

CHAPTER 3: PROPOSAL SUBMISSION INSTRUCTIONS

3.1 Overview

3.1.1 Contact and Mailing Address

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 #1927
Albany, New York 12237**

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

All submissions should be mailed to this address, including one copy of the NYC Addendum for those MCOs applying to serve NYC. For MCOs applying to serve Medicaid enrollees in NYC, submissions of the NYC Addendum should also be mailed to the NYC Department of Health, Division of Health Care Access (CDOH-HCA). Specifics regarding the submission (e.g. number of copies) are included in the NYC Addendum. Additionally, MCOs applying to serve NYC should include the ADA Compliance Plan in their NYC Addendum submission.

3.1.2 MCO Qualification Guideline Amendments

The State reserves the right to amend this Document at any time prior to the proposal due date by issuing written addenda. The State will issue such amendments in accordance with State law and The Stewardship Procurement Act of 1995.

3.1.3 Technical Assistance

Staff from the Office of Managed Care are identified throughout this document as a source of additional information or materials. They are available to provide technical assistance to interested MCOs as needed. The main numbers for each Bureau within the Office of Managed Care are found on Page 10.

3.1.4 Cost of Preparing Proposals

Applicants are solely responsible for the costs incurred in the preparation and submission of their proposals.

3.1.5 Disposition of Proposals

Successful proposals will be incorporated into resulting contracts and will be a matter of public record. All material submitted by applicants becomes the property of the State of New York,

which may dispose of it as it sees fit. The State shall have the right to use all concepts described in proposals, whether or not such proposals are accepted or rejected.

MCO proposals will consist of the following components:

- ! Full General Technical - (New MCOs and MCOs that did not qualify in previous cycles)
- ! ADA Compliance Plan [Section 3.2.7 Chapter 4] (New MCOs)
 - T New York City MCOs should submit in NYC Addendum
 - T Non-New York City MCOs should submit with General Technical and/or Network forms (as applicable)
- ! Abbreviated Network Composition (All MCOs)

New MCOs must submit an original, four (4) bound copies, and one unbound copy of their general technical proposals. The original proposal should be identified as such on the cover. All signatures in the original must be made in ink. The general technical proposals should be boxed together and the contents of the box(es) identified on the outside (i.e., labeled MCO Name - General Technical Proposals on the front and the binding).

MCOs also must submit Network Composition Proposals for every borough and county which they are proposing to serve. MCOs should submit three bound and one unbound copy of the Network Composition Proposal for each service area. Network data will be submitted via the Health Provider Network (HPN). (See Section 3.3.1 Network Composition for specifics of data submission.)

MCOs must submit five bound copies and one unbound copy of their business proposals. The copies should be boxed together and the contents of the box identified on the outside (i.e., labeled MCO Name - Business Proposals).

MCOs must submit a New York City Proposal Addendum, if they are proposing to serve any borough in the City. Specific instructions for preparing and submitting this document are included in the New York City Addendum to the MCO Qualification Guidelines.

3.1.6 Delivery of Proposals

MCO proposals submitted in response to this Document will be accepted at any time at the address shown in Section 3.1.1.

3.1.7 Request for Trade Secret Status

The New York State Department of Health is required to provide public access to certain documents it maintains. However, the Freedom of Information Law (FOIL), under Public Officers Law 87.2(d), allows exception for trade secret information which, if disclosed, could cause substantial injury to the competitive position of the applicant's enterprise.

Should the applicant believe certain portions of their response qualify for trade secret status, it must submit, in writing, explicit justification and cite the specific portions for which an exemption is being requested (please note that entire documents may not be exempted). The written request must accompany the proposal submission and should be included in a separate envelope placed in the General Technical Proposal box. Applicants requesting an exemption will be notified in writing of the Department's determination of their request.

3.1.8 Proposal Submission Checklist

Appendix 4.9 contains a checklist for MCOs, identifying the items that must be included in proposals. The checklist is provided for the benefit of applicants and need not be submitted with the proposal itself.

3.2 General Technical Proposals (New MCOs)

3.2.1 Format

General technical proposals must be organized as follows:

- ! County Election Form
- ! Transmittal Letter
- ! Chapter 1: Executive Summary
- ! Chapter 2: Compliance with Participation Standards
- ! Chapter 3: Proposal Submission Forms
- ! Chapter 4: ADA Compliance Summary

The required format for each proposal component is described below.

3.2.2 County Election Form

Applicants must complete the county election form identifying the boroughs/counties for which the proposal is being submitted (see Appendix 4.9 for the form template). The form should be inserted as the first page of the proposal, directly behind the cover.

3.2.3 Transmittal Letter

The transmittal letter must be signed by an individual duly authorized to make commitments on the organization's behalf and must contain ALL of the following:

- ! A statement attesting to the accuracy and truthfulness of all information contained in the

proposal, including, specifically, the applicant's network composition information.

- ! A statement that the applicant has read, understands, and is able and willing to comply with all standards and participation requirements described in the MCO Qualification Guidelines.
- ! A statement that the applicant is willing to enroll and serve all of the aid categories described in the MCO Qualification Guidelines as eligible for inclusion in managed care on either a mandatory or voluntary basis.
- ! A statement that the applicant has reviewed the county-specific standards for the counties it is proposing to serve and the New York City addenda (as applicable), understands, and agrees to conform its operations in each borough/county to meet these standards.
- ! A statement that the applicant's proposed capitation rates were developed independently, without collusion, conflict of interest, consultation, communications, or agreement for the purpose of restricting competition, as to any matter relating to such rates with any other applicant, prospective applicant, or competitor and that proposed rates were not knowingly disclosed prior to award, either directly or indirectly, to any other applicant or competitor.
- ! A statement indicating whether the applicant has chosen to be capitated for family planning and/or dental services.
- ! A statement that the applicant agrees to terminate its existing contract(s) (if any) to enroll and serve Medicaid beneficiaries in boroughs/counties participating in this qualification process, pursuant to execution of a new contract.

3.2.4 Chapter 1: Executive Summary

The Executive Summary should provide an overview of the proposing organization, with the applicant's key strengths highlighted. It should not be longer than five single-spaced or ten-double spaced pages in length, excluding tables or exhibits.

3.2.5 Chapter 2: Compliance with Participation Standards

In this chapter, applicants must document their compliance with program participation standards by responding to all of the questions listed below. Responses to questions must be preceded by a repetition of the question and must be in the same sequence as used in this Document. Each section of questions should be separately tabbed for easy identification and all pages should be numbered.

Any attachment(s) submitted in response to a question must be marked clearly with the question number to which it refers. Applicants are cautioned to submit only those materials that directly relate to the questions posed. Responses to questions should only be as long as necessary to demonstrate the applicant's ability to meet participation standards.

In general, it is anticipated that an applicant's answer to a question with respect to its operations will apply to all boroughs/counties that the applicant is proposing to serve. Where this is not the case, the applicant should clearly state how its status or operations vary between boroughs/counties.

Service Area

1. Identify all of the New York City boroughs and other counties which the applicant is proposing to serve. This should be consistent with the information on your county election form. Include a map displaying the zip codes/boroughs/counties.

Licensure (Certification)

2. Is the applicant licensed (certified) as an HMO or PHSP pursuant to New York State Law? If yes, attach a copy of the applicant's license. If no, describe the status of the applicant's activities to become licensed.

Experience

3. Complete and include in Chapter Three, Proposal Submission Form G-1, documenting the boroughs/counties in which the applicant currently serves Medicaid clients. If the applicant has no current contracts in New York State, indicate this here and do not include the form.
4. Complete and include in Chapter Three, Proposal Submission Form G-2, documenting any contracts the applicant currently holds to enroll and serve Medicaid clients in other states. If the applicant has no current contracts in other states, indicate this here and do not include the form.
5. Provide information regarding any instance in which the applicant has had a contract terminated or not renewed for nonperformance or poor performance within the past five years (January 1, 1992 or later).
6. Provide information regarding any instance in which a federal or state agency has ever made a finding of non-compliance against the applicant regarding any civil rights requirements.
7. Provide information regarding any instance in which the applicant has ever been suspended or excluded from any federal government program for any reason.
8. Provide information regarding any disciplinary actions by the New York State Department of Insurance, the State Department of Health, or any other State or county agency or State licensing board, taken against any of the applicant's participating providers.

Organization and Operating Staff

9. Provide an organizational chart that identifies the major operational components of the applicant's organization, including all of the functions listed in Section 2.3.
10. Identify the members of the applicant's Board of Directors and attach resumes or biographical descriptions for each. Specify which are New York residents and which are enrollees of the MCO (other than employees or providers).
- 11(a). Identify the following staff and attach resumes or biographical descriptions for each (resumes/descriptions should denote the individual's length of time in his/her current position and previous career history):

Chief Executive Officer
Chief Financial Officer
Medical Director(s)
Quality Assurance/Utilization Management Director
Member Services Director
Provider Services Director
Member Complaints Officer
Claims Processing Director
Management Information Systems Director

If any positions are vacant, attach a job description denoting educational/experience requirements.

- (b.) Identify the functions and services provided by a management contractor or administrative service agreement.
12. Complete and include in Chapter Three, Proposal Submission Form G-3, describing the number of non-clerical and -secretarial FTEs employed or contracted in each of the areas listed below. Also, specify on the form whether and by how much the applicant's staffing will be increased in each area if a contract is awarded. Finally, specify on the form the FTE equivalent (current and new staff) the applicant anticipates would be devoted to this program if a contract is awarded in all of the boroughs/counties which the applicant is proposing to serve:

Accounting and Budgeting
Medical Director's Office
Quality Assurance/Utilization Management
Member Services
Complaints
Provider Services
Claims Processing
Management Information Systems

The applicant should include all non-clerical and -secretarial staff who work within one of the above functional areas, even if the name of their functional area differs from what

is shown here.

13. Provide an implementation MCO outlining the major steps being taken by the applicant to prepare its organization for participation in this program. Include a timetable showing when each step is expected to be completed. The implementation MCO should not exceed five pages in length.

Member Enrollment

14. Complete and include in Chapter Three, Proposal Submission Form G-4, delineating the membership that the applicant expects to enroll through this program. If the applicant is proposing to serve more than one borough/county, a separate form must be completed for each borough/county, as well as a summary form across all boroughs/counties (the summary form should be placed in front and the enrollment figures shown on this form should be the sum of the individual borough/county forms) (note also that this form must be included in the other proposal binders as described below).
15. Describe how the applicant will notify new enrollees prior to their effective date of enrollment.
16. Describe the applicant's system for entering enrollment data into its system, including the name of the member's PCP. How quickly is enrollment data entered, from time of receipt?
17. Describe the applicant's new member orientation program. By what methods will new members be contacted? What information will they be given? What will the applicant do if its initial attempts to contact a member fail?
18. Describe the process and timeline whereby new enrollees will be allowed to choose a PCP.
19. Describe the process and timeline whereby new enrollees will be assigned to a PCP if they do not select one. Identify the factors the applicant will consider when making such assignments.
20. Describe the applicant's process for notifying PCPs about new patients. What actions, if any, are PCPs required to take upon learning of a new patient?
21. Describe the applicant's policy and process for allowing members to change PCPs. Describe specifically how enrollees will be made aware they are allowed to change a PCP. How quickly will change requests be processed and made effective? How many without cause change requests will be permitted in a twelve month period?
22. Describe the applicant's process and timeframe for distributing identification cards to new members. Provide a sample of the identification card the applicant intends to distribute to MCO members (a photocopied sample is satisfactory). How, if at all, will the cards differ from those used by other MCO members, if the applicant serves non-

Medicaid populations? Describe the type of confirmation or service authorization procedure the applicant will use (i.e., welcome letter, temporary MCO ID card, etc.) to enable new enrollees to access MCO providers prior to the issuance of permanent ID cards.

Status Changes

23. Describe the applicant's process for identifying and notifying the LDSS of changes in eligibility status among its members.

Member Disenrollment

24. Describe how members will be informed of their ability to disenroll from the MCO.
25. Describe member services staff policies and procedures regarding disenrollment.
26. What system does the applicant have in place to analyze disenrollment for use in the Quality Assurance Program?

Covered Services (Prepaid)

27. Describe the steps the applicant will take to encourage new members to make an initial visit to their PCP. How will the applicant monitor its success in encouraging members to visit their PCP? Will the applicant undertake any follow-up if a member does not make a visit within a preestablished period of time?
28. Describe and include copies of any formal health assessment screens the applicant uses to identify special health care needs among new members.
29. Describe the specific steps the applicant will follow to comply with C/THP requirements. Describe any special outreach or education programs the applicant will initiate with respect to C/THP.
30. Describe how the applicant will identify pregnant women and ensure that prenatal care begins at the earliest possible date. Describe any special outreach or education programs the applicant will initiate to ensure compliance with prenatal visit schedules.
31. Describe how the applicant will identify high risk pregnancies and the manner in which care will be coordinated for such pregnancies.
32. Describe how the applicant will identify the needs of, and case manage delivery of services to, members with complex or chronic medical conditions. Discuss adults and children separately.
33. Include the applicant's protocols for the case management and treatment of each of the following conditions/patient types: asthma; substance abusing pregnant women; diabetes; physical disabilities; and chronic mental health needs.

34. Describe how the applicant will identify individuals with mental health service needs and encourage these persons to begin treatment. What training and/or assessment tools will the applicant provide to its PCPs to assist them in identifying individuals requiring such services?
35. Describe how the applicant will identify individuals with alcohol or substance abuse treatment needs and encourage these persons to begin treatment. What training and/or assessment tools will the applicant provide to its PCPs to assist them in identifying individuals requiring such services?
36. Describe the manner in which the applicant will make available the following enhanced services: general health education classes; pneumonia/influenza immunizations for at risk populations; smoking cessation classes; childbirth education classes; parenting classes; extended care coordination for pregnant women; and nutrition counseling. Describe any special outreach or education programs the applicant will initiate with respect to enhanced services.
37. Describe how the applicant will use state supplied pharmacy claims data for use in case management.
38. Describe how the applicant will coordinate service delivery between network providers delivering prepaid services and other providers delivering wraparound services.

Primary Care Providers

39. Describe the types of physicians (specialties) the applicant will allow to serve as PCPs. Describe the process for allowing Specialists to act as a PCP.
40. Describe the manner and extent to which the applicant will use nurse practitioners as PCPs. Describe the manner and extent to which physician assistants will be used to deliver primary care services.
41. Describe the manner and extent to which the applicant will use medical residents to deliver health care services. What specifically will these residents be permitted to do? What will their reporting relationship to attending physicians be and how will they be supervised?
42. What is the minimum number of office hours per week (by site) that the applicant will permit its PCPs to offer. How will compliance with this standard be monitored? Has the applicant requested a waiver of the minimum office hours standard? If yes, then has the applicant submitted the necessary documentation?
43. What is the maximum number of MCO Medicaid enrollees that the applicant will allow its PCPs to serve (on an FTE basis)? What mechanism does the applicant have for tracking whether a PCP has attained a maximum enrollment?

44. How will the applicant monitor PCP capacity overall and what short term and long term actions will be taken when capacity problems are identified?
45. Describe the types of reimbursement arrangements the applicant has made with its PCPs (e.g., fee schedules, sub-capitations, risk pools, etc.). If more than one type of arrangement will be offered, provide an estimate of the percentage of PCPs with which the applicant expects to contract under each type of arrangement. Attach a copy of a model PCP contract.
46. Describe any Physician Incentive Plans,(PIP). If the MCO does not operate a PIP, then it must attest to that fact. If the PIP arrangements are at substantial financial risk, then the MCO must comply with federal requirements. An arrangement is at substantial financial risk when the incentive arrangements place the physician or physician group at risk for services beyond those provided directly by the physician or physician group for amounts beyond the risk threshold of 25 percent of potential payments for covered services. Is there substantial financial risk? Describe stop-loss protection?
47. What network changes does the applicant anticipate having to undertake to accommodate the enrollment of SSI beneficiaries? What type of analysis will the applicant conduct to determine its needs? Will the applicant allow specialists to serve as PCPs for these members and, if so, under what circumstances?

Traditional Medicaid Providers

48. Describe the status of the applicant's efforts to include the traditional Medicaid provider types listed in Section 2.6.6 in its network.
49. Provide an estimate of the portion (in units of service) of the applicant's mental health and substance abuse treatment services that it anticipates furnishing through OMH- and OASAS-licensed providers Statewide.

Major Sub-Contracted Providers

50. Describe any major, risk-based sub-contracts the applicant will employ to deliver a particular category of services. Discuss how the applicant will monitor the performance of these subcontractors. All such contracts must receive approval from SDOH.

Service Accessibility

51. What will the applicant instruct its members to do if they have a medical problem after business hours or on weekends?
52. What requirements will the applicant place on its PCPs in terms of providing after hours/weekend coverage? How will the applicant monitor their performance in this area?

53. Will the applicant allow PCPs to sign-out to nonparticipating providers for after hours coverage? If so, how will the applicant verify that such providers are in compliance with its credentialing standards?
54. Describe the applicant's toll-free twenty-four (24) hour telephone line. Who will staff this line? Describe procedures for responding to calls from enrollees who don't have a telephone. Describe training for PCPs and internal customer services staff on policies and procedures for checking on whether enrollees are in a position to take return phone calls and for dealing with enrollees who cannot receive such calls.
55. What specific mechanisms does the applicant intend to employ to discourage use of hospital emergency rooms in non-emergent/urgent situations?
56. What is the applicant's standard for days wait to appointments for each of the appointment types delineated in Section 2.7.5? How will the applicant monitor provider compliance with these standards?
57. What is the applicant's standard for waiting times in provider offices and in health centers/clinics (if different)? How will the applicant monitor provider compliance with this standard?
58. What is the applicant's standard for travel time to a PCP? To a network hospital? How will the applicant monitor its ability to offer members network providers whose distance to the member residence falls within its standards?
- 59.(a) How will the applicant inform members about their freedom to self-refer for OB/Gyn, mental health, substance abuse, dental, vision, HIV testing at anonymous sites, and family planning services (beyond stating such rights in the member handbook)? What steps will the applicant take to coordinate service delivery between PCPs and providers in these self-referral option categories?
- 59.(b) Describe procedures for providing a member with a standing referral to a specialist. Describe how a member can receive a referral to a specialty care center. Describe how the applicant will allow members access to services outside the MCO's network. Describe how the applicant allows new members to continue using a non-network provider or how the member can continue treatment with a provider that leaves the MCO's network.

Member Services

60. Describe the duties of the applicant's Member Services function. What hours will it operate? Will the applicant operate a separate Member Services function for its Medicaid enrollees?
61. How will the applicant monitor the language needs of its members? How will the applicant ensure access to translations of written materials when the threshold for any particular language group is surpassed? How will the applicant ensure access to interpreters?

62. What will the applicant do to ensure access to Member Services for hearing, visually or cognitively impaired members and others with special needs?

Provider Services

63. Describe the duties of the applicant's Provider Services function. What hours will it operate?
64. Will the MCO have separate Provider Service arrangements for its special needs networks? If so, please describe.

Quality Assurance and Utilization Management

65. Complete and include in Chapter Three, Proposal Submission Form G-5 documenting the applicant's success rate in serving Medicaid clients in the current program. Describe the methodology used to document performance in each area. If the applicant has no current contracts in New York State, or has had no contracts for more than six months, indicate this here and do not include the form.
66. Include a copy of the applicant's most recent approved quality assurance plan (QAP). Include a description of the applicant's QAP objectives and its approach to achieving these objectives.
67. Has the applicant adopted the New York Prenatal Care Standards for MCOs? If not, what standards does the applicant use?
68. Describe how the applicant has incorporated QARR standards into its QAP.
69. How will the applicant monitor the quality of care rendered by its providers? What corrective actions will the applicant undertake if it learns that substandard care is being rendered?
70. Who will be accountable within the applicant's organization for the QAP?
71. Describe the applicant's quality assurance committee, including its network composition, responsibilities, and the frequency with which it meets.
72. Describe how the applicant involves providers in its QAP. How will the applicant keep its providers informed about their performance relative to the organization's quality assurance standards?
73. Describe the applicant's system for documenting QAP activities.
74. Describe how the applicant coordinates QAP activities/findings with other MCO activities.
75. Describe the duties of the applicant's Medical Director's office. Indicate whether the

Medical Director is an FTE, and, if not, the number of hours he/she works in this capacity per week. If Assistant or Associate Medical Directors are used, describe their functions and FTE status as well.

76. Describe the applicant's credentialing and recredentialing standards and protocols, including how often recredentialing is performed. Attach copies of credentialing/reccredentialing forms used by the applicant.
77. What is the applicant's policy with respect to retention of medical records and access to records for QA purposes? Describe how the applicant informs network providers about its medical records standards and monitors their compliance with these standards.
78. Describe the applicant's policies with respect to prior authorization, including the types of services requiring authorization, the speed with which it is granted or denied, the means by which denials are communicated, and the process for appealing denials.
79. Describe the applicant's policies with respect to utilization review, including the cases on which it is performed, the frequency with which it occurs, and any linkages that exist between prior authorization and concurrent review.
80. Describe the applicant's policies with respect to retrospective medical review, including the types of cases on which it is performed and follow-up activities which occur based on the findings of the review.
81. How will the applicant inform its members about their rights and responsibilities, including external appeal, in addition to including such information in member handbooks?
82. Describe the applicant's policies for protecting the confidentiality of member information.

HIV/AIDS

83. Describe the applicant's clinical protocols for the treatment of both HIV+ persons who are asymptomatic and persons with AIDS. Provide information on the process and periodicity schedule for updating these protocols, to ensure that new treatment modalities are incorporated on a timely basis. Finally, discuss the applicant's methods for ensuring that providers are aware of and follow accepted treatment guidelines.
84. Describe the applicant's case management program for persons who are HIV+ and for persons with AIDS. Identify any special initiatives directed at children, adolescents, pregnant women, and intravenous or injection drug users.
85. Describe the applicant's outreach and educational efforts and programs for persons who are HIV+ and for persons with AIDS. Discuss the applicant's experience in identifying and bringing into treatment hard-to-serve persons.

86. Provide specific information on the expertise and experience of network providers in treating children, adolescents, and adults who are HIV+ or have AIDS. Descriptions should include an inventory of the applicant's HIV/AIDS network providers (e.g., physicians by specialty, AIDS designated treatment centers, nurse practitioners etc.), their specific experience with HIV/AIDS patients in general and for individuals with dual diagnoses (mental health and/or alcohol and substance abuse) in particular, and their linkages with other supportive services providers in the community. Also, describe any special training these providers have received from the applicant or as a condition for being credentialed to treat HIV/AIDS patients.
87. Describe the applicant's referral process for enrollees who identify themselves as HIV+ and wish to select a PCP with expertise in treating HIV/AIDS.
88. Describe the applicant's policies and procedures for ensuring appropriate confidentiality of the HIV status of its enrollees.

MCO Marketing

89. Describe the methods by which the applicant intends to market itself to potential enrollees. Discuss both direct and indirect (mass media) marketing activities. Also describe how the applicant will monitor the activities of its marketing staff.

Operational Data Reporting

90. Describe the applicant's plan for collecting and reporting operational data pursuant to program reporting requirements, as currently defined.
91. How will the applicant verify the accuracy of data reported by its providers? Discuss any data validation activities the applicant performs, including medical records audits.

Complaint Resolution

92. Describe the applicant's internal complaint resolution process, including who is responsible for this function, the timeframes for resolving complaints, how complaint levels are monitored, and any linkages that exist between this area and Quality Assurance.

Payments to Providers

93. Will the applicant process provider claims in-house or through a contractor? If processed in-house, attach a flow chart and supporting narrative depicting the applicant's claims processing function. If contracted-out, attach a copy of the applicant's contract with its claims processor.
94. How quickly, on average, does the applicant adjudicate and pay clean claims?
95. What is the applicant's methodology for estimating IBNRs? Describe the frequency with which projections are made and the data sources that are used.

96. Describe how the applicant will identify and pursue Third Party Health Insurance.

3.2.6 Chapter 3: Proposal Submission Forms

This chapter should contain the following completed technical proposal forms, all of which can be found in Appendix 4.9:

- ! G-1: Managed Care Experience in New York State
- ! G-2: Managed Care Experience in Other States
- ! G-3: Staffing
- ! G-4: Enrollment Projections
- ! G-5: MCO Performance Against Key Quality Indicators
- ! G-6: Attestation Form
- ! G-7: Disclosure Form

3.2.7 Chapter 4 ADA Compliance Plan

Applicants must submit an ADA Compliance Plan, describing in detail how the MCO will make its programs and services accessible to and usable by enrollees with disabilities. The State has developed guidelines for ADA and Section 504 of the Rehabilitation Act of 1973 compliance, and these guidelines are attached as Appendix 4.11. It is recommended that MCOs review and use these guidelines in the preparation of their ADA Compliance Plan. Additional materials are available from the Bureau of Managed Care Program Planning to assist MCOs in determining their level of compliance with ADA requirements, in identifying services/sites which are not accessible and in identifying reasonable alternative methods for making those services/sites accessible.

3.3 Network Composition

3.3.1 General

Applicants must submit a network proposal (three bound and one unbound copy) that identifies each county the MCO is proposing to serve, as well as New York City if they are proposing to serve any of the five boroughs.

The proposals must be organized as follows:

- ! County/Borough Election Forms
- ! Proposal Submission Form G-4 (for each county)

! Chapter 1: HPN Attestation Form

! Chapter 2: Schedule F FQHCs where applicable.

3.3.2 County Election Form

Applicants must include a copy of their county election form as the first page of the proposal, directly behind the cover.

3.3.3 Proposal Submission Form G-4

Applicants must include a copy of Proposal Submission Form G-4 (Enrollment Projections) for that county, directly behind the county election form.

3.3.4 Chapter 1: Detailed Provider Data

HPN Attestation Form.

Applicants are required to submit detailed provider network data using the HPN for each county in which the MCO wishes to operate. Applicants will submit two files, a “Physician and Other Providers Data File” and an “Ancillary/Service Centers File”.

Applicants may access and transmit the data via the HPN using Netscape utilizing the procedures outlined in the HPN training manual distributed to all MCOs. (The training manual is available from the Bureau of Quality Management and Outcomes Research). MCOs that have never submitted data via the HPN must establish an account and comply with security requirements. Each MCO should have the appropriate security forms, signed by the CEO, on file at SDOH. Copies of these forms are included in Appendix 4.9.

SDOH will use the data from the HPN to evaluate networks, and to calculate capacity. SDOH will also use the data submission to generate network information for the counties to use in evaluating accessibility (travel time and distance standards) of networks.

Attestation forms from MCOs must be submitted with the initial submission, then again with the annual submission. If an initial network submission includes providers who have not executed contracts, then the data must be submitted a second time prior to contracting with the LDSS and should only include providers who have executed contracts with the MCO. A second attestation form (attesting to the fact that all providers identified have executed contracts) should accompany the second submission.

3.3.5 Chapter 2: FQHCs

MCOs must submit a Schedule F, which demonstrates how the MCO satisfies the federal requirements regarding contracting with FQHCs. In Schedule F, MCOs will document all the FQHCs with which they contract, and/or provide data to support a request for an exemption for contracting with FQHCs in the MCO’s service area. See Section 2.6.6.6 for additional detail

regarding the federal policy.

3.4 Business Proposal Requirements

3.4.1 General

All MCOs proposing to enroll and serve beneficiaries under this program must submit a business proposal, which includes an Operating Plan and Premium Proposal. This section includes instructions for preparing the proposal, and describes financial information requirements. MCOs are cautioned to carefully review this section and follow all instructions.

The business proposal must be organized as follows:

- ! County Election Form
- ! Proposal Submission Form(s) G-4
- ! Chapter 1: MCO Financial Information
- ! Chapter 2: Reinsurance Election
- ! Chapter 3: Operating Plan and Premium Proposal

The required format for each business proposal component is described below.

3.4.2 County Election Form

Applicants must include a copy of their county election form as the first page of their proposal, directly behind the cover.

3.4.3 Proposal Submission Form(s) G-4

Applicants must include copies of their borough/county-specific and summary proposal submission forms G-4 (Enrollment Projections) directly behind the County Election Form. These forms will be used to determine the MCO's financial reserve and escrow deposit requirements, and will serve as the basis for contract enrollment maximums, along with calculated network capacity.

3.4.4 Chapter 1: MCO Financial Information

In this chapter all applicants must provide all of the financial information listed below. Such information should be provided for the organization holding a certificate of authority to operate as an MCO in the State of New York. If information is only available for a parent corporation, the applicant should include a letter from the parent corporation indicating its willingness to provide whatever financial support is necessary to assure the solvency of the applicant's New York operations. The applicant should provide as much detail and supporting documentation as it feels

is warranted for the items listed below to support that it is a fiscally viable entity for purposes of this bid.

The information to be submitted is as follows:

1. Audited financial statements for the two most recent fiscal years for which the statements are available. The statements must include a balance sheet, income statement, and a statement of cash flows. Statements must be complete with opinions, notes and management letters. If no audited financial statements are available, explain why and submit unaudited financial statements and any other supporting narrative and financial data.
2. Projected balance sheets, income statements, and cash budget for the provision of services monthly, for the term of the expected contract period. The financial statements should separately reflect New York Medicaid managed care line of business.
3. Projected balance sheet and statement of cash flows as of the projected start-date of the program.

The above information should be reported using the preprinted schedules available from the Bureau of Managed Care Financing.

3.4.5 Chapter 2: Reinsurance Election

MCOs have three options available with respect to reinsurance. They may:

1. Self-reinsure, assuming they have sufficient reserves and subject to SDOH or State Insurance Department approval where appropriate;
2. Directly contract with a reinsurance company licensed to do business in New York; or
3. Purchase reinsurance from the State (see Section 2.1.6.3 for a description of the State's reinsurance program).

In this chapter, the applicant must include a statement indicating which of the three options it is electing. If the applicant chooses the second option, also include in this chapter the name and address of the issuing insurer, scope of reinsurance, thresholds, and coinsurance amounts. Please note that the State will require a copy of the reinsurance contract prior to program start-up.

3.4.6 Chapter 3: Operating Plan and Premium Proposal

An Operating Plan/Premium Proposal must be submitted for each region where an MCO will enroll Medicaid recipients. MCOs that have existing rates (or have already submitted a rate proposal) for a particular region, do not need to submit an Operating Plan/Premium Proposal, in order to expand into other counties within the same region. County expansions do require submission of the information requested in Chapters 1 and 2. The proposal must be submitted in

hard copy and diskette. Instructions are included in the proposal format, which is available as Appendix 4.12 . The following information is to further clarify completion of this report

3.4.6.1 Regions

Applicants must submit proposed rates on a regional basis. The regions consist of groupings of counties and are defined as follows:

- ! Metro: Bronx, Brooklyn, Manhattan, Queens, and Staten Island boroughs
- ! Long Island: Nassau and Suffolk counties
- ! North Metro: Putnam, Rockland, and Westchester counties
(Note: The State is not accepting additional bids for Westchester County at this time.)
- ! Mid-Hudson: Dutchess, Orange, Sullivan, and Ulster counties
- ! Northeast: Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, and Washington counties
- ! Utica-Adirondack: Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Oneida, Oswego, and St. Lawrence counties
- ! Central: Cayuga, Chenango, Columbia, Cortland, Delaware, Greene, Madison, Onondaga, Otsego, Schoharie, and Tompkins counties
- ! Finger Lakes: Allegany, Broome, Cattaraugus, Chautauqua, Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Tioga, Wayne, and Yates counties
- ! Western: Erie, Genesee, Monroe, Niagara, Orleans, and Wyoming counties

Applicants may submit only one capitation proposal per premium group for each of the regions. Applicants may not submit different proposals for individual counties within a region, or for subgroups within individual premium groups. Applicants must submit bids for all premium groups, including SSI.

Applicants proposing to operate in more than one region should submit a separate Operating Plan/Premium Proposal for each region.

3.4.6.2 Categories of Service

There are fourteen categories of service (core benefits) for which utilization and unit cost information must be provided on the CRCS forms. In addition, dental, family planning, emergent transportation and non-emergent transportation will require utilization and unit cost data to be submitted if an applicant elects to offer any of these optional services. Guidelines are provided below for applicants to follow in defining units of services and their associated costs for the eighteen categories. The purpose for requiring this information is to assist the State in evaluating the applicant's ability to manage its medical and administrative costs, based on the assumptions presented, within the amount of the capitation premium.

3.4.6.2.1 Units of Service

In developing utilization estimates within categories of service, the applicant should use the following reporting standards.

1. Hospital Inpatient - Excluding Mental Health and Drug and Alcohol Treatment. The anticipated utilization should be expressed as the average number of hospital inpatient days expected per member. The utilization should exclude any inpatient days associated with newborn deliveries (these days should be entered on the NRCS forms) or mental health or drug or alcohol treatment. Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings.
2. Hospital Inpatient - Mental Health and Drug and Alcohol Treatment only. The anticipated utilization should be expressed as the average number of hospital inpatient days expected per member. The utilization should include any inpatient days associated with mental health or drug or alcohol treatment. Adjustments from historical utilization patterns should be made for any anticipated shifts from inpatient to outpatient settings.
3. Primary Care Physician. The anticipated utilization should be expressed as the average number of office visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from the emergency room and/or changes due to implementation of risk-sharing contracts. Obstetricians and Gynecologists are considered primary care physicians.
4. Physician Specialist. The anticipated utilization should be expressed as the average number of office visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from physician specialists to primary care physicians and/or changes due to implementation of risk-sharing contracts.
5. Ambulatory Surgical. The anticipated utilization should be expressed as the average number of ambulatory surgical or hospital outpatient visits expected per member. Adjustments from historical utilization patterns again should be made for any anticipated shifts from inpatient to outpatient settings.
6. Other Professional Services. The anticipated utilization should be expressed as the average number of office visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from physician specialists to primary care physicians and/or changes due to implementation of risk-sharing contracts.
7. Emergency Room. The anticipated utilization should be expressed as the average number of emergency room visits per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from the emergency room to urgent care centers and/or primary care providers.

8. Mental Health. The anticipated utilization should be expressed as the average number of office visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from physician specialists to primary care physicians and/or changes due to implementation of risk-sharing contracts.
9. Drug & Alcohol Treatment. The anticipated utilization should be expressed as the average number of office visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from physician specialists to primary care physicians and/or changes due to implementation of risk-sharing contracts.
10. Home Health Care. The anticipated utilization should be expressed as the average number of home health visits expected per member. Adjustments from historical utilization patterns should be made for any anticipated shifts away from inpatient settings toward home health care and/or changes due to implementation of risk-sharing contracts.
11. Diagnostic Lab & X-Ray. The anticipated utilization should be expressed as the average number of independent diagnostic tests, laboratory tests, and x-ray services expected per member. Adjustments from historical utilization patterns should be made for any changes due to implementation of risk-sharing contracts.
12. Vision Care. The anticipated utilization should be expressed as the average number of exam services expected per member. Adjustments from historical utilization patterns should be made for any changes due to implementation of risk-sharing contracts.
13. Durable Medical Equipment. Utilization should be expressed as the average number of units of service per member.
14. All Other. The anticipated utilization should be expressed as the average number of services expected per member.
15. Transportation - Emergent and Non-emergent. The anticipated utilization should be expressed as the average number of transportation services expected per member. Adjustments from historical utilization patterns should be made for any changes due to implementation of risk-sharing contracts. Please note that emergent and/or non-emergent transportation may or may not be a covered service under the program, depending on the county. However, all applicants are required to complete this item and the capitation rates will be adjusted accordingly for those counties which elect to exclude transportation from the list of covered services.
16. Family planning. The anticipated utilization should be expressed as the average number of services expected per member. Please note that family planning is an optional covered service. This item should only be completed by applicants who intend to cover family planning services. Those applicants who do not intend to cover these services should insert N/A on this line.

17. Dental. The anticipated utilization should be expressed as the average number of services expected per member. Please note that dental is an optional covered service. This item should only be completed by those applicants who intend to cover dental services. Those applicants who do not intend to cover these services should insert N/A on this line.

For each of the categories of service, the applicant should make certain that its estimates are consistent with its projected balance sheets, income statements and cash budget.

Applicants should also estimate costs, on a per unit basis, for each premium group and category of service, and present these estimates, along with their underlying assumptions. The unit cost and utilization estimates should support the applicant's gross capitation rate.

3.4.6.9.2 Unit Costs

Cost estimates should be based on the actual reimbursement method negotiated with the subcontractor(s) or provider(s) in the MCO's network, including hospitals, PCPs, pharmacies, etc. Adjustments should be made to account for the effect of expected inflation within the bid period. The applicant should take full advantage of its position as a purchaser of health care for the State to negotiate as favorable a rate as possible with its providers.

In developing cost estimates within the categories of service, the applicant should use the following reporting standards:

1. Hospital Inpatient - Excluding Inpatient Mental Health and Drug and Alcohol Treatment. The anticipated unit cost should be the average expected per diem or per discharge payment that the applicant has negotiated with its hospitals for the geographic region.
2. Hospital Inpatient - Inpatient Mental Health and Drug and Alcohol Treatment Only. The anticipated unit cost should be the average expected per diem or equivalent payment for mental health and drug and alcohol treatment that the applicant has negotiated with its hospitals for the geographic region.
3. Primary Care Physician. The anticipated unit cost should be the average cost per primary care physician office visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Include laboratory, and x-ray charges here if such charges are part of the provider's contract and reimbursement. Obstetricians and Gynecologists are considered primary care physicians. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.

4. **Physician Specialist.** The anticipated unit cost should be the average cost per specialty care physician office visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Include laboratory, and x-ray charges here if such charges are part of the provider's contract and reimbursement. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
5. **Ambulatory Surgical.** The anticipated unit cost should be the average cost per visit or a special contracted rate that the applicant has negotiated. If there is a facility charge plus supplies and equipment billed by the outpatient facility, include those charges here. Include laboratory, x-ray, medical imaging and physical therapy charges here if they are hospital charges.
6. **Other Professional Services.** The anticipated unit cost should be the average cost per other health care professional office visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Include laboratory and x-ray charges here if such charges are part of the provider's contract and reimbursement. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
7. **Emergency Room.** The anticipated unit cost should be the average cost the MCO has negotiated. Include laboratory, x-ray, medical imaging, and physical therapy charges here if they are performed in the emergency room and the patient was not admitted to the hospital. If the patient was admitted to the hospital, all costs for emergency room should be included in the inpatient hospital line. Costs for physicians should be included in the respective physician line.
8. **Mental Health.** The anticipated unit cost should be the average cost per mental health office visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Include laboratory and x-ray charges here if such charges are part of the provider's contract and reimbursement. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
9. **Drug & Alcohol Treatment.** The anticipated unit cost should be the average cost per drug or alcohol office visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Include laboratory and x-ray charges here if such charges are part of

the provider's contract and reimbursement. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.

10. Home Health Care. The anticipated unit cost should be the average cost per home health visit or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
11. Diagnostic Lab & X-Ray. The anticipated unit cost should be the average cost per independent diagnostic test, laboratory test, or x-ray service or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
12. Vision Care. The anticipated unit cost should be the average cost per vision exam or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost.
13. Durable Medical Equipment. The average unit cost should be the anticipated average price paid for the provision of this service.
14. All Other. The anticipated unit cost should be the average cost per service or a special contracted rate the applicant has negotiated.
15. Transportation. The anticipated unit cost should be the average cost per transportation service or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost. Please note that transportation may or may not be a covered service under the program, depending on the county. However, where required, the applicant should complete these items and the capitation rates will be adjusted accordingly for those counties which elect to include emergent and/or non-emergent transportation in the benefit package.

16. Family planning. The anticipated unit cost should be the average cost per family planning service or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold Plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost. Please note that family planning is an optional covered service. This item should only be completed by those applicants who intend to cover family planning services.

17. Dental. The anticipated unit cost should be the average cost per dental service or a special contracted rate that the applicant has negotiated. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid, with supporting documentation showing the amount and structure of the incentive/withhold Plan. Adjustments should be made for risk-sharing capitated contracts with the providers which allow the applicant to give quality care at the lowest cost. Please note that dental is an optional covered service. This item should only be completed by applicants who intend to cover dental services.

3.5 Proposal Evaluation

3.5.1 General

The State will establish an evaluation process and will conduct a comprehensive and impartial evaluation of all proposals. The State and its New York City/county partners will be the sole judges in reviewing proposals and awarding contracts.

Technical proposals, the NYC Addendum (if applicable), networks and business proposals will be evaluated separately. MCOs must complete all evaluations successfully to be considered for contract award.

The specific evaluation process will occur in four steps.

- ! Comprehensive Technical Evaluations
- ! Network Evaluation
- ! Identification of Qualified MCOs
- ! Contract Awards by Boroughs/Counties

3.5.2 Preliminary Technical Evaluation

The State first will evaluate each proposal to determine if it conforms with all of the proposal submission instructions delineated in this Chapter. Proposals found to be incomplete or non-responsive will be disqualified and returned to the applicant. In conducting this preliminary

evaluation, the State reserves the right to waive minor irregularities at its discretion.

3.5.3 Comprehensive Technical Evaluation

For proposals passing the preliminary technical evaluation, the State will evaluate the proposals based on their responses to the questions contained in Section 3.2 of this Document and on the composition of the networks. As part of this evaluation process, the State reserves the right to seek additional clarifying information from MCOs before assigning final point scores.

3.5.4 Network Evaluation

Networks will be evaluated using data from the HPN submission. Networks will be evaluated for compliance with program standards, comprehensiveness, and accessibility.

3.5.5 Financial Qualification of MCOs

The proposed capitation rates will be reviewed to ensure they are reasonable and conform to all applicable state and federal laws. MCOs with regional rates previously established under the prior procurement will receive these rates for new counties within those regions. MCOs without existing rates in the particular region will be held to UPL standards and rates will be agreed to based on a negotiation process with the state.

MCO revenue and expense projections and actual and projected balance sheets will be reviewed to ensure that the MCO has adequate capital and can meet state required reserve and escrow deposit requirements, based on the MCO's projected enrollment for the upcoming year. Business Plan approval will be granted based on agreement to MCO rates and a specific enrollment maximum that is supported by the MCOs escrow deposit and capital.

3.5.6 Identification of Qualified MCOs

At the conclusion of the evaluations, the State will identify those MCOs that have successfully completed the evaluation process and have qualified for contract award. The State reserves the right to qualify individual MCOs in only a portion of the boroughs/counties for which they have submitted proposals, depending on the outcome of the evaluation.

3.5.7 Contract Awards by Boroughs/Counties

At the conclusion of the evaluations, the State will provide New York City and each county with a list of MCOs that have qualified for contract award within their jurisdictions. The City and counties then will make a final determination as to the number of contracts to be awarded, based on freedom of choice and capacity considerations.

3.5.8 Special Terms and Conditions

The State reserves the right to specify special terms and conditions for individual applicants when making awards. Such terms and conditions must be accepted by the applicant for the award to take effect.

3.5.9 Readiness Reviews

The State intends to conduct on-site reviews of qualified MCOs prior to execution of contracts. The purpose of these reviews will be to verify that MCOs are able to comply with all participation standards and are prepared to begin enrollment. The reviews also will be used to verify the accuracy of MCO network information, as submitted in the proposals.