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**INITIAL
MEDICAID OPERATING PLAN & PREMIUM PROPOSAL
FOR
FULL CAPITATION
MANAGED CARE ORGANIZATIONS**

INTRODUCTION

The Initial Medicaid regional operating plan/premium proposal must be completed by each Managed Care Organization (MCO) proposing to initiate Medicaid enrollment in a new Medicaid rating region (where the MCO has no current Medicaid operations). One operating plan should be completed for each new Medicaid Managed Care Rating (MMCR) Region in which the MCO intends to enroll Medicaid.

The operating plan requests specific enrollment and financial information necessary to develop actuarially based rates and demonstrate financial viability. Re-insurance arrangements and benefit package variances that are to be reflected in MCO/county contracts should also be identified. The MCO's proposal must conform to the general methodology presented in the first section of this document. We reserve the right to request additional information and/or meet with the plans for clarification.

Three (3) hard copies and a floppy disk copy of each regional operating plan should be submitted to the New York State Department of Health, Bureau of Managed Care Financing. Requests for the floppy disk or any questions regarding the operating plan should be directed to the Bureau at (518) 474-5050. Note that requests for premium adjustments will be reviewed only if the operating plan is completed in full per the attached instructions and guidelines.

Diskette Files

The 3.5" diskette contains copies of all schedules under Lotus 123 wk4 format and Excel 97 xls format. The Lotus files are contained in a compressed archive called OPIN_123.EXE while the Excel files are contained in an archive called OPIN_EXL. EXE. To work with the files, select the appropriate archive, copy the file into a directory on your computer, and double click on the file (i.e., run the executable file) to recreate the individual worksheet files. There will be one file for each Schedule in the operating plan, plus a copy of these instructions in Word Perfect format.

Do not alter the file template formats in any way, as the information entered by the MCO will be electronically read into a database. Note that files for Schedules D and E contain multiple tables as you page down the spreadsheet, while several files, notably Schedules I and J, contain several "sheets" with the file. A separate diskette should be submitted for each regional operating plan.

Enter zeros where data is not appropriate. **Do not delete or add any lines.** One diskette should be submitted for each regional operating plan.

GENERAL PREMIUM METHODOLOGY GUIDELINES

Targeted Medicaid Population

New York State is enrolling Medicaid recipients who are categorically eligible in the Aid to Families with Dependent Children (ADC) Program, Home Relief (HR) Program and Medicaid Assistance Only Program (MA) for health and mental health/substance abuse benefits, and the Supplemental Security Income (SSI) Program for health-only benefits (SSI members would receive mental health and substance abuse services on a Medicaid Fee-For-Service (FFS) basis).

Capitated Premium Groups

Medicaid managed care capitation rates are paid according to premium groups that vary by the aid category, age and sex of the enrollee. The following are the premium groups currently available for enrollment in full capitation managed care plans:

ADC & HR <6 Mo. Male & Female
ADC & HR 6 Mo.-14 Female
ADC & HR 15-20 Female
ADC & HR 6 Mo.-20 Male
ADC 21-64 Male & Female
HR 21-29 Male & Female
HR 30-64 Male & Female
SSI 6 Mo. – 20 Male & Female
SSI 21 – 64 Male & Female
SSI 65+ Male & Female

MA-ADC/HR <6 Mo. Male & Female
MA-ADC/HR 6 Mo.-14 Female
MA-ADC/HR 15-20 Female
MA-ADC/HR 6 Mo.-20 Male
MA-ADC 21-64 Male & Female
MA-HR 21-29 Male & Female
MA-HR 30-64 Male & Female
MA-SSI 6 Mo. – 20 Male & Female
MA-SSI 21 – 64 Male & Female
MA-SSI 65+ Male & Female

Inpatient kick (one time payment for the inpatient birthing cost of the newborn)

Note the inpatient kick payment is made only when the newborn is enrolled at birth and the MCO is responsible for payment of the hospital bill for the inpatient birthing costs of the newborn. Also note there are no SSI newborn premium rates.

Construction of Premium Proposal - Budget-Actuarial Method

The budget-actuarial approach should be used by each MCO to develop Medicaid premiums based on an evaluation of its own experience and other reference data.

The budget/actuarial method establishes capitation rates on the basis of the MCO's explicit assumptions about the demographic composition of the projected enrollee population, the utilization rate for the various types of health services in the benefit package, and the cost per unit of service (unit cost) for each type of service. In addition to the medical component, the method requires the MCO to identify costs attributable to administration and marketing, and allows for allocation of contingent reserves.

For plans with no previous Medicaid experience, the utilization indicators may be based historical Medicaid fee-for-service (FFS) utilization data adjusted for the impact of managed care. Utilization projections may also reflect a blending of the MCO's current non-Medicaid enrollee population, its Medicaid experience in other regions of the State and the experience of other MCOs currently enrolling Medicaid on New York.

Unit costs should reflect the payment rates that the plan expects to pay its providers, and should not be based on historical Medicaid unit costs. The projected unit costs will be assessed to determine the reasonableness and adequacy of the plan's payment rates. Where plans pay capitation to a provider for a service, actual utilization must still be provided on the CRCS and the price per unit would be the capitation divided by utilization. Capitation arrangements should be noted as such in the written explanation of assumptions provided in support of the premium proposal.

Core Benefit Package and Added Benefits

Each plan offers a core benefit package plus additional "optional" benefits that is dependent upon county policy; the optional benefits are dental, family planning, emergency transportation and non-emergent transportation. County specific regional rates are built by adding the value of the core benefit, which is identical in all counties within a region, to the added benefits offered in the county, plus regional allocations for administration and profit/reserves. See Schedule D for further instructions.

Contingency Reserves

The MCO should build into its premium proposal a provision for contingency reserves if it can demonstrate that a comparable provision is included in its community based rate or otherwise required by Health or Insurance Department regulation.

Premium Rate Period

Premiums will be set on a twelve month basis beginning April 1st. However, plan's requesting premiums subsequent to April 1 may receive premiums for a lesser or greater period.

Service Area

The service area is defined as the entire area where a Medicaid recipient would be eligible to enroll in the MCO, and for which exists a certified provider network that is sufficient to serve the Medicaid population. Premium rates will be established on a regional basis consistent with the Medicaid rating regions found at the end of these instructions. As noted above, county variations will be accepted based on the additional benefits offered in the county.

Mandatory Enrollment Programs

Separate premium requests should be made in Schedule E for counties operating under mandatory enrollment programs. Since there are no current mandatory enrollment programs for the SSI population, voluntary premiums (Schedule D) should always be requested for SSI members.

Reinsurance

MCOs must choose a form of reinsurance for their Medicaid membership. Reinsurance is a type of financial protection for the plan in the event that medical benefit expenses greatly exceeds expectations in the aggregate or per enrollee. MCOs with sufficient reserves may choose self-reinsurance, subject to DOH or State Insurance Department approval, or may directly contract with a reinsurance company licensed to do business in NYS.

MCOs may also elect to have New York State provide reinsurance. NYS pays 80% of the inpatient costs for an enrollee that exceeds a \$50,000 stop-loss threshold per calendar year up to and including \$250,000. For cases whose inpatient expenses exceed \$250,000, the State will reimburse the plan 100% of costs in excess of \$250,000. If the MCO chooses to have NYS provide the reinsurance, the Medicaid premium rate would be reduced to reflect the cost to NYS of stop-loss coverage.

Mental Health, Substance Abuse and Alcoholism Treatment Stop-Loss

All plans will also be subject to three additional stop-loss provisions related to mental health, substance abuse and alcoholism treatment services. For each enrollee, the MCO's financial liability will be limited to the following utilization per member per calendar year:

- 20 Outpatient Mental Health Visits
- 60 Outpatient Substance Abuse and Alcoholism Visits
- 30 Psychiatric/Substance Abuse Inpatient Days

Outpatient visits or inpatient days in excess of these limits will be paid by NYS to the MCO. The plan will still be responsible for maintaining its overall case management responsibilities for these services and for making payments to its providers.

Upper Payment Limits

The proposed premium will be evaluated in light of a FFS "ceiling", also called FFS caps or upper

payment limits (UPL), as long as the reliability and reasonableness of the FFS data is maintained. However, it is important to understand that actual premiums will not be constructed simply at the UPL, nor will FFS data be the sole means of evaluating the premiums. The ceiling merely acts as one yardstick to help ensure that New York State does not pay more for services under prepayment than it would have in the existing service delivery system.

The UPL represent the predicted amount which NYS would have paid per Medicaid eligible per month of eligibility in the existing FFS environment. It is based on a summary of actual historical claims paid for services rendered within a particular year. The data used in the UPL calculation is October through September of the most current federal fiscal year available, and will reflect the FFS experience of the appropriate Medicaid rating region in which the plan will serve.

The UPL is determined through application of a series of adjustments to the average base year cost per eligible month. A separate average cost per month is determined for each premium group. Adjustments are then made to the average cost per month to account for claim lag, benefit package differences, reinsurance, program changes, and trending from the base year to the rate year. Additional risk adjustments are also made to reflect prior periods of coverage, retroactive eligibility, enrollment lag, voluntary selection, subsequent changes in Medicaid FFS payment rates and NYS administrative costs.

The MCO should contact the Bureau of Managed Care Financing for current information about the UPLs.

Regional Filings

Note that Operating Plans/Premium Proposals are required for each Medicaid rating region in which the MCO plans to enroll the Medicaid population.

Regional Expansion of Existing Medicaid MCOs

MCOs wishing to begin enrollment in a new county that resides within a region for which rates have already been established will receive the existing regional rates for an identical benefit package in the new county. In this case, the MCO should note in a cover letter that it is filing a shortened version of the Operating Plan containing only the following schedules:

Schedule A	Summary Information
Schedules B1 & B2	Enrollment Projections
Schedule G	Hospital Cost and Utilization
Schedule I1	Rate Period Medicaid Revenue & Expense Projections
Schedule J1	Rate Period Consolidated Revenue & Expense Projections
Schedule K	Pro-Forma Balance Sheets
Schedule M	Provider Contracts & Risk Incentive Arrangements

INSTRUCTIONS FOR COMPLETING THE OPERATING PLAN

General: The following pages provide the general guidelines, by major component, which should be addressed in the Operating Plan. Where a specific format is requested, the instructions refer to an attached schedule which displays the format to be followed. When a MCO provides services in more than one county in a Medicaid rating region, and the benefit package, rate period, etc. are the same for each county, only one set of premiums should be requested for all counties. Differences in rates between counties with different benefit packages may be accommodated in Schedules D and E.

SCHEDULE A:

Service Area

Enter the name of the region and the counties within the region for which the MCO is requesting Medicaid premiums.

Reinsurance

Select the type of reinsurance program the plan has chosen for its Medicaid enrollment. Briefly describe the amount and type of coverage.

Benefit Package – Core Benefits and Optional Services

Enter by indicating Yes or No in the table provided the optional benefits that will be added to the core benefit package in each county within the region. The benefits included in the core benefit package are the same for all ADC, HR and related MA-only enrollees in the State; these services are defined for rating purposes in Schedule F. Note that for SSI enrollees the core benefit excludes all inpatient and outpatient mental health and substance abuse services, which are provided on a Medicaid FFS basis.

The optional benefits are dental, emergency and non-emergent transportation and family planning and should be offered consistent with current county policy.

SCHEDULES B1 & B2 - ENROLLMENT

Schedule B1 request the number of member months and members, respectively, by premium group during the rate period, while Schedule B2 requests enrollment totals by county.

SCHEDULE C1 & C2 - MEDICAID PREMIUM PROPOSAL SUMMARY

Enter the proposed rates for each unique benefit package in the region. The proposed rates should equal the sum of the pmpm amounts entered in the D (voluntary) or E (mandatory) Schedules for the core benefits, administration and profit/reserves, which are the same in all counties in the region, plus the optional benefits provided in the specific county(s).

For example, if the MCO offers dental, family planning and all transportation benefits in three counties in the region, but does not offer transportation services in a fourth county, then the MCO should request two different regional rates.

Enter voluntary program rates in Schedule C1 and mandatory program rates in Schedule C2.

SCHEDULES D 1 – D11 Voluntary Program Rate Calculation Sheets (CRCSs) **SCHEDULES E1 - E8 Mandatory Program CRCSs**

For each premium group as well as the inpatient kick payment, enter the actuarial assumptions that underlie the premium rate proposals for each premium group in the Capitation Rate Calculation Sheets (CRCSs). The premium groups are listed in the General Methodology Guidelines section as well as in Schedule D itself. Schedules D1 - D11 should be used for counties enrolling on a voluntary basis while Schedule E1 - E8 should be used for mandatory enrollment programs. The D and E schedules represent the actual premium rates proposed by the MCO.

The MCO should enter capitation amounts for the core medical benefits first; these comprise lines 1 – 15 in the D and E Schedules. The actuarial assumptions for the optional benefits being offered by the MCO are listed next, followed by the pmpm administration allocation, and profit/reserves. The proposed capitation rates listed by the plan in Schedule C is the sum of the pmpm amount for the core benefits, administration and reserves, which are identical in all counties in the region, plus the county specific optional benefits from Schedules D and E.

Note that definitions of each medical service and administrative cost category used in the following schedules may be found in the instructions for the Medicaid Annual and Quarterly Financial Reports. Also note pharmacy is no longer a covered managed care benefit as of 8/1/98, and is now a Medicaid fee-for-service benefit.

Per member per year (PMPY) utilization rates and cost per unit of service should be entered for each medical service category shown, as well as per member per month (PMPM) costs. Inpatient utilization should be expressed in terms of the predominant method of payment - per diems or discharges. Other utilization indicators should be expressed as visits for outpatient care, number of visits for emergency room, number of procedures for diagnostic tests, etc.

Capitation arrangements should be reported by breaking down the capitated amounts into utilization frequencies and unit cost. For example, a capitation agreement for primary care services should be expressed in terms of the PMPY utilization and unit costs that make up the capitation. For capitation agreements that cover more than one medical category of service, the MCO should specify the utilization and unit cost assumptions for each medical category that comprises the capitation.

Mandatory vs. Voluntary Enrollment Programs

In recognition that case mix and costs under mandatory enrollment programs may differ from voluntary programs, MCOs should submit Schedule E CRCSs for counties operating mandatory enrollment programs. Wherever possible, plans with experience with existing mandatory programs, such as the programs in Southwest Brooklyn and several upstate counties throughout the state, that have also operated programs in voluntary counties, should use this experience to develop the mandatory program rates.

Additionally, plans operating in upstate regions may serve a mixture of voluntary and mandatory counties and should submit separate sets of mandatory and voluntary CRCSs for the region. For regions where none of the counties are currently mandatory and the implementation date of mandatory is uncertain, plans should complete a voluntary CRCS sheet. If a county becomes mandatory during the rate period, the plan may submit a mandatory CRCS for the county at that time.

Factors used to adjust actuarial assumptions when deriving mandatory program rates should be explained in Schedule F – Justification.

Allocation of Administration Costs

Administrative costs and profit/reserves should be allocated to each premium group by applying a uniform percent of premium method. Note that the sum of projected rate period member months multiplied by the respective pmpm administration allocation for each premium group in the D and E Schedules should equal the total administration budget entered in Schedules H (Administrative Budget) and I1 (Rate Period Medicaid Revenues and Expenses).

SSI CRCS

Schedules F8 – F10 for the SSI premium groups do not include projections for Inpatient Mental Health & Substance Abuse, Outpatient Mental Health, and Outpatient Drug & Alcohol Treatment; these services are provided on a Medicaid FFS basis. In addition, there is no rate for the SSI < 6 month group. Also note that only SSI voluntary CRCSs (Schedules D8 - D10) should be completed even in counties operating mandatory programs, as the SSI population will continue to be enrolled on a voluntary basis statewide until further notice.

Newborn Supplemental Payment

Schedule D11 should be used to request the newborn supplemental payment ("kick payment") for the ADC/HR < 6 Months M&F premium group. This rate is a lump sum payment that will cover the inpatient birthing costs of the newborn. There is no administrative portion for the kick rate as administrative costs are already included in the < 6 month capitation rate.

SCHEDULE F JUSTIFICATION

Schedule F, Utilization and Unit Cost Justification, should be completed in hard copy only for each of the standard medical cost categories that comprise the premium. The justification represents the rationale behind the actuarial assumptions found in the D and E Schedules.

The utilization justification should include the data sources (e.g., the MCO's own Medicaid experience, community rated experience, etc.) and reflect the projected impact of managed care on utilization rates, and the impact of educational efforts. The unit cost justification should note the fee schedules being paid, the application of any inflation factors, changes in provider network and contracted fee arrangements, case mix assumptions, etc.

In addition, all services which the plan capitates should be identified along with the provider accepting such capitation.

Assumptions made to derive mandatory enrollment program rates and the basis for those assumptions should be also be noted here.

Additional pages needed to complete Schedule F should be appended to the Operating Plan.

SCHEDULE G - DISTRIBUTION OF HOSPITAL UTILIZATION

For each hospital representing 10% or more of inpatient utilization, enter the average inpatient cost per day, the total number of days, and the total payments expected to be made to the hospital. Use the number discharges and average cost per discharge in place of per diems should the predominant method of payment be on a discharge basis.

Utilization and cost data for hospitals incorporated into *sub-capitation* arrangements should still be reported in these schedules, as collection of this data is required regardless of payment arrangement.

SCHEDULE H - ADMINISTRATIVE EXPENSE BUDGET

This schedule requires identification of all administrative or marketing expenses that will be incurred for Medicaid enrollees during the first 12 months of Medicaid enrollment.

If the MCO is sharing administrative expenses with other entities, then the basis of allocating expenses to the Medicaid business should be described on a separate sheet

SCHEDULES I1, I2 and I3- MEDICAID REVENUE AND EXPENSE PROJECTIONS

The I Schedules require the MCO to project monthly Medicaid revenue and expenses for three calendar year periods ending December 31 - Schedules I1, I2 and I3, respectively. Year one would start on the date the new or expended Medicaid program is projected to begin.

As noted earlier, the definitions of the medical cost categories used in these schedules can be found in the instructions for completing the Medicaid Annual and Quarterly Financial Statements.

SCHEDULES J1, J2 and J3 - CONSOLIDATED REVENUE AND EXPENSE PROJECTIONS

The MCO should project its consolidated annual revenues and expenses over the same three calendar year periods reflected in the I Schedules for each applicable line of business - commercial, Child Health Plus, Medicaid, and Medicare - and summing its projections in the "Totals" columns.

SCHEDULE K - BALANCE SHEETS

Pro-forma Balance sheets should be completed for four periods. The first period is as of the first day of the month new Medicaid enrollment is projected to begin, the second is December 31 of same year and the third and fourth are at the end of the following two calendar years. The pro-forma balance sheets are required to assist DOH in determining the MCO's compliance with state solvency and reserve standards.

If Medicaid is operated as a line of business, then the balance sheet of the consolidated organization should be reported.

SCHEDULE L - MIS/REPORTING (New applicants only)

MCOs with no previous experience with the NYS Medicaid program should describe the ability of its Management Information System to track cost and utilization data by the age, sex and Medicaid aid categories used by the NYS Medicaid program, as well as comply with NYS quarterly and annual financial reporting requirements.

SCHEDULE M - PROVIDER CONTRACTS/RISK-INCENTIVE ARRANGEMENTS

This section should the payment arrangements made with contracted providers of medical services, including capitation agreements, fee-for service arrangements, negotiated inpatient per diems or discharges rates of payment, etc. This section should also include a discussion of any risk-incentive provisions in provider contracts, such as withhold arrangements, the use of risk pools, global capitation payments, etc. Note that any provider contract that shifts financial risk to the provider requires separate approval by the Department of Health.

Medicaid Managed Care Rating Regions

Western Region	Finger Lakes Region	Adirondack Region	Northeast Region	Central Region	Mid-Hudson Region	No. Met Region	NYC Region	Long Island Region
Erie	Allegany	Clinton	Albany	Cayuga	Dutchess	Putnam	Bronx	Nassau
Genesee	Broome	Essex	Fulton	Chenango	Orange	Rockland	Brooklyn	Suffolk
Monroe	Cattaraugus	Franklin	Montgomery	Columbia	Sullivan	Westchester	Manhattan	
Niagara	Chautauqua	Hamilton	Rensselaer	Cortland	Ulster		Queens	
Orleans	Chemung	Herkimer	Saratoga	Delaware			Richmond	
Wyoming	Livingston	Jefferson	Schenectady	Greene				
	Ontario	Lewis	Warren	Madison				
	Schuyler	Oneida	Washington	Onondaga				
	Seneca	Oswego		Otsego				
	Steuben	St. Lawrence		Schoharie				
	Tioga			Tompkins				
	Wayne							
	Yates							

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