4.9 Proposal Submission Forms

Proposal Submission Checklist

This checklist is provided for MCOs to use in verifying that their proposals contain all required items, as delineated in Chapter Three of the Plan Qualification Guidelines. This form need not be included in MCO proposals themselves.

The following documents must be submitted, as applicable:

1. General Technical Proposal (one original, 4 bound copies, and one unbound copy) containing - **(New MCOs that have never been qualified)**

    - County election form.
    - Transmittal letter covering the items described in Section 3.2.3 (original signed in ink).
    - Executive summary not to exceed five pages in length.
    - Answers to questions I - 94, with each question section separately tabbed.
    - Proposal submission forms G- I through G-7.

2. Network Composition Proposals for New York City (if applicable) and each additional county the applicant is proposing to serve, containing (three bound copies and one unbound copy for each service area) - (**New MCOs and qualified MCOs seeking to expand service areas)**

    - County election form.
    - Proposal Submission Form G-4 (borough/county-specific).
    - Attestation form.
    - FQHC contracting/exemption (Schedule F).

3. Business Proposal (five bound copies and one unbound copy) containing - **(New MCOs and Qualified MCOs expanding into new rate regions)**

    - County election form.
    - Proposal Submission Form(s) G4.
    - Operating Plan/Premium Proposal
    - Reinsurance election.
    - Physician Incentive Plan Disclosure requirements (See Section 2.12.2.3)

4. ADA Compliance Plan (if not submitting as part of General Technical Proposal) (**New MCOs).**

5. New York City Proposal Addendum (if applicable). [See instructions in Section 3.1 of the NYC Addendum; the following documents will be submitted directly to HCA:] **(New MCOs that wish to serve New York City and Qualified MCOs that have not previously qualified in New York City.)**

Part A (one bound and four unbound copies) containing:

- Response to New York City-specific questions.

Part B (two unbound copies) containing:

- Completed Vendex questionnaire.
- Division of Labor Services report.
- Americans with Disabilities Act compliance plan.
- Completed MacBride Principles Rider.
- Copies of all Statements of Deficiancy issued to the Plan by SDOH since January 1, 1993, with approved Plans of Correction.
- Model participating provider agreements for primary care providers, specialist and hospital providers

New York State Managed Care Program
Borough/County Election Form

Place an "X" in the box for each of the boroughs/counties which you are proposing to serve and indicate whether it represents an expansion for the plan.

County/Borough (list alphabetically)	Proposing to Serve ("X" if yes)	Service Area Expansion ("X" if yes)

PROVIDER NETWORK ATTESTATION

I (Name of CEO)_____ hereby attest that the submitted provider network information on the Health Provider Network (HPN) system represents that (Name of HMO/PHSP) HMO/PHSP, has executed contracts that are currently in effect with the providers and service centers, obligating them to provide care and services to members residing in (list all applicable counties) _____ County.

_____

(Signature)

Plan Chief Executive Officer

_____

Notary Seal and Signature

PROVIDER NETWORK ATTESTATION

I (Name of CEO0)_____ hereby attest that the submitted provider network information on the Health Provider Network (HPN) system represents that (Name of HMO/PHSP) HMO/PHSP, has received **letters of intent** from the providers identified indicating that they are interested in contracting with the MCO to provide care and services to members residing in (list all applicable counties) _____County and that prior to executing a contract with a local department of social services the network data will be updated to reflect those providers that have actually executed contracts.

_____

(Signature)

Plan Chief Executive Officer

_____

Notary Seal and Signature

Health Provider Network (HPN)
Security and Use Policy for Organizations
with Connections to the Network

I. INTRODUCTION

The New York State Department of Health has created the New York State Health Provider Network (HPN) to be used as an intranet connection for all MCOs. This connection will enable personal computers or other computer equipment at each MCO location to send and receive information.

NYSDOH will maintain the security of data on the HPN, and protect such data obtained from each MCO from intrusions originating on the HPN.

The successful implementation of the HPN will improve the exchange of data between MCOs and the NYSDOH, and will provide increased provider access to NYSDOH data in general. This document highlights security issues outside the control of NYSDOH that MCOs must consider when handling sensitive data.

II. OVERALL SECURITY

MCOs are responsible for the security of data physically located on or transported over their network. This includes validation of users accessing their network, physical security of computers on their network, and security of removable media.

III. DATA DISCLOSURE

Employees or agents of the MCO who have acquired knowledge of information that originated from the HPN shall not disclose this information to any other person unless that person is authorized to see that information and requires that information to perform an official task.

IV. RESPONSIBILITY

The MCOs assume responsibility for the actions of their employees or agents. The MCOs employees or agents requiring access to the HPN will be given an HPN User Security and Use Policy and will require the employee or agent to acknowledge the terms of that policy by signing a copy of the document.

V. MCO HPN COORDINATOR

MCOs are required to designate a HPN network services coordinator who will be the principal point of contact. The coordinator will keep NYSDOH apprized of issues and problems, and will

also advise NYSDOH of provider network changes that could affect the HPN connection. The CEO will notify NYSDOH of any change in the person designated as the HPN Coordinator.

VI. INVESTIGATIONS

The MCO HPN network coordinator will promptly notify NYSDOH of any actual or suspected violations of this policy and will cooperate with NYSDOH in any subsequent investigations. Detailed logging of all HPN network communications activity may be required during the course of an investigation.

VII. ACKNOWLEDGMENT

I am the Chief Executive Officer for _____.
I have read and understand the Organizational Network Security Policy and the attached HPN User Security and Use Policy. I agree to the terms and conditions of these agreements. I have designated _____as the HPN Coordinator.

Printed MCO Name: _____

Chief Executive Officer Printed: _____

Signature CEO:_____

Telephone: ____-____-_____

Date: _____

Subscribed and sworn to before me on

this ____ day of _____, 19___

_____
Notarization

HPN Coordinator accepts these responsibilities identified above :

HPN Coordinator signature: _____

NYSDOH Health Provider Network (HPN)

Security and Use Policy for Operating and Running the Technology (SUPORT)

I. INTRODUCTION

The New York State Health Department (NYSDOH) employs a variety of proprietary and customized technical processes to protect the data residing on, or being transported on, the Health Provider Network (HPN). Access to data reported by the MCO is restricted to use by that specific plan.

The connection provided through the HPN is intended to aid reporting to the NYSDOH. HPN access is a useful resource that must be managed in a manner that will maximize its appropriate use. The department has adopted a Security and Use Policy described herein to maintain the integrity of the HPN.

This document describes the policy that users of the HPN must follow to assure appropriate security, access, and use.

II. OVERVIEW

It is expected that authorized participants will use the services and tools provided through the HPN to achieve related goals consistent with the mission of the NYSDOH Office of Managed Care:

- to promote and facilitate high quality, accessible and cost effective health care to the citizens of New York through managed care delivery systems,
- to ensure that MCOs maintain a network of health care providers adequate to meet the comprehensive health needs of its participants, and
- to provide an appropriate choice of providers sufficient to provide the services to its participants.

The use of HPN and its facilities by any employee or other authorized person must be consistent with this Security and Use Policy.

III. SECURITY

Each MCO must identify one or more specific users for accessing the HPN; these users must sign the Security and Policy Acknowledgment and Request. HPN users are assigned various access codes, including user ids and passwords by NYSDOH. These codes are unique for every user and must not be shared with others. NYSDOH uses these codes to manage and control access to data, including

confidential information. NYSDOH must be notified immediately if a user suspects that any of their secret access codes have been compromised. Upon termination of employment users shall discontinue use of his or her user identification and password and the employer will provide notice within no more than three days of such termination to the NYSDOH HPN Security Unit.

- HPN users are expected to respect the privacy of data on the HPN. While HPN has routines in place to maintain this privacy, it is expected that users will not try to purposefully circumvent the routines. Users accessing the NYSDOH HPN network shall not intentionally seek information on, obtain copies of, or modify files, data or identification codes belonging to other users, unless explicit written permission has been given by the NYSDOH. Users shall not seek electronic means to gain unauthorized access to managed care information present on the HPN for which they have not been granted explicit access.

- For both security and performance reasons, logs are kept of all HPN accesses. Users, therefore, understand and agree to the fact that these logs and monitoring sessions can trace their activities on the HPN.

- Using the HPN without authority granted herein is a violation of this agreement.

IV. USAGE

1. ACCEPTABLE USE

Use of the HPN shall be consistent with the broad purposes of: regulation of managed care entities; state, local, or national government affairs; public service; and the administrative activities necessary to carry out those purpose.

- information and data accessible via the HPN shall be determined by the Bureau or Division responsible for collection and maintenance and all questions concerning denial of access should be addressed to such Bureau or Division

2. UNACCEPTABLE USE

The following are examples of unacceptable uses of the HPN:

- for any illegal purpose
- to transmit threatening, obscene, or harassing materials
- to interfere with or disrupt network users, services or equipment
- distribution of any advertising material or products
- propagation of computer worms or viruses
- using the network to make unauthorized entry to other computer's information, or communications devices or resources
- using the network to infringe any copyright protections applicable to programs and/or

data available on the HPN
- for personal profit or gain
- advertising of products or services
- for the distribution of “Chain letters”, or “broadcasting” messages to lists or individuals, or other types of use which cause congestion or otherwise interfere with the work of others
- for recreational activities
- to intentionally develop programs that harass and/or damage or alter the software components of a computer or computing system

V. DATA DISCLOSURE

Health data/information originating from the HPN is protected under state and federal confidentiality laws as well as NYSDOH policy/procedures. Employees or agents of the provider who have acquired knowledge of health data/information from the HPN shall not disclose this information to any other person unless that person:

- is explicitly authorized to see that information,
- requires that information to perform an official task, and
- has signed and filed a HPN Security and Use Policy agreement with NYSDOH.

VI. ENFORCEMENT

The guidelines established with this policy are intended to be illustrative of the range of acceptable and unacceptable uses of the HPN and its facilities, and are not necessarily exhaustive. Questions about specific uses not enumerated in this policy statement should be directed by e-mail to ftk01@health.state.ny.us. Reports of specific unacceptable uses must be reported by e-mail to security @health.state.ny.us and ftk01@health.state.ny.us immediately.

VII. VIOLATIONS

Clear violations of the policy which are not immediately remedied will result in termination of HPN services for the person(s) at fault. Unauthorized use, fraudulent use, abuse of computing on network facilities, or unauthorized disclosure of information will lead to suspension of access and loss of privilege.

VIII. ACKNOWLEDGMENT AND REQUEST

By signing this agreement, I am requesting access to the HPN. I have read and understand the attached NYSDOH Health Information Network (HPN) Security & Use Policy and agree to the terms and conditions of this agreement. I understand that non-compliance with this agreement can result in immediate suspension of any and/or all network access, as well as investigation, and/or referral for disciplinary action.

I also understand that logging and monitoring of keystrokes and other monitoring activities may occur.

I will not share this access with anyone else. This is my individual account and I am responsible for any activity attributable to the use of this account.

Printed Name: _____

Title: _____

Provider Name: _____

Mailing Address: _____

Telephone: ____-____-_____

Signature: _____

Date: _____

Subscribed and sworn to before me on

this _____ day of _____, 19___

_____
Notarization

G-1 Applicant Managed Care Experience in New York State

Borough/County	Month/Year in which service began	Current Enrollment (all aid categories)
Boroughs		
1. Brooklyn		
2. Bronx		
3. Manhattan		
4. Queens		
5. Staten Island		
Counties (List alphabetically)		
1.		
2.		
3.		
4.		
5.		
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35.		

G-2 Applicant Managed Care Experience In Other States

State (alphabetically)	Month/Year in which service began	Voluntary or mandatory	Aid categories served (LIF, SSI, SC/C etc.)	Current enrollment (all aid categories)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
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40.				

G-3 Number of FTEs employed or contracted

Area	Current FTEs	Additional FTEs to be hired if contract awarded	Total	% of total devoted to Program
Accounting & Budgeting				
Medical Director's Office				
QA/UM				
Member Services				
Provider Services				
Claims Processing				
MIS				

G-4 Enrollment Capacity*

Borough/County/Summary:_____

Month	Year 1	Year 2
Month 1(April)		
Month 2		
Month 3		
Month 4		
Month 5		
Month 6		
Month 7		
Month 8		
Month 9		
Month 10		
Month 11		
Month 12		

*For each category, indicate the TOTAL number of enrollees (all rate categories) the applicant is able and willing to enroll each month. For example, if the applicant's capacity is 1,000 in Month 1, and an additional 500 in Month 2, enter 1,500 for Month 2.

G-5 MCO Performance on Key Quality Indicators

Note: Report your performance in the aggregate for all parts of the State in which you operate. Statistics should be reported for Medicaid enrollees only.

	Measure	Performance	For Time Period
1.	C/THP Periodicity Schedule Compliance Rate (% of total)		
	-Preventive Screens		
	-Immunizations		
2.	Adult members seen by a physician for a preventive visit (% of total)		
3.	Emergency Room Visit - per 1,000 enrollees (annualized)		
4.	Prenatal visits (Initial Visit) (% of total)		
	- Seen in first trimester		
	- Seen in second trimester		
	- Seen in third trimester		
	- Not seen before delivery		
5.	Low birthweight birth rate (% of total)		
	- Under 1,500 grams		
	- Under 1,000 grams		
6.	Cesarean Section Rate (% of total)		

G-6 Attestation Form

MCO Name**:**_____

I hereby attest that throughout the term of this contract, I shall comply with all Federal and State laws prohibiting discrimination and I assure that services will be provided without distinction on the basis of race, sex, color, national origin, or handicap and that no distinction is made on the basis of age except as the law allows. I assure compliance with the 1964 Civil Rights Acts, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, as amended, Executive Orders I 1 246 and 1 13 75, and the Americans with Disabilities Act of 1990 (Public Law 101-326), all amendments to and all requirements imposed by the regulations issued pursuant to this act.

I hereby certify to comply with Anti-Lobbying Law, Section 1935, Title 31 of the U. S. Code, implemented at 45 CFR Part 93, Section 93.105 and 93.110, for persons entering into a grant or cooperative agreement over $ 100,000. 00.

I hereby certify to comply in providing or continuing to provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988 and implemented at 45 CFR Part 76, Subpart F for grantees, as defined at 45 CFR Part 76, Section 76.605 and 76.61 0.

I further certify that the MCO and its principals meet all requirements found at 45 CFR 76, for prospective participants in primary covered transactions, as defined at 45 CFR Part 76, Section 76.105, 76. 110, Debarment, Suspension and other Responsibility Matters.

I further certify that the MCO does not knowingly have an individual who has been debarred, suspended or otherwise excluded from participating in procurement activities:

1. as a director, officer, partner or person with beneficial ownership of more than 5% of the MCO's equity; or

2. as a party to an employment, consulting or other agreement with the MCO for the provision of items and services that are significant and material to the MCO's obligations in the Medicaid managed care program, consistent with the requirements of SSA Section 1932(d)(1)

I shall maintain adequate records to disclose fully the extent of services provided to individuals under the ***New York Managed Care Program*** and to furnish information regarding any fee-for-service payments claimed for providing services under the State Title XIX Plan. Authorized personnel of the U.S. Department of Health and Human Services and the State of New York shall have the right to access any books, documents, papers or other records of the MCO which are pertinent to the performance or payment of this contract in order to audit, examine, make excerpts, and/or transcripts. The MCO shall keep records of services delivered for 6 years from date of service or 3 years from age of majority, whichever is longer.

G-6 Attestation Form
Page 2

MCO Name:_____

I hereby certify that the MCO shall comply with all other terms and conditions as described in the Qualification Document.

I understand that the State may withhold enrollment of Program members into my health plan until I am able to satisfy each of these requirements.

Authorized Signature	Date
Printed Name	Title

G-7 Disclosure Form

MCO Name: _____

The disclosures requested below are required by HCFA and are in accordance with 42 CFR 455. 100 through 455.106.

1. Information on Ownership

A. List the names and addresses and percent of ownership or control' of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of disclosing entity, directly or indirectly.

Name	Address	Percent of Ownership/Control

B. List the names and addresses and percent of ownership or control of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

Name	Address	Percent of Ownership/Control

' Control, which shall be synonymous with the terms controlling, controlled by and under common control with, means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities or voting rights, by contract (except a commercial contract for goods or non-management services) or otherwise; but no person shall be deemed to control another person solely by reason of his being an officer or director of such other person. Control shall be presumed to exist if any person directly or indirectly owns, controls or holds the power to vote 5 percent or more of the voting securities or voting rights of any other person, or is a corporate member of a not-for-profit corporation.

MCO Name: _____

C. List **the names** of persons listed in (A) **and** (B) above who are related to **another as spouse, parent,** child, or sibling of those individuals with an **ownership** or controlling interest.

First Name	Second Name	Relationship

D. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

2. Information Related to Business Transactions

A. List the ownership of any subcontractor with whom the offeror has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request.

Describe Ownership of Subcontractor	Type of Business Transaction	Dollar Amount of Transaction

MCO Name: _____

B. List any significant business transactions between the offeror and any wholly-owned supplier or between the offeror and any subcontractor during the five (5) year period ending on the date of the request.

Describe Ownership of Subcontractor	Type of business Transaction	Dollar Amount of Transaction

C. List the name and address of each creditor whose loans or mortgages exceed 5% of the total plan equity and are secured by assets of the plan.

Name	Address	Description Of Debt	Amount of Security

MCO Name: _____

3. Information on Persons Convicted of Crime

A. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that persons involvement in any program under Medicare, Medicaid, or the Title XIX services program since the inception of those programs.

Name	Address	Title

I hereby attest that the information contained in this Disclosure Form is current, complete, and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the MCO, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable State laws. In addition, I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in disqualification from participation in the ***New York Managed Care Program.***

_____ _____
Authorized Signature Date

_____ _____
Printed Name Title