chapter:

! Singles/Childless couples - cash and Medicaid only

- ! Low income families with children - cash and Medicaid only
- ! Pregnant women whose net available income is at or below 185% of the federal poverty level (FPL) for applicable household size
- ! Children aged one (1) or below whose family's net available income is at or below 185 percent of the federal poverty level for the applicable household size
- ! Children between ages one (1) and five (5) whose family's net available income is at or below 133 percent of the federal poverty level for the applicable household size.
- ! Effective 1/1/99, children aged six (6) to nineteen (19) whose family's net available income is at or below 100 percent of the federal poverty level for the applicable household size
- ! Transitional Medical Assistance beneficiaries

Mandatory enrollment will be implemented in five phases. Phase I began October 1, 1997; Phase II will begin mid-1999; Phase III will be implemented in accordance with the timeframes specified in the HCFA Special Terms and Conditions document (four months after Phase II); Phase IV and Phase V are expected to begin in late 1999 or 2000.

At this time, the State has assumed that enrollment of SSI recipients will follow the same five-phase approach in the second year of the waiver.

### **1.3.3.1 Mandatory Populations**

All individuals in the aid categories listed in 1.3.3 will be required to participate in The Partnership Plan unless they are eligible for an exemption or exclusion.

### **1.3.3.2 Voluntary (Exempt) Populations**

While the majority of the Title XIX populations will ultimately be enrolled in managed care under The Partnership Plan, there are a number of population groups that will be eligible for an exemption from mandatory enrollment in a mainstream MCO. (Information on the exemption criteria and process will be included in the enrollment materials sent to all potential eligibles. A separate pamphlet will discuss the implications and conditions of any exemptions from enrollment which are allowed). Individuals who fall into one of the following categories will be enrolled in MCOs only on a voluntary basis:

1. Individuals who are HIV+. Once Special Needs Plan (SNPs) are established and certified through the milestone process, individuals with HIV disease must enroll in a managed care arrangement (either mainstream MCOs or SNPs). As soon as HIV SNPs are established through the milestone process in a given service area, those HIV positive individuals in that area who have voluntarily enrolled in mainstream MCOs will be given the option of enrolling in a SNP.

2. Individuals who are seriously and persistently mentally ill (SPMI) or seriously emotionally disturbed. Individuals who have utilized 10 or more mental health visits (mental health clinic services or mental health specialty services, or a combination of these services) in the previous calendar year will be considered SPMI or in the case of a child under 18, SED. Once SNPs are established and certified through the milestone process, enrollment in SNPs will remain voluntary for the SNP-eligible population, with the exception of SPMI adults and SED children who have not selected a mental health option and are auto-assigned to a mental health SNP, and any Partnership Plan enrollee who exhausts the basic mental health benefit package offered by the mainstream MCOs in which they are enrolled. These individuals will be mandatorily enrolled in a certified SNP for receipt of mental health services. However, only a FFS option for mental health services will be offered in counties where there is only one mental health SNP which is operated by the county.
3. If SNPs are not eventually established in certain areas of the State, individuals who would otherwise be eligible for enrollment in mental health SNPs may: (a) receive both mental health and physical benefits on a FFS basis; (b) voluntarily enroll in certified mainstream MCOs and receive the same physical and mental health services available to other Partnership Plan enrollees residing in the same service area; or (c) voluntarily enroll in certified mainstream MCOs for the provision of physical health-only services and receive mental health benefits on a FFS basis.
4. Individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services. To qualify for this exemption, a person must demonstrate that no participating MCO has a provider located within thirty minutes/thirty miles travel time who is accepting new patients, and that there is a fee-for-service Medicaid provider available within the thirty minutes/thirty miles travel time.
5. Pregnant women who are already receiving prenatal care from a provider authorized to provide such care not participating in any MCO (note: this status will last through a woman's pregnancy and sixty (60) days post partum and will end on the last day of the month in which the 60th day occurs; after that time, she will be enrolled mandatorily into an MCO if she belongs to one of the mandatory aid categories).
6. Individuals with a chronic medical condition who, for at least six months, have been under active treatment with a nonparticipating subspecialist physician who is not a network provider for any MCO participating in the Medicaid managed care program service area. This status will last as long as the individual's chronic medical condition exists or until the physician joins an MCO network. The OMC Medical Director will, upon the request of an enrollee or his/her guardian or legally authorized representative (health care agent authorized through a health care proxy), review cases of individuals with unusually severe chronic care needs for a possible exemption from mandatory enrollment in managed care if such individuals are not otherwise eligible for an exemption (i.e., meet one of the eighteen criteria listed here). The OMC Medical Director may also authorize a plan disenrollment for such individuals. Disenrollment requests should be made in a manner consistent with the overall disenrollment request process for "just cause" disenrollment.

7. Individuals with end stage renal disease (ESRD).
8. Individuals who are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
9. Individuals with characteristics and needs similar to those who are residents of ICF/MRs based on criteria cooperatively established by the State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the NYS Department of Health (DOH).
10. Individuals already scheduled for a major surgical procedure within 30 days of scheduled enrollment with a provider who is not a participant in the network of an MCO under contract with a local social services district. This exemption will apply only until such time as the individual's course of treatment is complete.
11. Individuals with a developmental or physical disability who receive services through a Medicaid Home-and-Community-Based Services waiver or Medicaid Model Waiver (care-at-home) through a Section 1915c waiver, or persons having characteristics and needs similar to such persons (including persons on the waiting list), based on criteria cooperatively established by OMRDD and DOH.
12. Individuals who are residents of Alcohol and Substance Abuse Long Term Residential treatment programs.
13. Medicare/Medicaid dually eligible individuals who are not enrolled in a Medicare + Choices plan. These individuals are excluded from enrollment until program features are in place. At that time, enrollment will become voluntary.
14. In New York City, individuals who are homeless and do not reside in a DHS shelter are exempt. Homeless persons residing in a NYC DHS shelter and already enrolled in an MCO at the time they enter the shelter may choose to remain enrolled. In areas outside of NYC, exemption of homeless persons, and homeless persons residing in the shelter system is at the discretion of the local district.
15. Eligible Native Americans. See Section 2.7.10.8 for further information on this voluntary populations
16. Individuals who cannot be served by a managed care provider due to a language barrier which exists when the individual is not capable of effectively communicating his or her medical needs in English or in a secondary language for which PCPs are available within the managed care program. Individuals with a language barrier shall have a choice of three PCPs, at least one of which is able to communicate in the primary language of the eligible individual or has a person on his/her staff capable of translating medical terminology, and the other two PCPs have access to the AT&T language line as an alternative to communicating directly with the eligible individual in his/her language. Individuals will be eligible for an exemption when:

- (i) The individual has established a relationship with a primary care provider who:
  - (a) has the language capability to serve the individual and;
  - (b) does not participate in any of the managed care plans within a thirty minute/thirty mile radius of the individual's residence;

OR

- (ii) Neither a fee-for-service provider nor the above described three participating PCPs are available within the thirty minute/thirty mile radius and;
  - a fee-for-service provider with the language capability to serve the individual is available outside the thirty minute/thirty mile radius and;
  - the above described three participating PCPs are not available outside the thirty minute/thirty mile radius.

- 17. Individuals with a "County of Fiscal Responsibility" code of 97 (OMH in MMIS) or 98 (OMRDD in MMIS) will be exempt until the state establishes appropriate program features. However, many of these individuals will qualify for other exemptions (SPMI/SED) or exclusions.
- 18. Individuals temporarily residing out of district, (e.g., college students) will be exempt until the last day of the month in which the purpose of the absence is accomplished. The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p).
- 19. Mandatory enrollment of SSI and SSI-related beneficiaries is scheduled to begin in the second year of the waiver, assuming HCFA has approved the addition of this population to the mandatory program. **Until such time, SSI and SSI-related beneficiaries will be considered exempt and may enroll on a voluntary basis.**

Determination of an individual's eligibility for exemption will be conducted by the local districts upon the request of the individual or his/her designee. Local districts (or the enrollment broker) will follow state guidelines in determining eligibility for exemption. When exemption status is unclear, the District may request assistance from the SDOH Office of Managed Care. A description of the process the local districts will follow in determining eligibility is available from the Bureau of Intergovernmental Affairs.

Individuals may request an exemption to enrollment in an MCO. Individuals eligible for an exemption (based on any of the conditions listed in the previous section except for #s 4, 5, 6, 10, 15, or 16) who choose to enroll in managed care will be treated as voluntary enrollees for purposes of disenrollment provisions. Accordingly, these individuals may disenroll from an MCO with thirty days notice and return to the fee-for-service program.

Individuals who become eligible for exemption due to a change in eligibility status after they have

enrolled in managed care may apply for exemption and be disenrolled within 30-60 days. All managed care enrollees will have received information on the exemption criteria and process in the enrollment kits.

SDOH may add additional exemption categories or modify the exemption categories listed above.

### **1.3.3.3 Excluded Populations**

The following population groups will not be eligible for enrollment in The Partnership Plan:

1. Medicare/Medicaid dually eligibles who are enrolled in a Medicare + Choice plan are excluded until program features and reimbursement rates are developed. The State will identify for local social services districts those individuals who are dually eligible [see “Voluntary (Exempt) Populations” for dual eligibles not enrolled in a Medicare + Choice plan].
2. Individuals who become eligible for Medicaid only after spending down a portion of their income.
3. Individuals who are residents of State-operated psychiatric facilities and residential treatment facilities for children and youth.
4. Individuals who are in a residential health care facilities at time of enrollment and individuals who enter a residential health care facility subsequent to enrollment, except for short term rehabilitation stays anticipated to be no greater than 30 days.
5. Individuals participating in the State’s existing, fully-capitated long term care demonstration projects, including beneficiaries with Medicare. These programs include the two “Program for All-Inclusive Care for the Elderly” (PACE) projects and the planned Monroe County Chronic Care Networks, “PACE for Under -55’s” network, and the Commonwealth Fund research projects.
6. Medicaid eligible infants living with an incarcerated mother.
7. Infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for the SSI related category (shall not be enrolled or shall be disenrolled retroactively to date of birth).
8. Individuals with access to comprehensive private health care coverage that is available from or under a third-party payer which may be maintained by payment, or part payment, of the premium or cost-sharing amounts, when payment of such premiums or cost-sharing amounts would be cost-effective, as determined by the local social services district.
9. Foster children in the placement of a voluntary agency.

10. Certified blind or disabled children living or expected to be living separate and apart from the parent for 30 days or more.
11. Individuals expected to be eligible for Medicaid for less than six months (e.g., seasonal agricultural workers or employable Single/Childless couples).
12. Foster care children in direct placement (*unless LDSS opts to enroll them*).
13. Homeless persons residing in a NYC DHS shelter and not enrolled in an MCO at the time they enter the shelter.
14. Individuals in receipt (at the time of enrollment) of institutional long-term care services through Long Term Home Health Care programs or Child Care Facilities (except ICF services for the Developmentally Disabled).
15. Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
16. Individuals receiving mental health family care services pursuant to Mental Hygiene Law.
17. Individuals enrolled in the Restricted Recipient Program.
18. Individuals who have a “County of Fiscal Responsibility” code of 99 in the State Medicaid Management Information System (MMIS).
19. Individuals receiving hospice services at the time of enrollment. If an enrollee enters a hospice program while enrolled in an MCO, they may remain enrolled to maintain continuity of care with the enrollee’s PCP. Hospice services are accessed through the fee-for-service Medicaid program.

#### **1.3.4 Other Waiver Programs**

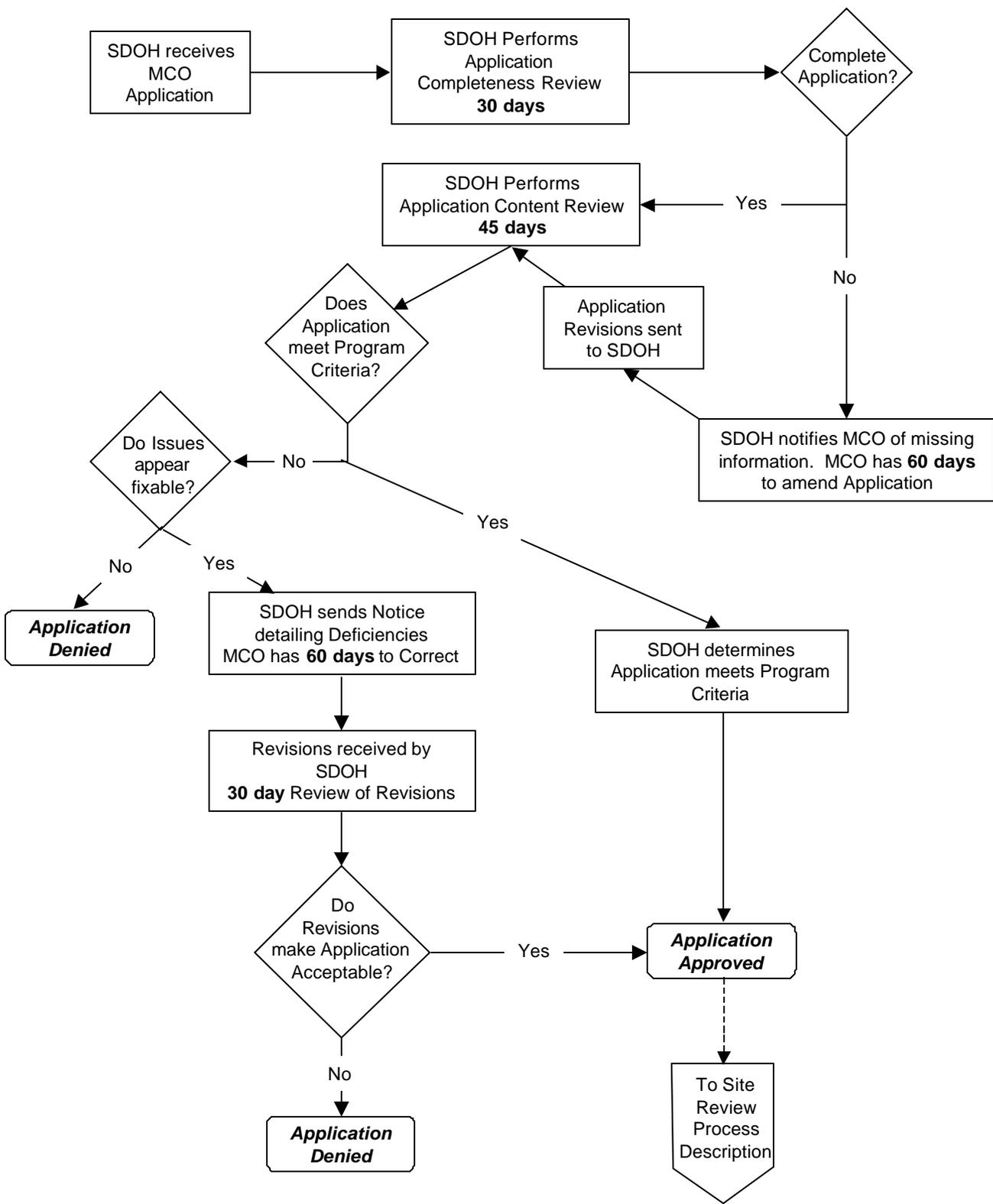
New York State currently has a Section 1915(b) waiver program in place in Westchester County. Westchester is scheduled to be part of Phase III of the State’s Section 1115(a) waiver program. At such time, Westchester County’s Section 1915(b) program also will be subsumed within it. However, the SSI population will remain under the 1915(b) program. **MCOs wishing to expand to Westchester should respond to this document.**

#### **1.4 MCO Qualification Schedule**

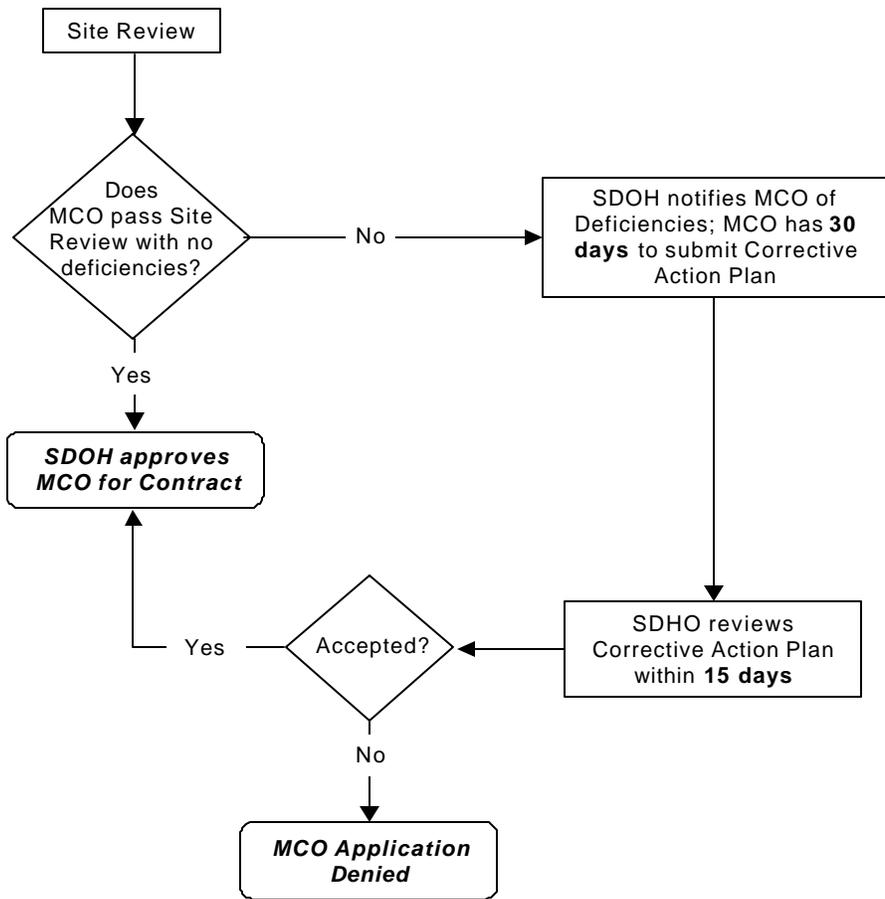
Because MCO qualification will be an ongoing process, MCOs may submit an application at any time. SDOH will evaluate the application in the time period noted below, and will notify the pending applicant of relevant issues as outlined. These notifications will give the MCO a written summary of any problems. Should the MCO’s application eventually be denied during the review process, it may not be resubmitted for three (3) months from the date of the notice from

SDOH denying the application.

<b>Evaluation Process &amp; Timeline</b>	
1	When an application is received, SDOH will take up to 30 days to review the document for completeness. Any incomplete items will be noted in a letter to the MCO; the MCO will have 60 days from the date on the notification letter to submit the material requested.
2	Once SDOH has certified that an application is complete, SDOH will have an additional 45 days to review the application against program requirements. Deficiencies may come in two forms – those that are too severe to fix and those that are correctable. Applications that are unfixable will be denied (the MCO will receive a notice explaining the denial). MCOs with proposals that appear to be correctable will have 60 days from the date on the notification letter to submit revisions. SDOH will have up to 30 additional days to review such revisions. If the proposed revisions continue to fall short of program requirements, the application will be denied.
3	SDOH can approve an application once it has gone through the processes described in step 2 above, and once the proposal meets all program requirements. Once approved, the next stage is for SDOH and (possibly LDSS staff) to perform an on-site visit to the MCO to check for program/enrollment readiness.
4	After the on-site visit, SDOH will send a letter detailing any concerns. These concerns will be noted as either major or minor. The MCO will be asked to prepare and submit a corrective action plan within 30 days covering all noted issues. SDOH will review the plan within 15 days and either accept it or deny the application. Only after the MCO has acted on the major concerns will SDOH allow the LDSS to contract with the MCO.



**MCO Qualification Process and Timeline**



**MCO Qualification Process and Timeline**

SDOH is committed to working closely with MCOs during the entire application process to ensure a timely review and approval determination. SDOH staff are available to provide technical assistance throughout the process (including the period after an application is denied). MCOs may seek assistance from the bureaus in the following chart.

Bureau	Topic
Bureau of Managed Care Certification and Surveillance (BMCCS) (518) 474-5515 or 473-4842	Licensure Fair Hearing Process
Bureau of Quality Management and Outcomes Research (BQMOR) (518) 486-9012 or 486-6074	Network Submissions Quality Assurance Reporting Requirements Encounter Data
Bureau of Managed Care Financing (BMCF) (518) 474-5050	Business Proposal submission Financial Reporting requirements MMIS Systems issues
Bureau of Managed Care Program Planning (518) 473-0122	General Technical Proposal Special Populations Public Health Welfare Reform ADA Compliance
Bureau of Intergovernmental Affairs (518) 486-9015	LDSS issues Enrollment policies Member Handbook Guidelines Marketing Guidelines Contracts