

**NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF MANAGED CARE**

**MANAGED CARE ORGANIZATION
QUALIFICATION GUIDELINES**

for

MEDICAID MANAGED CARE

June, 1999

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CHAPTER 1: INTRODUCTION

1.1 Program Overview

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

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

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

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

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

1.2 MCO Qualification Process

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

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

New MCOs

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

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

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

Existing Partnership Plan MCOs/Service Area Expansions

MCOs that were qualified during the initial 1995 or 1997 Partnership Plan program cycles and that wish to expand their service areas may submit a Network Composition proposal and Business Proposal for each county in which the MCO wishes to operate (and a New York City addendum, if appropriate). Existing Partnership Plan MCOs are not required to submit a General Technical Proposal, nor a New York City addendum if the MCO is

already qualified to operate in New York City.

1.3 General Information for Applicants

1.3.1 Program Administration

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

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

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

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

1.3.2 Contract Period

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

1.3.3 Covered and Excluded Populations

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

! Singles/Childless couples - cash and Medicaid only

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

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

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

1.3.3.1 Mandatory Populations

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

1.3.3.2 Voluntary (Exempt) Populations

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

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

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

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

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

OR

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

17. Individuals with a "County of Fiscal Responsibility" code of 97 (OMH in MMIS) or 98 (OMRDD in MMIS) will be exempt until the state establishes appropriate program features. However, many of these individuals will qualify for other exemptions (SPMI/SED) or exclusions.

18. Individuals temporarily residing out of district, (e.g., college students) will be exempt until the last day of the month in which the purpose of the absence is accomplished. The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p).

19. Mandatory enrollment of SSI and SSI-related beneficiaries is scheduled to begin in the second year of the waiver, assuming HCFA has approved the addition of this population to the mandatory program. **Until such time, SSI and SSI-related beneficiaries will be considered exempt and may enroll on a voluntary basis.**

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

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

Individuals who become eligible for exemption due to a change in eligibility status after they have enrolled in managed care may apply for exemption and be disenrolled within 30-60 days. All managed care enrollees will have received information on the exemption criteria and process in the enrollment kits.

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

1.3.3.3 Excluded Populations

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

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

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

1.3.4 Other Waiver Programs

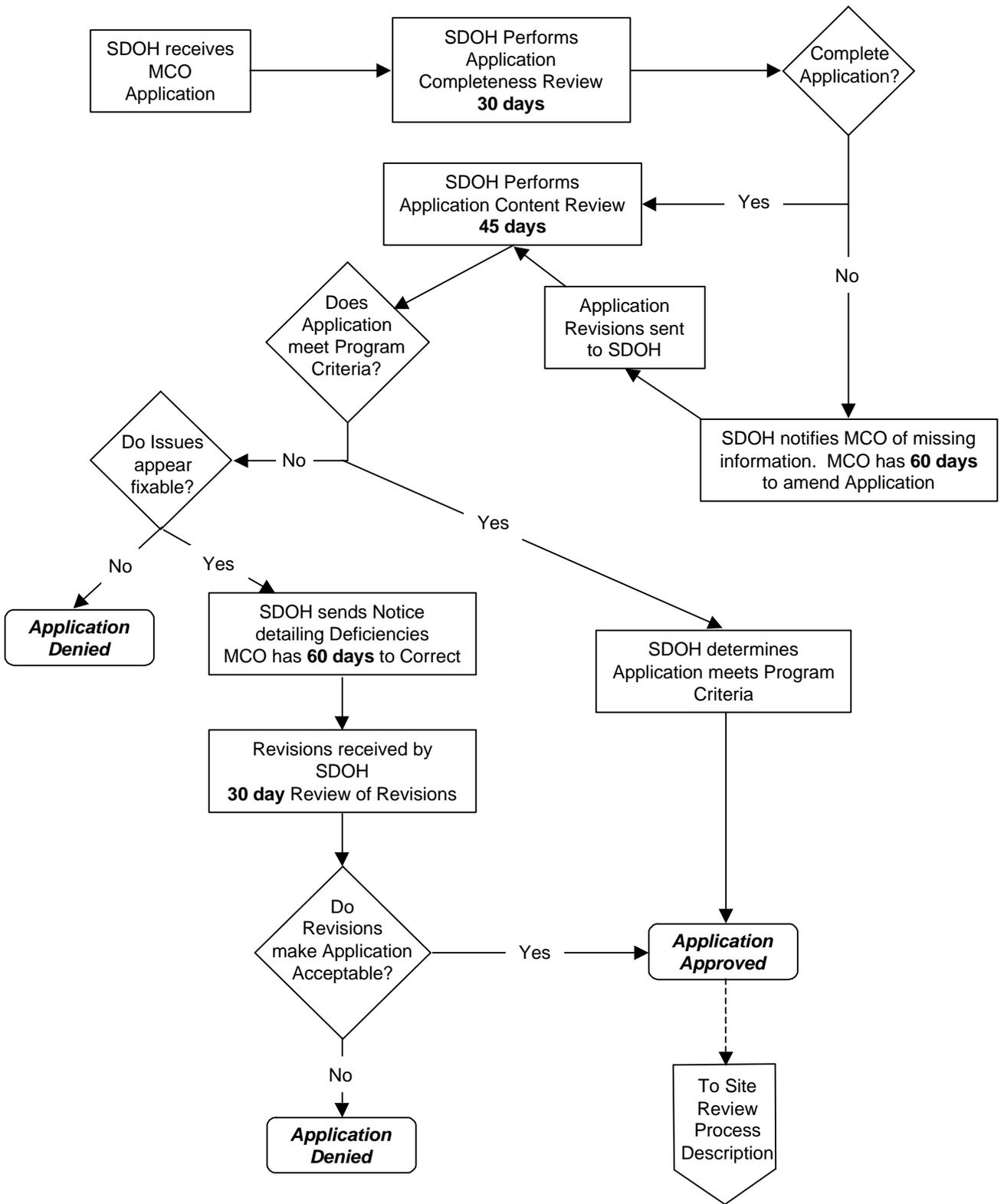
New York State currently has a Section 1915(b) waiver program in place in Westchester County. Westchester is scheduled to be part of Phase III of the State’s Section 1115(a) waiver program. At such time, Westchester County's Section 1915(b) program also will be subsumed within it. However, the SSI population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

1.4 MCO Qualification Schedule

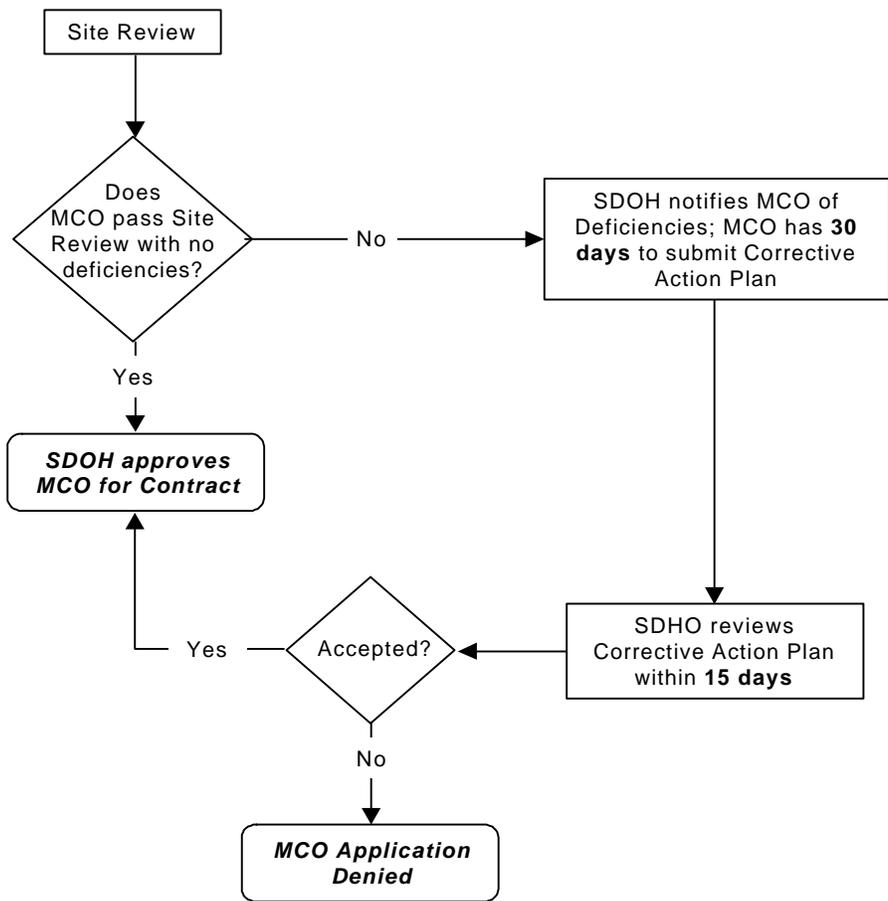
Because MCO qualification will be an ongoing process, MCOs may submit an application at any time. SDOH will evaluate the application in the time period noted below, and will notify the pending applicant of relevant issues as outlined. These notifications will give the

MCO a written summary of any problems. Should the MCO’s application eventually be denied during the review process, it may not be resubmitted for three (3) months from the date of the notice from SDOH denying the application.

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



MCO Qualification Process and Timeline



MCO Qualification Process and Timeline

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

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

CHAPTER 2: MCO PARTICIPATION STANDARDS

2.1 General

This chapter describes the operational and financial standards with which MCOs must comply in full. The standards have been set to allow MCOs flexibility in their approach to meeting program objectives, while ensuring that the special needs of the Medicaid population are addressed and ready access to services is assured.

2.2 Licensure (Certification)

2.2.1 General

Participation in this qualification process is limited to organizations that are certified as HMOs, PHSPs or IDSs by the New York State Department of Health under Article 44 of the State Public Health Law, NYPHL Section 4400 et seq., or as Health Maintenance Organizations under Article 43 of the State Insurance Law. Organizations that are not yet licensed (certified) also may submit responses as long as they are actively seeking certification. Although a plan may be qualified under this process, no contract will be awarded until such time as the entity is certified.

2.2.2 Service Area and Programmatic Expansions

In the case of existing MCOs that wish to participate in counties for which they are not currently certified, or who anticipate programmatic changes within an approved service area, the following requirements must be met:

- ! MCOs must submit a notarized affidavit which attests that the providers in the network have executed contracts approved by SDOH (a standardized affidavit is available from the State). New MCOs may submit a network of providers from whom they have letters of intent to contract, but provider contracts must be executed prior to contracting with the local district. Additionally, if there is a significant change, as determined by SDOH, in the provider network after submission, the entire network must be resubmitted. The provider network should include but is not limited to: primary care, specialty care, hospitals, home health care agencies, physical therapy providers, occupational therapy providers, speech therapy providers, optometry, etc. **All network data will be submitted via the Health Provider Network (HPN).**
- ! If new or amended administrative service agreements or management contracts are proposed in relation to the Medicaid program, they must be submitted to SDOH for review and approval.
- ! If new physician or allied health contracts are proposed, they must be submitted to SDOH for review and approval.
- ! If contractual arrangements with previously uncontracted IPA's are proposed, they must be submitted to SDOH for review and approval.

2.3 MCO Administration

MCOs must maintain sufficient administrative staff and organizational components to comply with all program standards described in this document. At a minimum, MCOs must employ or contract with qualified staff in the following areas in sufficient numbers to carry-out all of the administrative responsibilities described throughout Chapter Two:

- ! Executive management with clear oversight authority for all other functions.
- ! Medical Director's office.
- ! Accounting and Budgeting function.
- ! Member Services function.
- ! Provider Services function.
- ! Medical Management function for physical and behavioral health, including quality assurance and utilization review.
- ! Internal complaint resolution function.
- ! Claims processing function.
- ! Management information system.

MCOs generally may combine functions (e.g., Member Services and complaint resolution) as long as they are able to demonstrate that all necessary tasks are being performed. MCOs also may use management contractors pursuant to 10NYCRR 98.11 and subject to the prior approval of the SDOH Commissioner.

2.4 Member Enrollment and Disenrollment

2.4.1 Eligibility Determination and Enrollment

Eligibility determination for this program will be performed by the HRA in New York City and the LDSS in each of the other counties. Eligibility for the program is based on a combination of factors, including family composition, income and resource levels, insurance status, and/or pregnancy status.

The HRA in New York City and the LDSS in other counties also will have responsibility for enrolling clients into MCOs. In the voluntary program, specific enrollment procedures will vary by county. The State and interested counties may contract with one or more private organizations to assist in some portion of the enrollment process, including providing non-biased enrollment counseling to families/individuals making an MCO selection.

The role of these counselors will be to educate clients about the major differences between fee-for-service and managed care, and to point out some of the important factors to consider when choosing an MCO (e.g., whether the client's current provider participates in any MCO s). Counselors also will seek to learn whether the client has any existing medical (e.g., pregnancy or chronic illness) or behavioral condition requiring immediate follow-up by the MCO, so that an identifier can be attached to the client's roster information alerting the MCO to that fact. SDOH has developed a health screening tool for this purpose.

The specific enrollment process for eligible clients will occur as follows:

- ! Individuals enrolled in MCOs at the time of implementation of mandatory enrollment will be sent a notification by the SDOH informing them they have the option of remaining in their current MCO (if it has been awarded a new contract) or of selecting a new MCO. The notification will include information on how enrollees can execute an MCO change if they so desire. The notification also will specify that if a change request is not made, the client will automatically be left in his/her current MCO, assuming it has been awarded a contract under the plan qualification process.
- ! In the mandatory program, members of the same family will be required to enroll in the same MCO. The only exception will be for families in which one or more members are receiving prenatal care and/or continuous care for a complex/chronic medical condition from providers available only through different MCOs. Such exceptions will be granted by the LDSS on a case-by-case basis.

Accordingly, family members already enrolled in different MCOs will be informed that, if anyone in the family wishes to change MCOs, all family members must enroll together in the newly-selected MCO. They also will be told that if no changes are made at time of program start-up, all members of the family still will be required to enroll together in a single MCO following their next recertification for Medicaid eligibility.

- ! Individuals/families currently in fee-for-service who belong to one of the enrollment categories listed in Section 1.3.3.1 will be sent a general notice, as they are phased in, informing them of the new program and their options within it. They will be offered the chance to select an MCO at any time by following procedures outlined in their notification. The decision to enroll or remain in fee-for-service will have to be made by all eligible family members as a group. If the decision is made to enroll, the family will be required to select a single MCO, subject to the one exception provision described above.
- ! At such time as enrollment is converted from voluntary to mandatory, individuals/families still in fee-for-service who belong to any of the mandatory enrollment groups will be sent a notice by the LDSS about the new program two to four weeks (depending on the county) before their next recertification or before being called in to select an MCO through any type of targeted enrollment. The notice will include information about the program in general and about each of the available MCOs in their borough/county.

These persons will be informed that an MCO selection can be made prior to their recertification (or targeted enrollment) interview, or during the period after the interview by following procedures outlined in the notification letter. Recipients must have at least sixty (60) days from the date the notice was sent to choose. As an alternative, they may be told that an MCO selection can be made during the interview itself. Further, they will be told that if a selection is not made within the sixty (60) days, all members of the family will be assigned to an MCO (see Appendix 4.4 for a description of the auto-assignment methodology). Following selection or assignment, and verification of continued eligibility, the individual/family will be sent a second notice identifying their MCO and the enrollment effective date.

! Some aid categories will be voluntary prior to implementation of the Section 1115(a) waiver in their geographic area. Following the waiver's implementation in that area, new notices will be sent to these clients informing them of their conversion to mandatory status and describing a selection/assignment process identical to the one outlined above.

! Enrollment occurs at the first of each month.

2.4.2 Guaranteed Eligibility Period

Individuals enrolled in a participating MCO will, under certain circumstances, be eligible to receive six months of continuous coverage, even if they otherwise lose their eligibility for Medicaid. All MCOs will qualify to offer guaranteed eligibility.

The guaranteed eligibility period will be governed by the following rules:

! Enrollees who lose Medicaid eligibility due to incarceration, moving out of State, death, or whose medical assistance benefits were terminated because of recipient-initiated fraudulent activities at the time of application for eligibility, will forfeit any guaranteed eligibility period still remaining.

! Also, women with a net available income up to and including 185% of the federal poverty level for the appropriate family size, who are eligible for Medicaid only because they are pregnant, and are only eligible for Medicaid through the end of the month in which the sixtieth day following the end of the pregnancy occurs, are not eligible to remain enrolled in the MCO.

! The services covered during the guaranteed eligibility period will be limited to those contained in the MCO's prepaid benefit package, including dental, if the MCO has elected to be capitated for this benefit. The only exceptions will be with regard to prescriptions and family planning services. If an MCO has not elected to be capitated for family planning, this benefit will continue to be offered on a fee-for-service basis (see Sections 2.6.4.3 and 2.7.6.4 for a description of the dental and family planning capitation options, respectively). Pharmaceuticals found on the New York State Formulary will be covered by the Medicaid program on a fee-for-service basis during

the guarantee period.

- ! Individuals who lose and regain eligibility within a three-month period will not be entitled to a new period of six months guaranteed eligibility. Individuals who lose eligibility for more than three months will be entitled to a new period of six months guaranteed eligibility if they enroll into a qualifying MCO.

2.4.3 Automatic Re-enrollment into MCOs

Individuals who are disenrolled from an MCO after the completion of their six months of continuous coverage due to loss of eligibility, and who regain their eligibility within three months will automatically be re-enrolled with the same MCO (subject to available capacity in the MCO).

2.4.4 MCO Lock-ins and Changes

Under the Section 1115(a) waiver, all new enrollees will be locked into their MCOs. Enrollees who choose an MCO will have a 30 day period after the effective date of enrollment to change MCOs; enrollees who are auto-assigned will have 60 days after the effective date of enrollment to change MCOs. The lock-in will remain in effect for the remainder of the first twelve (12) months after the effective date of enrollment (eleven months if the enrollee chose the MCO, ten months if the enrollee was auto-assigned).

Enrollees in voluntary counties may also be subject to a lock-in. If this is the case, then the potential enrollee will be advised of this prior to enrolling in an MCO. Enrollees will have a 90 day period after the effective date of enrollment to change MCOs. The lock-in will remain in effect for the remainder of the first twelve months after the effective date of enrollment (nine months).

In New York City, prior to the full implementation of the 1115(a) waiver all new enrollees, in either a voluntary or mandatory area will have a 90 day period after the effective date of enrollment to change MCOs. After the 90 day period enrollees will be locked in for the remainder of the first twelve months after the effective date of enrollment (nine months). Upon full implementation of the waiver, the opt-out period may be changed to 30 days for those new enrollees who chose their MCO and 60 days for those enrollees who were auto-assigned. The lock-in will remain in effect for the remainder of the first twelve months of enrollment, (eleven months if the MCO was chosen and ten months if the enrollee was auto-assigned).

2.4.5 MCO Non-Discrimination

MCOs may not refuse an assignment or seek to disenroll a member or otherwise discriminate against a member on the basis of age, sex, race, physical, mental or developmental disability, national origin, religion, sexual orientation, or type of illness or condition, except when that condition can better be treated by another provider type, subject to the limitations expressed in Section 2.4.12.4.

2.4.6 Enrollment of Newborns

MCOs are required to enroll and provide coverage for eligible newborn children of enrollees effective from the time of birth. MCOs must register unborn children of members with the LDSS and enroll newborn children of members effective from the time of birth. In voluntary counties, parents may in writing indicate to the MCO or the LDSS prior to birth that they do not wish to have the unborn enrolled in the MCO. MCOs will be responsible for doing all of the following with respect to newborns:

- ! Notify the LDSS in writing of any enrollee that is pregnant within 30 days of becoming aware of the pregnancy.
- ! Upon the newborn's birth, the MCO must send verification of the infant's demographic data to the LDSS. The data must include: the mother's name and Client Identification Number (CIN), the newborn's name and CIN (if newborn has a CIN), sex and the date of birth.
- ! Notifying the LDSS of the birth, or changes in pregnancy status.
- ! Issuing a member identification card within fourteen (14) days of birth.
- ! Linking the newborn with a PCP within fourteen (14) days of birth.

Capitation payments for newborns will begin the month following certification of the newborn's eligibility, retroactive to the first day of the month in which the child was born. A one-time supplemental newborn birth capitation payment will be paid to the MCO upon submission of evidence of payment to the hospital of the inpatient claim for the newborn hospital stay.

An exception to this process occurs when a newborn has SSI coverage. Such newborns should not be enrolled, or if initially enrolled should be retroactively disenrolled. A newborn whose birth weight is <1200 grams is considered SSI eligible and should not be enrolled in the MCO for the first 6 months.

2.4.7 New Member Orientation

2.4.7.1 Initial Contact

MCOs must make all reasonable efforts to contact new members, in person, by telephone, or by mail, within thirty (30) days of their enrollment effective date. Reasonable efforts are defined to mean at least three attempts, with more than one method of contact being employed (e.g., combination of telephone and mail). Upon contacting the new member(s), MCOs must do at least the following:

- ! Inform the member about the MCO's policies with respect to obtaining medical services, including services for which the member may self-refer, and what to do in an emergency.

- ! Assist the member in selecting a primary care provider (PCP) (see also Section 2.4.8, PCP Selection and Changes).
- ! Conduct a formalized health screening to inquire about or assess for any special health care (e.g., prenatal or behavioral health services) or language/communication needs that the member may have. If a special need is identified, assist the member in arranging for an appointment with his/her PCP or other appropriate provider.
- ! Assist to arrange an initial visit to the member's PCP for a baseline physical and other preventive services, including a comprehensive risk assessment.
- ! Inform members about their rights for continuation of certain existing services, as defined in Section 2.7.7.
- ! Provide the member with the MCO toll free telephone number that may be called twenty-four (24) hours a day, seven (7) days a week if the member has questions about obtaining medical services and cannot reach his/her PCP (this telephone number need not be the Member Services line and need not be staffed to respond to Member Service-related inquiries).
- ! Advise the member about available opportunities to learn about MCO policies and benefits in greater detail (e.g., welcome meetings, complaint lines).
- ! Offer to provide the member with a complete list of providers, including those that may be accessed directly without referral. It should be an up-to-date listing of providers, including their specialty, office locations, office hours, telephone number, and wheelchair accessibility status. The listing also should note any languages other than English spoken in the provider's office.

2.4.7.2 Failure to Contact

MCOs must inform the LDSS of any members they are unable to contact within ninety (90) days of enrollment through reasonable means (e.g., all mailed materials are returned as undelivered and no working telephone number is available) and who have not presented for any health care services through the MCO or its participating providers. The method for informing the LDSS of such members will be specified by the LDSS in the contract.

2.4.8 Primary Care Provider Selection and Changes

2.4.8.1 Initial Selection

MCOs must allow every member the opportunity to select a physician or other qualifying practitioner to serve as his or her primary care provider, and must assign a PCP if one is not chosen. The types of providers eligible to serve as PCPs are described in Section 2.6.3.2, Eligible Specialties. MCOs may take into consideration such factors as previous provider relationships, capacity, and geographic proximity when offering PCP choices to

their members. MCOs must have a process to ensure that PCPs are advised in a timely manner of the enrollees for whom the PCP is responsible. This notice should be at least monthly but more often if necessary to ensure enrollee access to care.

MCOs must provide the LDSS and offer to provide to new enrollees up-to-date listings of providers, including their specialty, office locations, office hours, telephone number, and wheelchair accessibility status. The listings also should note any languages other than English spoken in the provider's office.

Members must be offered a choice of at least three PCPs by the MCO at the time they are first contacted. If the member does not make a choice within thirty (30) days of enrollment, the MCO must assign the member to a PCP and inform him/her of the assignment. (MCOs may, at their discretion, assign a PCP within as few as ten (10) days, but may take no longer than 30 days to assign a PCP.) PCP assignments should be made taking into consideration the following: 1) a member's geographic location; 2) any special health care needs, if known by the MCO; and 3) any special language needs, if known by the MCO.

In circumstances where the MCO operates or contracts with a multi-provider clinic to deliver primary care services, the member must choose or be assigned a specific provider or provider team within the clinic to serve as his or her PCP. This lead provider will be held accountable for performing the PCP duties listed in Section 2.6.

2.4.8.2 Changes

2.4.8.2.1 At Member's Initiative

Enrollees may change their PCP without cause within thirty (30) days of their first appointment, and may also change once every six (6) months, except for good cause as defined in regulation. Enrollees must be notified of the effective date of the change within thirty days of the request. Changes must be effective by the first day of the month following the month in which the request is made. The MCO may not take longer than forty-five (45) days to process a request.

2.4.8.2.2 At MCO's Initiative

MCOs may initiate a PCP change for a member under the following circumstances:

- ! The member requires specialized care for an acute or chronic condition and the member and MCO agree that reassignment to a different PCP is in the member's interest.
- ! The member's place of residence has changed such that he or she has moved beyond the PCP travel time distance standard, as listed in Section 2.6.3.7. (Unless enrollee selects a participating MCO located farther from his/her home, and is able to arrange and pay for transportation - see Section 2.6.1.2)
- ! The member's PCP ceases to participate in the MCO's (see also Section 2.6.3.8 for

MCO notification responsibilities in this situation).

- ! The member's behavior toward the PCP is disruptive and the PCP has made all reasonable efforts to accommodate the member.

Whenever initiating a change, MCOs must offer affected members the opportunity to select a new PCP in the manner described in Section 2.4.8.1.

2.4.9 Identification Cards

MCOs must issue identification cards to enrolled members containing the following information: 1) the name of the individual's clinic (if applicable); 2) the name of the individual's PCP and his or her telephone number; and 3) the toll-free telephone number referenced in Section 2.4.7.1.

PCP information may be affixed to the card by a sticker, rather than embossed. If a member is being served by a PCP team, the name of the individual shown on the card should be the lead provider, as defined in Section 2.6.3.5. In the case of teams comprised of medical residents and an attending physician, this will be the attending physician.

For MCOs with non-Medicaid enrollment, identification cards may identify the member as a Medicaid beneficiary through use of an alpha-numeric code, but may not differ overtly in design from identification cards issued to the MCOs other members.

MCOs must issue an identification card within 14 days of a member's effective date of enrollment. MCOs also must have another method for individuals to identify themselves as members prior to receiving the card (e.g., using a welcome letter from the MCO). PCP information on identification cards must be updated as appropriate.

2.4.10 Member Handbook

At a minimum, the MCO will send, within 14 days of the effective date of enrollment, the MCO's member handbook to all beneficiaries who select or who are assigned to that MCO. If unforeseen circumstances prevent the MCO from forwarding the approved member handbook and official identification card to new enrollees within the 14-day period, a welcome letter or temporary identification card would be acceptable. However, under no circumstances should a welcome letter or temporary identification card serve as a substitute for an approved member handbook or official identification card. Handbooks should be written at a fourth-to-sixth grade reading level and must be submitted to the State for review and approval prior to being issued. The State has developed a model member handbook to assist MCOs in the development of handbooks that meet both the technical and literacy requirements. (Available from the Bureau of Intergovernmental Affairs.)

Member handbooks must conform to the New York State Department of Health member handbook guidelines, including the following information:

- ! Services included in the MCO benefit package and how to obtain them.

- ! Services included in the MCO benefit package for which members may self-refer in certain instances (e.g., initial behavioral health assessments).
- ! Services not covered in the benefit package, but available on a fee-for-service basis.
- ! Excluded (non-covered) services.
- ! Instructions on what to do in an emergent or urgent medical or behavioral health situation.
- ! Instructions on how to choose a PCP and how to change PCPs, and notification that the MCO will assign the member a PCP if one is not selected within thirty (30) days of enrollment;
- ! A statement strongly encouraging the enrollee to obtain a baseline physical examination and comprehensive risk assessment, and further encouraging attendance at scheduled orientation sessions and other educational and outreach activities.
- ! Notification of the enrollee's right to obtain family planning services and the full range of reproductive health services and HIV blood testing and pre- and post-test counseling, when performed as a family planning encounter, from either an MCO provider or any appropriate non-contracted provider without a referral from the MCO.
- ! Notification of the enrollee's right to direct access to obstetrics and gynecology services from MCO participating providers pursuant to Public Health Law Section 4406 b(1) (see also Section 2.6.3.3).
- ! Conditions of guaranteed eligibility, as specified in Section 2.4.2, and lock-in, as specified in Section 2.4.4 (if applicable), disenrollment procedures and timeframes, and causes for which an enrollee would lose entitlement to receive services under this program (e.g., moving out of the state, dying or being incarcerated).
- ! Information about an enrollee's ability to access specialty care and specialty care centers.
- ! Information about the enrollee's ability to obtain a standing referral for specialty care.
- ! A description of the circumstances under which an enrollee may continue to receive services from a provider when that provider leaves the MCO's network. Also, a description of the circumstances under which a new enrollee may continue treatment with a provider who is not a member of the MCO's network.
- ! A notice that enrollment and disenrollment are subject to verification and approval by the LDSS.
- ! A description of the Member Services function and listing of the MCO's Member

Services telephone number and toll-free twenty-four (24) hour telephone number (if different).

- ! A description of the MCO's complaint procedure, including the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in complaint resolution. The description must inform members of their right to contact the LDSS or SDOH at any time and must include addresses/telephone numbers for both agencies.
- ! Description of the MCO's utilization review process.
- ! Instructions on what to do when there is a change in family size or eligibility status.
- ! Information regarding member rights and responsibilities.
- ! Information concerning the enrollee's rights under State law to formulate advance directives, and of the MCO's policies respecting the implementation of such rights and proxies pursuant to 10 NYCRR Sections 98.14(f) and 700.5.
- ! Description of the manner in which members may participate in the development of MCO policies.
- ! Description of the information available to members upon request in accordance with Section 4408 of the Public Health Law.
- ! Description of the payment methodologies used by the MCO to reimburse providers.

2.4.11 Status Changes

MCOs must notify the LDSS within seven (7) days of learning of any changes in a member's status (e.g., address) or circumstances that could affect the member's eligibility for the program.

2.4.12 Member Disenrollment

2.4.12.1 At the Initiative of the LDSS

The LDSS will disenroll members under the following circumstances:

- the member dies,
- loses Medicaid eligibility (subject to any remaining applicable “six months guaranteed eligibility” coverage),
- they move out of the MCO's service area unless the enrollee voluntarily elects to remain enrolled and will have sufficient access to services

2.4.12.2 Due to Eligibility Status Change

Individuals whose eligibility status changes such that they move out of a mandatory category will be disenrolled at the end of the month in which their status change occurs. The only exception will be for persons who move to a category from which voluntary enrollment is still permitted. In those cases, the individuals (e.g. HIV+) will be left in their MCO and will be free to request disenrollment in the manner described in Section 2.4.12.3 below.

2.4.12.3 At Member's Request

Individuals enrolled on a voluntary, non-lock in basis may disenroll back to the fee-for-service program at any time without cause. Disenrollment requests will be processed to take effect on the first of the following month if the request is made before the fifteenth day of the month, or on the first day of the second following month if the request is made on the fifteenth day of the month or later. However, in no event shall the effective date of disenrollment be later than the first day of the second month after the month in which an enrollee requests a disenrollment.

During the lock-in period, enrollees will not be permitted to disenroll from an MCO, unless authorized as the result of a formal complaint disposition or an approved good cause disenrollment request. After the lock-in period (the first twelve months following the effective date of enrollment), enrollees may disenroll at any time for any reason.

If disenrollment is authorized as the result of a formal complaint disposition, the individual may be required to select another MCO or may be disenrolled into the fee-for-service program, depending on what is determined to be in his/her best interests and the best interests of the program. (See Section 2.14 Complaint Resolution for more information.)

2.4.12.4 At Request of MCO

MCOs may seek to disenroll a member under two circumstances:

- ! The member is habitually noncompliant, defined to mean he/she regularly fails to arrive for scheduled appointments (without canceling), despite aggressive outreach efforts by the MCO; he/she regularly seeks care at hospital emergency rooms for non-emergent conditions, despite aggressive outreach efforts by the MCO; or he/she refuses to accept medically necessary treatment, despite aggressive outreach efforts by the MCO.
- ! The member is physically abusive to MCO employees/providers or is verbally abusive and such verbally abusive behavior is not due to an underlying medical condition (e.g., Tourette's Syndrome).

In both instances, the MCO must seek disenrollment through the formal complaint process, as described in Section 2.14.2. Once a member has been disenrolled at the MCO's request, he/she will not be enrolled with that same MCO again in the future, unless the MCO first agrees to such enrollment.

2.4.12.5 By Order of the State or LDSS

The State or LDSS may disenroll members from any MCO found to be in violation of service accessibility or financial solvency standards, pursuant to the termination language contained in Section 2.18.

2.4.13 Enrollment/Disenrollment Updates

The State provides, in electronic form and on a monthly basis, a listing of each MCO's current enrollment. MCOs will be responsible for reconciling this membership list against internal records and notifying the LDSS of any discrepancies.

2.5 Covered Services

2.5.1 General

MCOs are required to offer a comprehensive benefit package that includes all services covered under the Medicaid fee-for-service program, except those service expressly excluded by the contract. Services that are covered in New York's Medical Assistance State Plan, but which are not included in the MCO benefit package, will continue to be available out-of-plan and will be reimbursed on a fee-for-service, or wraparound basis.

The benefit package has been designed to place a particular emphasis on Child/Teen Plan (C/THP) services, also known as EPSDT. The package also includes a number of enhanced services intended to foster healthier lifestyles among managed care enrollees. C/THP and enhanced services are described in greater detail below.

2.5.2 Benefit Package

Appendix 4.5 contains a detailed listing of the benefit package for which MCOs will be capitated. Generally the prepaid benefit package will be identical for all enrollees, except for county and plan specific services (e.g. dental, transportation, family planning.) The benefit package will also be different for those enrollees who fall into a physical health services only category (SSI- and SSI- related). These enrollees will not receive the behavioral health (mental health and substance abuse) benefits listed in Appendix 4.5 through their MCO, but instead will receive them through existing Medicaid FFS providers. MCOs still will be responsible for participating in the coordination of physical and behavioral health services for members receiving a physical health only benefit.

2.5.3 Child/Teen Health Plan Services

2.5.3.1 General

C/THP services are included in the prepaid benefit package for children and adolescents up to age 21. The State considers the C/THP program and its associated periodicity schedule for screening, dental, vision, hearing, and immunization services to be one of the

highest priorities of the Medicaid program. A copy of the periodicity schedule is included as Appendix 4.6. The State's C/THP manual is available upon request from the Bureau of Managed Care Program Planning.

MCOs must adhere to C/THP program standards and must do at least the following with respect to all members under age 21:

- ! Educate pregnant women and families with under age 21 members about the program and its importance to a child's or adolescent's health.
- ! Educate network providers about the program and their responsibilities under it.
- ! Conduct outreach by means including mail, telephone, and through home visits (where appropriate) to ensure children are kept current with respect to their periodicity schedules.
- ! Schedule appointments for children and adolescents pursuant to the periodicity schedule, assist with referrals, and conduct follow-up with children and adolescents who miss or cancel appointments.
- ! Ensure that all appropriate diagnostic and treatment services, including specialist referrals, are furnished pursuant to findings from a C/THP screen.
- ! Achieve and maintain an acceptable compliance rate for screening schedules during the contract period. Acceptable compliance rates will be defined prior to issuance of MCO contracts and may vary by region.

The State intends to monitor closely the compliance rates of individual MCOs during the first year of the program and may incorporate findings into the auto-assignment algorithm for year two, assuming the mandatory program has commenced (see Appendix 4.4 for a description of the assignment algorithm).

2.5.3.2 Organ Transplants

MCOs will be required to furnish medically necessary solid organ and bone marrow transplants (including stem cell and tissue transplants) to their enrollees. The cost of these transplants has been reflected in capitation rate ranges.

2.5.4 Enhanced Services

The prepaid benefit package also includes a schedule of enhanced services that the State considers to be essential for promoting wellness and preventing illness. Specifically, MCOs must offer the following to their members:

- ! General health education classes.
- ! Pneumonia and influenza immunizations for at risk populations.

- ! Smoking cessation classes, with targeted outreach for adolescents and pregnant women.
- ! Childbirth education classes.
- ! Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- ! Nutrition counseling, with targeted outreach for pregnant women and diabetics.
- ! Extended care coordination, as needed, for pregnant women.

2.5.5 Prescriptions

As of August 1, 1998, prescription drugs are not an MCO covered benefit and will be reimbursed on a fee-for-service basis pursuant to Chapter 19 of the Laws of 1998. Over-the-counter pharmaceuticals and medical supplies will also be reimbursed on a fee-for-service basis. Co-payment requirements are not applicable to Medicaid managed care enrollees at this time.

The State's Drug Utilization Review Committee will monitor drug utilization to ensure the necessity and appropriateness of prescription drugs and to identify instances of over-medication and potential drug interactions.

Individuals who lose eligibility for Medicaid will continue to be eligible for pharmacy services on a fee-for-service basis during the guarantee period.

2.5.6 Experimental or investigational treatment

Experimental and investigational treatment is covered on a case-by-case basis according to the following criteria:

Experimental or investigational treatment for life-threatening and/or disabling illnesses may also be considered for coverage under the external appeal process pursuant to the requirements of Section 4910 of Public Health Law.

- (1) If the enrollee has had coverage of a health care service denied on the basis that such service is experimental and investigational, and
- (2) if the enrollee's attending physician has certified that the enrollee has a life-threatening or disabling condition or disease:
 - (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or

- (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or
 - (c) for which there exists a clinical trial, and
- (3) the enrollee's attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life threatening or disabling condition or disease, must have recommended either:
- (a) a health service or procedure that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard health service or procedure; or
 - (b) a clinical trial for which the enrollee is eligible. And
- (4) the specific health service or procedure recommended by the attending physician would otherwise be covered except for the health care plan's determination that the health service or procedure is experimental or investigational.

2.6 Provider Network

2.6.1 General

MCOs must establish and maintain provider networks with sufficient numbers of providers and in geographically accessible locations for the populations they serve (e.g. language capability and access for the disabled).

2.6.1.1 Types of Providers

MCO networks must contain all of the provider types necessary to furnish the prepaid benefit package, including but not limited to: hospitals, physicians (primary care and specialist), mental health and substance abuse providers, allied health professionals, DME providers etc. All network providers must be licensed and meet credentialing standards.

MCOs shall not include in their networks, for purposes of serving Medicaid enrollees, any medical provider who has been sanctioned by Medicare or Medicaid if the provider has, as a result of the sanctions, been prohibited from serving Medicaid clients or receiving Medical Assistance payments.

2.6.1.2 Geographic Accessibility

The MCO network should include primary care providers, specialty care providers, hospitals, mental health providers, lab and x-ray providers within the following travel time and distance standards (by car or public transportation):

Primary Care Physicians:

! Non-Metropolitan areas - 30 miles/30 minutes.

! Metropolitan areas - 30 minutes by public transportation.

Specialty care providers, hospitals, mental health providers, lab and x-ray providers:

! 30 miles/30 minutes.

Transport time and distance in rural areas to primary care sites may be greater than 30 minutes/30 miles only if based on the community standard for accessing care or if by beneficiary choice. Where greater, the exceptions must be justified on the basis of community standards.

2.6.2 Physicians

All network physicians must meet at least *one* of the following standards:

! Be Board-Certified or -Eligible in their area of specialty;

! Have completed an accredited residency program; or

! Have admitting privileges at one or more MCO network hospitals.

2.6.3 Primary Care Providers

2.6.3.1 Responsibilities

MCOs must allow each enrollee to select a primary care provider and must make an assignment if one is not chosen. Members must be offered a choice of at least three PCPs within program distance/travel time standards. Staff or group practice or center-based models may require that enrollees first select a site (clinic or health center) and subsequently select a PCP from among those available at the site.

Primary care providers will serve as each member's initial and most important point of interaction with the provider network. To qualify as a PCP, a provider must practice at least two days per week (16 hours) at each of his/her primary care sites. For example, if a provider has three office locations and practices 16 hours per week at location #1, 16 hours per week at location #2, and 8 hours per week at location #3, he/she could be offered as a PCP at the first two sites, but not the third.

Waiver of the Sixteen Hours requirement for PCPs

Under the following unique circumstances the State will waive the requirement for a physician to be available at least sixteen hours.

A request for a waiver must be submitted by the MCO to the Medical Director of the

SDOH Office of Managed Care for review and approval; and

- ! The physician must be available at least 8 hours/week; and
- ! The physician must be practicing in a Health Provider Shortage Area (HPSA) or other similarly determined shortage area; and
- ! The physician must be able to fulfil the responsibilities of a PCP (as described in this Section); and
- ! The waiver request must demonstrate there are systems in place to guarantee continuity of care and meet all access and availability standards, (24-hr/7 day week coverage, appointment availability, etc.).

Other PCP responsibilities

PCPs also must:

- ! Deliver medically necessary primary care services, including C/THP screening services for children and adolescents and a behavioral health screening for all members as appropriate.
- ! Make referrals for specialty care and other medically necessary services covered by the State Medicaid program, whether or not they are included in the MCO's prepaid benefit package.
- ! Coordinate each patient's overall course of care with in and out-of-network providers to the extent possible.
- ! Maintain a current medical record for the member.

2.6.3.2 Eligible Specialties

MCOs generally must limit their PCPs to the following primary care specialties:

- ! Family Practice
- ! General Practice
- ! General Pediatrics
- ! General Internal Medicine

Exceptions to these limits are described below.

2.6.3.3 OB/Gyn Providers

MCOs, at their option, may permit OB/Gyn providers to serve as PCPs, subject to SDOH qualifications. MCOs also must permit direct access for female members to in-network, qualified providers of OB/GYN services (i.e., obstetricians, gynecologists, family practitioners, certified midwives or nurse practitioners) pursuant to Public Health Law Section 4406 b(1). A copy of SDOH guidelines for direct access services is available from BCS.

2.6.3.4 Nurse Practitioners/Physician Assistant

MCOs may use nurse practitioners as PCPs, subject to their scope of practice limitations under New York State Law.

Physician Assistants may provide primary care services subject to their scope of practice limitations under New York State Law.

2.6.3.5 PCP Teams

MCOs with clinic provider sites may designate teams of physicians/nurse practitioners/physician assistants to serve as PCPs for members receiving primary care at those sites. Such teams may include no more than three practitioners or medical residents as specified in Section 2.6.5 and, when a member chooses or is assigned to a team, one of the practitioners must be designated as lead provider for that member. In the case of teams comprised of medical residents under the supervision of an attending physician, the attending physician must be designated as the lead physician.

2.6.3.6 Member-to-Provider Ratios

In assessing plan capacity, MCOs must adhere to the member-to-PCP ratios shown below. These ratios are for Medicaid members only, are plan-specific, and assume the practitioner is an FTE (practices 40 hours per week for the MCO):

Individual providers with office-based practices:	1,500 enrollees: 1 PCP
practicing with a Physician extender:	2,400 enrollees : 1 PCP & PE

The ratios should be prorated for providers who represent less than an FTE to an MCO. For example, if a physician devotes one-half of his/her practice to MCO A, he/she should be considered to represent capacity for no more than 750 of MCO A's Medicaid enrollees.

2.6.3.7 Distance/Travel Time Primary Care

MCOs must offer every member the opportunity to select from at least three PCPs within the following distance/travel time standards (by car or public transportation):

! Non-Metropolitan areas - 30 miles/30 minutes.

! Metropolitan areas - 30 minutes by public transportation.

Transport time and distance in rural areas to primary care sites may be greater than 30 minutes/30 miles only if based on the community standard for accessing care or if by beneficiary choice. Where greater, the exceptions must be justified on the basis of community standards.

Enrollees may, at their discretion, select plan participating PCPs located farther from their homes as long as they are able to arrange and pay for transportation to the PCP themselves.

2.6.3.8 PCP Status Changes

MCOs must notify their members of any of the following PCP changes within three (3) business days of the date the MCO becomes aware of the change:

- ! Office address/telephone number change.
- ! Office hours change.
- ! Separation from Plan (termination from network).

Should the enrollee need to change PCPs as a result of the change in status, the change shall be processed in accordance with procedures outlined in Section 2.4.8.2.

2.6.4 Specialty Care and other Ancillary Providers

2.6.4.1 Access to Specialty Care

a. Standing Referrals:

In general, PCPs will be drawn from the primary care specialties listed above. However, for enrollees that require ongoing care from a specialist, the MCO must have a procedure for implementing a standing referral for that enrollee with an appropriate specialist. Determination for such standing referral must be made pursuant to a treatment plan approved by the MCO in consultation with the primary care provider, the specialist and the enrollee or his/her designee.

b. Specialist as PCP

For enrollees diagnosed with a life threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, MCOs must have a procedure in place that allows for a referral to a specialist with appropriate expertise who will be responsible for both the primary and specialty care of the enrollee. Determination for such referral must be made pursuant to a treatment plan approved by the MCO in consultation with the primary care provider, if appropriate, the specialist and the enrollee or his/her designee

c. Specialty Centers

For enrollees diagnosed with a life threatening condition or disease, or a degenerative

and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, MCOs must have a procedure in place that allows for a referral to a specialty care center which has expertise in treating the specific condition/disease. Determination for such referral must be made pursuant to a treatment plan approved by the MCO in consultation with the primary care provider (if any) the designated specialist and the enrollee or his/her designee, and must be based on the most appropriate method of coordinating care for the enrollee.

2.6.4.2 Hospitals

MCOs must establish hospital networks capable of furnishing the full range of tertiary services to members. MCOs must ensure that all members have access to at least one general acute care hospital within thirty (30) minutes/(30) miles travel time. If none are located within thirty (30) minutes/(30) miles travel time, the MCO must include the next closest site in its network.

MCOs may reimburse for inpatient care using: 1) the State's Medicaid rates; 2) the elected Medicaid alternate payment rate; or 3) a negotiated rate.

2.6.4.3 Dental Providers

MCOs may elect to be capitated for dental care furnished to enrollees. MCOs that choose to capitate dental services must establish a dental network to deliver dental services to these enrollees consistent with the benefit guidelines described in the State's MMIS dental manual (a copy of the manual is available from the Bureau of Managed Care Program Planning), with the exception of orthodontic services which will remain covered through the Medicaid fee-for-service system. MCOs should refer children identified as needing orthodontic services to the Physically Handicapped Children's Program (PHCP) or the local social services district (PHCP sites are available from the Bureau of Managed Care Program Planning (518) 473-0122).

MCOs that choose to be capitated for dental services must include general dentists in their networks sufficient to offer each enrollee a choice of two primary care dentists in their service area and to achieve a ratio of at least one primary care dentist to 2,000 enrollees. Networks must also include at least one pediatric dentist and one oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral. MCOs are encouraged to include dentists with expertise in serving special needs populations (e.g., HIV+ and developmentally disabled patients).

2.6.5 Medical Residents

Primary Care

MCOs may utilize Medical residents as participants (but not as designated 'primary care providers') in the care of enrollees as long as all of the following conditions are met:

- ! Residents are a part of patient care teams headed by fully licensed and MCO credentialed attending physicians serving patients in one or more training sites in an "up weighted" or "designated priority" residency program. Residents in a training program which was disapproved as a designated priority program solely due to the outcome measurement requirement for graduates may be eligible to participate in such patient care teams.
- ! Only the attending physicians and nurse practitioners on the training team, NOT RESIDENTS, may be credentialed to the MCO and may be empaneled with enrollees. Enrollees must be assigned an attending physician or nurse practitioner to act as their PCP, though residents on the team may perform all or many of the visits to the enrollee as long as the majority of these visits are under the direct supervision of the enrollee's designated PCP. Enrollees have the right to request care by their PCP in addition or instead of being seen by a resident.
- ! Residents may work with attending physicians and nurse practitioners to provide continuity of care to patients under the supervision of the patient's PCP. Patients must be made aware of the resident/attending relationship and be informed of their rights to be cared for directly by their PCP.
- ! Residents eligible to be involved in a continuity relationship with patients must be available at least 20% of the total training time in the continuity of care setting and no less than 10% of training time in any training year must be in the continuity setting and no fewer than 9 months a year must be spent in the continuity care setting
- ! Residents meeting these criteria provide increased capacity for enrollment to their team according to the following formula:

PGY-1	300 per FTE
PGY-2	750 per FTE
PGY-3	1125 per FTE
PGY-4	1500 per FTE

Only hours spent routinely scheduled for patient care in the continuity training site may count as providing capacity and are based on 1.0 FTE=40 hours.

- ! In order for a resident to provide continuity of care to an enrollee, both the resident and the attending PCP must have regular hours in the continuity site and must be scheduled to be in the site together the majority of the time.
- ! A preceptor/attending is required to be present a minimum of 16 hours of combined precepting and direct patient care in the primary care setting to be counted as a team supervising PCP and accept an increased number of enrollees based upon the residents working on his/her team. Time spent in patient care activities at other clinical sites or in other activities off-site is not counted toward this requirement.

- ! A 16-hour per week attending may have no more than 4 residents on their team. Attendings spending 24-hours per week in patient care/supervisory activity at the continuity site can have 6 residents per team. Attendings spending 32-hours per week can have 8 residents on their team. Two or more attendings may join together to form a larger team as long as the ratio of attending to residents does not exceed 1:4 and all attendings comply with the 16-hour minimum.
- ! Specialty consults must be performed or directly supervised by the MCO credentialed specialist. The specialist may be assisted by a resident or fellow.
- ! Responsibility for the care of the enrollee remains with the attending physician. All attending/resident teams must provide adequate continuity of care, 24-hour 7-day coverage and appointment and availability access which meets RFP standards.
- ! Residents who do not qualify to act as continuity providers as part of an attending/resident team may still participate in the episodic care of enrollees as long as that care is under the supervision of an attending physician credentialed to the MCO. Such residents will not add to the capacity of that attending to empanel enrollees, however.
- ! Nurse practitioners may not act as attending preceptors for resident physicians.

Specialty Care

Residents may participate in the specialty care of Medicaid managed care patients in all settings supervised by fully licensed and MCO credentialed specialty attending physicians.

- ! Only the attending physicians, not residents or fellows, may be credentialed by the MCO. Each attending must be credentialed by each MCO with which they will participate. Residents may perform all or many of the clinical services for the enrollee as long as these clinical services are under the supervision of an appropriately credentialed specialty physician. Even when residents are credentialed by their program in particular procedures, certifying their competence to perform and teach those procedures, the overall care of each enrollee remains the responsibility of the supervising MCO credentialed attending.
- ! It is understood that many enrollees will identify the resident as their specialty provider but the responsibility for all clinical decision-making remains with the attending physician of record.
- ! Enrollees must be given the name of the responsible attending physician in writing and be told how they may contact their attending physician or covering physician, if needed. This allows enrollees to assist in the communication between their primary care provider and specialty attending and enables them to reach the specialty attending if an emergency arises in the course of their care. Enrollees must be made aware of the resident /attending relationship and must have a right to be cared for directly by the responsible attending physician, if requested.

- ! Enrollees requiring ongoing specialty care must be cared for in a continuity setting. This requires the ability to make follow-up appointments with a particular resident/attending physician, or if that provider team is not available, with a member of the provider's coverage group in order to insure ongoing responsibility for the patient by his/her MCO credentialed specialist. The responsible specialist and his/her specialty coverage group must be identifiable to the patient as well as to the referring primary care provider.
- ! Attending specialists must be available for emergency consultation and care during non clinic hours. Emergency coverage may be provided by residents under adequate supervision. The attending or a member of the attending's coverage group must be available for telephone and/or in-person consultation when necessary.
- ! All training programs participating in Medicaid managed care must be accredited by the appropriate academic accrediting agency.
- ! All sites in which residents train must produce legible (preferably typewritten) consultation reports. Reports must be transmitted so they are received in a time frame consistent with the clinical condition of the patient, the urgency of the problem and the need for follow-up by the primary care physician. At a minimum, reports should be transmitted so that they are received no later than two weeks from the date of the specialty visit.
- ! Written reports are required at the time of initial consultation and again with the receipt of all major significant diagnostic information or changes in therapy. In addition, specialists must promptly report to the referring primary care physician any significant findings or urgent changes in therapy which result from the specialty consultation.
- ! All training sites must deliver the same standard of care to all patients irrespective of payor. Training sites must integrate the care of Medicaid, uninsured and private patients in the same settings.

2.6.6 Traditional Medicaid Providers

2.6.6.1 General Requirements

One of the State's goals for managed care is to better integrate Medicaid beneficiaries into the health care delivery system used by privately insured individuals (see also Section 2.6.11, Mainstreaming). However, the State also has an interest in preserving access for Medicaid clients to providers who traditionally have served this population. These providers include school-based health centers, public health departments, federally qualified health centers (FQHCs), rural health clinics (RHCs), presumptive eligibility providers, Title X (family planning) providers, and community mental health and substance abuse providers.

With the exception of school-based health centers and presumptive eligibility providers in

certain cases (see below) and FQHCs, the State is not requiring MCOs to include any particular class or number of traditional Medicaid providers in their networks. However, the State is encouraging MCOs to contract with traditional providers who meet MCO and Medicaid managed care credentialing and programmatic standards. The State will show preference in its MCO selection process to those organizations which offer contracts to such traditional providers at terms equivalent to what is offered to other providers and which demonstrate a commitment to integrating traditional Medicaid providers with other network providers.

The State similarly will show preference in its selection process to MCOs that propose:

- ! to cover areas defined as medically underserved with respect to primary care capacity.
- ! to expand primary care capacity to those areas.

A listing of such areas is available from the Bureau of Managed Care Program Planning (518) 473-0122.

2.6.6.1.2 Coordination of Services

Linkage Agreements/Coordination of Care - The State may require agreements and coordinate care arrangements for their Medicaid enrollees in each borough and county with: school-based health clinics, the court system (i.e., for court-ordered evaluations and treatment), family planning clinics, SNPs, programs funded through the Ryan White CARE Act, providers of health care for the homeless, shelters and other providers of services for victims of domestic violence, Prenatal Care Assistance Program providers, community health centers, migrant health centers and other pertinent entities that provide services out of network. Coordination may involve MCO contracts or linkage agreements or other mechanisms to assure care for these individuals.

Coordination and Payment of Out-of-Network Services - MCOs will be responsible for reimbursement of care provided outside the network if there is no network provider with appropriate training and expertise to meet Partnership Plan enrollees' needs. In addition, if there is no subcontract for particular types of medically necessary specialist services for which the MCO is liable, the MCO will be responsible for arranging for the provision of such services and reimbursing the specialty providers on a fee-for-service basis.

Coordination of Care for Partnership Plan Enrollees in Need of Mental Health and Substance Abuse Treatment Services - MCOs will be responsible for actively identifying enrollees in need of mental health and substance abuse treatment services and ensure that they receive appropriate care. The MCO is responsible for:

- ! targeting high-risk populations;
- ! utilizing screening tools; and
- ! coordinating PCP services with mental health and substance abuse treatment services.

MCOs must have policies and procedures to ensure that all network primary care and

behavioral health care providers have and use formal assessment instruments to identify members requiring behavioral health services and to determine the type of treatment that should be furnished. MCOs must offer formal training for network providers in the use of these assessment instruments, and in techniques for identifying individuals with unmet behavioral health care needs, including key inquiries made at the time an initial medical history is taken.

MCOs must also have policies and procedures in place to ensure that members who have been evaluated and determined in need of treatment actually receive referrals to appropriate providers. As a part of the C/THP program MCOs are also required to ensure that network providers appropriately screen children for behavioral and developmental problems and to make referrals for follow-up care and treatment as needed.

Finally, MCOs must have in place a mechanism through which high-risk patients can be evaluated and referred for treatment. This must include a referral mechanism whereby network primary care providers, including pediatricians, internists, family and general practitioners, obstetricians, and nurse practitioners may request that an MCO representative or behavioral health provider reach out to any patient they believe to be in need of mental health or chemical dependence treatment services and attempt to arrange for an evaluation of their needs.

2.6.6.2 School-Based Health Centers

- (a) By August 1, 1999, MCOs must develop, in collaboration with school-based health centers in their service area, protocols for reciprocal referral of MCO members enrolled in school-based health centers.
- (b) By October 1, 1999, MCOs must develop, in collaboration with school-based health centers in their service areas, protocols for reciprocal communication of data and clinical information on MCO members enrolled in school-based health centers.
- (c) By March 31, 2000, the Contractor must enter into contractual and payment arrangements consistent with SDOH clinical coordination guidelines and the protocols referred to in (a) and (b) above.

2.6.6.3 Presumptive Eligibility Providers (PEP)

Since 1990, New York has provided access to prenatal care for pregnant women by allowing certain qualified health care providers to perform presumptive eligibility determinations for Medicaid at time of first contact with the woman. The qualified provider assists the woman in completing the appropriate application forms and submitting these forms to the LDSS, which then determines the woman's eligibility for Medicaid. Since auto-assignment might result in assignment of a woman to an MCO other than the one in which her PEP participates, we anticipate that PEPs will inform a woman of the MCOs in which they participate and encourage her to make an informed choice of MCOs, in order to avoid the auto-assignment process. There are currently about 175 presumptive eligibility providers in the State.

MCOs must offer these providers the opportunity to contract at terms which are at least as favorable as the terms offered to other providers performing equivalent services (prenatal care). MCOs need not contract with every presumptive eligibility provider in their borough/county, but must include a sufficient number in their networks to meet the distance/travel time standards defined for primary care (see Section 2.6.1.2).

2.6.6.4 Traditional Medicaid Provider Listing

A listing of traditional Medicaid providers, by borough/county, is available from the Bureau of Managed Care Program Planning at (518) 473-0122.

2.6.6.5 Supplemental Payments to Traditional Providers

The State has committed to making supplemental payments to Federally Qualified Health Centers (FQHCs) and certain other free-standing comprehensive primary care providers who serve large numbers of Medicaid and/or indigent patients, to assist them in the transition from fee-for-service to managed care. Such payments will be made directly by the State to qualified providers. MCOs are not required to take any action with regard to the supplemental payments; mention of such payments is included in this document for MCO information only.

2.6.6.6 FQHCs

In voluntary counties MCOs are not required to contract with FQHCs.

However, whenever an MCO contracts with an FQHC the MCO must agree to compensate the FQHC for services provided to enrollees at a payment rate that is not less than the level and amount which the MCO would make to a provider which is not an FQHC.

Under the 1115 demonstration, HCFA requires MCOs to contract with FQHCs if FQHCs operate in their service areas. However, HCFA can make an exception in areas where FQHCs sponsor a managed care MCO. In these areas, MCOs are not required to include within their networks any FQHC providers. Additionally, MCOs may request an exemption from the FQHC contracting requirement, subject to verification of service accessibility by the State.

If it can be demonstrated that an MCO has adequate capacity and will provide a comparable level of clinical and enabling services to vulnerable populations in lieu of contracting with FQHCs in their service areas, the MCO may be granted an exemption by HCFA.

To apply for such an exemption, MCOs must document that they provide a comparable level of Title XIX services to what is actually being delivered by the FQHC, including covered outreach, referral services, social support services, and culturally sensitive services such as training for medical and administrative staff. Additionally, MCOs will be

required to document in their request for exemption from HCFA's requirement how they will provide comparable outreach and case management services (medical and non-medical) and how they will assure a level of cultural sensitivity equivalent to that available in the FQHC.

2.6.7 Pharmacies

Pharmacy is not part of the MCO benefit package. Enrollees will receive pharmacy services on a fee-for services basis. SDOH will provide MCOs with information about the use of pharmacy services from claims data. MCOs are expected to use this information for case management purposes.

2.6.8 Mental Health and Substance Abuse Providers

MCOs must include a full array of mental health and substance abuse provider types in their networks in sufficient numbers to assure accessibility to services on the part of both children and adults, using either individual practitioners or New York State Office of Mental Health (OMH)- and Office of Alcohol and Substance Abuse Services (OASAS)-licensed programs and clinics, or both (the State strongly encourages MCOs to include OMH- and OASAS-licensed programs in their networks).

The State defines mental health and substance abuse providers to include the following:

Individual Practitioners

- ! Psychiatrists
- ! Psychologists
- ! Psychiatric Nurse Practitioners
- ! Psychiatric Clinical Nurse Specialists
- ! Licensed Certified Social Workers
- ! Certified Drug and Alcohol Counselors.

OMH and OASAS Programs and Clinics

- ! Providers of mental health and/or alcoholism/substance abuse services certified or licensed pursuant to article 23 or 31 of Mental Hygiene Law, as appropriate.

2.6.9 Home Health Providers

MCOs must contract with and use Certified Home Health Agencies (CHHAs) for provision of home health services to Medicaid enrollees. CHHAs may in turn sub-contract

with licensed home health care agencies, but MCOs must restrict their contracting to the CHHAs themselves.

2.6.10 Laboratory

MCOs must restrict their laboratory provider network to entities having either a CLIA certificate of registration or a CLIA certificate of waiver.

2.6.11 Mainstreaming

The State considers mainstreaming of Medicaid beneficiaries into the broader health delivery system to be an important program objective. MCOs must take all necessary steps to ensure that network providers do not segregate Medicaid patients in any way from other persons receiving services.

MCOs serving both Medicaid and non-Medicaid populations also are encouraged to make their entire network available to Medicaid enrollees, and, at a minimum, to make sixty percent (60%) available in the first year of the contract and eighty percent (80%) in the second year of the contract. The State will take into consideration the degree to which an MCO has opened its network to Medicaid enrollees during the proposal evaluation process. Depending on the degree of mainstreaming achieved, the State may mandate MCOs to open their entire networks in a future qualification cycle.

2.6.12 Notification Regarding Network Changes

MCOs must notify the State in a timely manner of any material changes (e.g., 10% decrease in available providers) in network composition that negatively affect member access to services. Such changes may result in suspension of new enrollment or constitute grounds for contract termination.

2.7 Service Accessibility

2.7.1 General

The State considers service accessibility to be one of the key determiners of quality of care and overall member satisfaction. Accordingly, MCOs will be expected to take all necessary measures to ensure compliance with the access standards issued below. The State and its borough/county partners will actively monitor MCO performance in this area and will take prompt corrective action if and where problems are identified.

2.7.2 Twenty-Four (24) Hour Coverage

MCOs must provide coverage to members, either directly or through their PCPs, on a twenty-four (24) hours a day, seven (7) days a week basis. MCOs also must instruct their members on what to do to obtain services after business hours and on weekends.

In addition, service accessibility standards must require all primary care providers (PCP)

to provide coverage on a 24-hour a day, seven-day a week basis; to have systems for back-up when the PCP is not available; and to have mechanisms to follow up with enrollees who miss appointments.

2.7.3 Telephone Access

MCOs may require their PCPs to have primary responsibility for serving as an after hours on-call telephone resource to members with medical problems. If the PCP performs this function, he/she cannot be permitted to sign out (i.e., automatically refer calls) to an emergency room.

MCOs must provide training to affiliated PCPs and internal customer service 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. In the event an enrollee calls a PCP after hours and the enrollee does not have a telephone to receive a return call, the following should occur. The enrollee should reach a live voice at an answering service that will instruct the enrollee to call his/her MCO toll-free member services department telephone number or instruct the enrollee to obtain services directly if the problem appears to be a true emergency (according to the prudent layperson standard). For enrollees that contact their MCO member services departments, the MCOs should advise enrollees to remain on the telephone while the MCO representative attempts to reach the physician or gather information necessary to determine the best course of action. As an alternative, the answering service or member services department can establish a set time to call back either the number from which the enrollee is calling or another telephone number where he or she can be reached. Those physicians that utilize an answering machine will need to refer enrollees to a number where a live voice is available and instruct enrollees that are unable to receive a return call to contact their MCO toll-free member services department.

Whether or not the MCO assigns primary responsibility for after hours telephone access to the PCP, it also must have a twenty-four hour toll free telephone number for members to call which is answered by a live voice (answering machines are not acceptable). This number need not be staffed by the Member Services department and need not be equipped to respond to non-medical inquiries (see also Sections 2.4.7.1 and 2.4.9).

2.7.4 Emergency Services

MCOs are prohibited from requiring members to seek prior authorization for services in a medical or behavioral health emergency. MCOs must inform their members that access to emergency services is not restricted and that if the member experiences a medical or behavioral health emergency, he or she may obtain services from a non-MCO physician or other qualified provider, without penalty. However, MCOs may require members to notify the MCO or their PCPs within a specified time after receiving emergency care and may require members to obtain prior authorization for any follow-up care delivered pursuant to the emergency. (See also Section 2.15.4.3 for a discussion of hospital emergency room triage fees and Appendix 4.1 for the State's definition of a medical emergency.)

2.7.5 Availability

2.7.5.1 Days to Appointment

MCOs must abide by the following appointment standards:

- ! Urgent medical or behavioral problems within 24 hours.
- ! Non-urgent sick visits within 48 to 72 hours, as clinically indicated.
- ! Routine, non-urgent or preventive care visits within four weeks.
- ! Adult baseline and routine physicals within twelve weeks.
- ! Initial prenatal visits within three weeks during first trimester, and two weeks thereafter.
- ! Initial visit for newborns to their PCP within two weeks of hospital discharge.
- ! Initial family planning visits within two weeks.
- ! In-plan mental health or substance abuse follow-up visits (pursuant to an emergency or hospital discharge) within five days, or as clinically indicated.
- ! In-plan, non-urgent mental health or substance abuse visits within two weeks.

2.7.5.2 Appointment Waiting Times

Enrollees with appointments shall not routinely be made to wait more than one hour.

2.7.6 Self-Referral for Designated Services

2.7.6.1 General

Except for the categories described below, MCOs may require members to obtain authorization prior to receiving any non-emergent, non-primary care services included in the MCO benefit package.

2.7.6.2 Mental Health and Substance Abuse

MCOs must allow members to self-refer for one mental health and one substance abuse assessment from an MCO network provider in a twelve-month period. In the case of children, such self-referrals may originate at the behest of a school guidance counselor or similar source, as appropriate for the age of the child.

MCOs must make available to all members a complete listing of their network mental

health and substance abuse providers, including those providers who practice in a mental health clinic setting. MCOs also must ensure that their providers have available and use formal assessment instruments to identify members requiring mental health and substance abuse services, and to determine the types of services that should be furnished. Finally, MCOs must have policies and procedures to ensure that members receive follow-up services from appropriate providers based on the findings of their assessment.

The Bureau of Managed Care Program Planning has examples of State-approved assessment instruments. However, MCOs may use their own assessment tools as long as they are consistent with the general approach laid out in the State's tools.

2.7.6.3 Vision Services

MCOs must allow their members to self-refer to any network vision provider (ophthalmologist or optometrist) for refractive vision services.

2.7.6.4 Family Planning Services

MCOs must be responsible for providing or arranging for family planning services. MCOs are required to ensure that these services are provided in a timely and coordinated manner.

MCO members may also obtain family planning services from any qualified provider without referral, whether or not the provider is part of the MCO's network, and without prior approval, referral or notice to the MCO. MCOs must inform members of their right to access these services from any qualified provider in or out of network. MCOs will have two options regarding payment for family planning services. MCOs may elect to:

- a. Be capitated for family planning services. Under this option MCOs receive capitated payments for family planning and reproductive health services (including labs and supplies) and accept responsibility for paying both network and non-network providers. Network providers submit claims to the MCO. Non-network providers submit claims to the Medicaid Management Information System (MMIS) and will be reimbursed at existing Medicaid physician fee and clinic rate schedules, which will be offset against monies due to the MCO. The Department will charge the MCOs for non-network provider claims incurred by the MCO's enrollees without identifying enrollees. This system will be administered in such a manner that the service remains confidential for the enrollee.

If the Contractor includes family planning and reproductive health services in its benefit package, the Contractor must notify all enrollees of reproductive age (including minors who may be sexually active) about their right to obtain family planning and reproductive health services and supplies from any network or non-network provider without referral or approval. The notification must contain the following:

- 1.) at the time of enrollment, notification of the Medicaid enrollees right to obtain the full range of family planning and reproductive health services (including

HIV counseling and testing when performed as part of a family planning encounter) from either a Contractor network provider or any qualified non-network provider which undertakes to provide such services to them, without referral, approval or notification;

- 2.) a current list of qualified network family planning providers, within the geographic area, including addresses and telephone numbers, who provide the full range of family planning and reproductive health services. Contractor may also choose to provide a list of qualified non-network providers who provide the full range of family planning and reproductive health services;
 - 3.) information that the cost of the enrollees care will be fully covered by Medicaid, regardless of where the enrollee obtains services.
- b. Exclude family planning services from the capitation rate and all providers, both in and out of network, are required to bill the State directly, through MMIS, for such services.

MCOs that do not include family planning services in their capitation must submit a statement of the policy and procedure they will use to inform members prospective members and network providers using the following guidelines within 90 days of signing the contract.

The policy and procedure statement regarding family planning services must contain the following:

- 1) A statement that you will inform prospective enrollees, new members and current members that:
 - a. Certain family planning and reproductive health services (such as abortion, sterilization and birth control) are not included in your plan's capitation.
 - b. Such services may be obtained through fee-for-service Medicaid from any provider who accepts Medicaid.
 - c. No referral is needed for such services, and that there will be no cost to the member for such services.
- 2) A statement that this information will be provided in the following manner:
 - a. Through the plan's written marketing materials, including the member handbook.
 - b. Orally at the time of enrollment and any time an inquiry is made regarding family planning and reproductive health services.

- 3) The procedure for informing the plan's primary care providers, obstetricians, and gynecologists that the plan has elected not to cover certain reproductive and family planning services.
- 4) Mechanisms to inform the plan's providers who also participate in the fee-for-service Medicaid program that, if they render non-covered reproductive and family planning services, they do so as a fee-for-service Medicaid practitioner, independently of the plan.
- 5) The member handbook and marketing materials indicating that the plan has elected not to cover certain reproductive and family planning services, and explaining the right of all members to secure such services through free access to the Medicaid program.
- 6) With the advent of mandatory enrollment and auto-assignment, mechanisms to provide all new members with an SDOH approved letter explaining how to access family planning services and the SDOH approved or county DSS approved list of family planning providers. This material will be furnished by SDOH to the plan and mailed with the first new member communication, prior to the enrollment effective date.
- 7) If a member or prospective enrollee requests information about these non-covered services, the plan's member services department will advise the member or prospective enrollee as follows:
 - a. Family planning and reproductive services such as abortion, sterilization and birth control are not covered through the plan.
 - b. Members can receive these non-covered services using their Medicaid card from any doctor or clinic that provides these services and accepts Medicaid.
 - c. The plan will mail to each member or prospective enrollee who calls, a copy of the SDOH approved letter explaining the member's right to receive these non-covered services and an SDOH approved or county DSS approved list of family planning providers in the member's community. The plan will mail these materials within 48 hours of the contact.
 - d. Members or enrollees can call the plan's member services number or the New York State Growing-Up-Healthy Hotline (1-800 522-5006) for further information about how to obtain these non-covered services.
- 8) The procedure for maintaining a manual log of all requests for such information, including the date of the call, the member's ID number, and the date the SDOH approved letter and SDOH approved list was mailed. The plan will review this log monthly and upon request, submit a copy to SDOH by county.

- 9) Mechanisms to inform participating providers that if in the provider's best professional judgement, certain reproductive and family planning services not offered through the plan are medically indicated in accordance with generally accepted standards of professional practice, an appropriately trained professional should so advise the member and either: (1) offer those services on a fee-for-service basis; or (2) provide the member with a copy of the SDOH approved or county DSS approved list of family planning providers.
- 10) The plan must recognize that the exchange of medical information, when indicated in accordance with generally accepted standards of professional practice, is necessary for the overall coordination of members' care and will assist primary care providers in providing the highest quality care to the plan's members. The plan must acknowledge that medical record information maintained by network providers may include information relating to family planning services provided under the fee-for-service Medicaid program.
- 11) Quality assurance initiatives to ensure compliance with this policy. These should include the following procedures:
 - a. The plan will submit any materials to be furnished to members and providers relating to access to non-covered reproductive and family planning services to SDOH, Office of Managed Care for its review and approval before issuance. Such materials include, but are not limited to, member handbooks, provider manuals, and marketing materials.
 - b. Monitoring calls to membership services and providers will be conducted to access the quality of the information provided.
 - c. Monitoring calls will be performed weekly by the manager/director or his or her designee.
 - d. Every month, the plan will prepare a list of members who have been sent a copy of the SDOH approved letter and the SDOH approved or county DSS approved list of family planning providers. This information will be submitted to the Chief Operating Officer and President/CEO on a monthly basis.
 - e. The plan will provide all new employees with a copy of this policy. The plan's orientation programs will include a thorough discussion of all aspects of this policy and procedure. Annual retraining programs for all employees will also be conducted to ensure continuing compliance with this policy.

The election should be specified in the MCO's proposal, as described in Chapter Three.

2.7.6.5 HIV Testing

MCO members may receive HIV antibody testing and pre- and post-test counseling, either

in MCO or out-of-MCO, when performed as part of a family planning visit. Such testing may be furnished without prior approval by the MCO or notification to the MCO, and may be conducted at anonymous testing sites available to clients.

Reimbursement for HIV counseling and testing, when performed as part of a family planning encounter, will be based on the family planning election made by the MCO, pursuant to Section 2.7.6.4 above. Counseling and testing rendered outside of a family planning encounter, as well as other services provided as the result of an HIV+ diagnosis, will be furnished through the MCO following normal policies (see also Section 2.7.10.7 for a discussion of HIV+ individuals).

2.7.7 Service Continuation for New Members

MCOs will be required to continue to furnish services (in or out-of-network) to new members until such time as the MCO is able to arrange a first visit with a physician. In meeting this obligation, MCOs may require providers to obtain prior authorization and to submit clinical encounter data as a condition of payment. MCOs also may reimburse providers at the lesser of any negotiated rate or the Medicaid fee schedule.

2.7.8 Second Opinions for Major Surgical Procedures

MCOs must allow members to obtain second opinions within the MCO's network of providers for major surgical procedures. Major surgical procedures are defined as all surgical procedures performed on an inpatient basis and any surgical procedure performed on an outpatient basis which requires the services of an anesthesiologist.

2.7.9 Public Health-Related Services

2.7.9.1 Coordination with Local Public Health Agencies

MCOs will be required to coordinate their public health-related activities with public health agencies in each borough/county (e.g., communicable disease reporting). The State has drafted guidelines for the interaction of MCOs and public health agencies which are available from the Bureau of Managed Care Program Planning. Each county will be permitted to customize these guidelines to reflect its particular priorities. The New York City Guidelines are available from HCA and include the rates to be paid to the NYC Department of Health for certain mandated services.

- ! Satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and/or disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc.
- ! Satisfactory case management systems to ensure all required services are furnished on a timely basis.
- ! Satisfactory systems for coordinating service delivery with out-of-network providers,

including behavioral health providers in the case of SSI physical health only members, and ongoing service providers for all members.

- ! Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best medical interest of the member.

2.7.9.2 Treatment of Tuberculosis

2.7.9.2.1 General

Under New York law, public health clinics are required to provide treatment to individuals presenting with Tuberculosis (TB), regardless of the person's insurance or MCO enrollment status. It is the State's preference that MCO members receive TB diagnosis and treatment through their MCO, to the extent that providers experienced in this type of care are available in the network.

Toward this end, each borough/county will be responsible for reviewing the Tuberculosis treatment protocols and provider networks of MCOs in their jurisdictions to verify their readiness to treat Tuberculosis patients. MCO protocols will be evaluated against State and local guidelines. State and local departments of health also will be available to offer technical assistance to MCOs in establishing TB policies and procedures.

2.7.9.2.2 Reimbursement

Because members cannot be prohibited from self-referring to public health clinics, and because not all MCOs will be adequately staffed with physicians who have specific expertise in TB, including drug resistant cases, the State will require MCOs to reimburse public health clinics when any of the following services are rendered to their members within the context of TB diagnosis and treatment:

- ! Physician visit and patient management.

- ! Laboratory and radiology.

Currently, contractors are using locally negotiated fees, and there have been no requests for State-established fee schedules. In the absence of a negotiated rate in any given locality, the State will establish fee schedules for these services. As a condition of payment, MCOs may require public health clinics to give notification before delivering services. MCOs may not require formal prior authorization, except for inpatient hospital admissions.

MCOs will not be capitated or financially liable for Directly Observed Therapy (DOT) costs. MCOs also will not be financially liable for treatments rendered to members who have been involuntarily institutionalized due to non-compliance with TB care regimens.

2.7.9.3 Immunizations

Although public health clinics do not have the same degree of legal responsibility for immunizations as for TB, the State considers immunization rates to be a vital public health concern. Accordingly, the State's policy, with respect to immunizations, will be to include this service in the prepaid benefit package and require MCOs to reimburse clinics when members self-refer to them.

In order to be eligible for reimbursement, a public health clinic will have to 1) make reasonable efforts to verify with the member's PCP that he/she has not already provided the immunization and 2) provide documentation of services rendered along with the claim. The MCO then will be permitted to reimburse the clinic at the lesser of a negotiated rate or a special fee schedule to be released prior to program start-up.

The State is currently working to establish an immunization registry with on-line access for MCOs and public health clinics. At such time as the registry is activated it will serve as an alternate source for clinics seeking to verify whether a child is current on his or her immunizations.

The State also will require individual network physicians and staff/group model MCOs to participate in the Vaccines for Children program. The State in turn will furnish participating providers/MCOs with vaccines at no charge.

2.7.9.4 Prevention and Treatment of Sexually Transmitted Diseases

MCOs will be responsible for educating their members about the risk and prevention of sexually transmitted diseases. MCOs also will be responsible for screening and treating their members for sexually transmitted diseases and reporting information to local health departments in accordance with existing State and local laws and regulations.

2.7.9.5 Lead Poisoning

MCO PCPs will be responsible for screening, diagnosing, and treating children with elevated blood lead levels. MCOs/PCPs also must coordinate the care of such children with local health departments to assure appropriate follow-up by the departments in terms of environmental investigation and risk management.

2.7.10 Populations with Special Health Care Needs

2.7.10.1 General

Under the managed care program, New York will be enrolling significant numbers of children and adults with complex/chronic medical conditions, including physical and developmental disabilities, as well as persons with other special health care needs. In general, MCOs must have in place adequate case management systems to identify the service needs of all such members and ensure that medically necessary covered benefits are delivered on a timely basis. More specific standards for certain population groups are

described below.

2.7.10.2 Adults with Chronic Illnesses and Physical or Developmental Disabilities

Health plans must have in place all of the following to meet the needs of their adult members with chronic illnesses and physical or developmental disabilities:

- ! Satisfactory methods for ensuring their providers are in compliance with Title II of the Americans with Disabilities Act. The Americans with Disabilities Act accessibility checklist is included in the Technical Assistance library.
- ! Satisfactory methods/guidelines for identifying persons at risk of, or having, chronic diseases and disabilities and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services etc.
- ! Satisfactory case management systems to ensure all required services are furnished on a timely basis.
- ! Satisfactory systems for coordinating service delivery with out-of-network providers, including behavioral health providers in the case of SSI physical health only members, and ongoing service providers for all members.
- ! Policies and procedures to allow for the continuation of existing relationships with out-of-network providers, when considered to be in the best medical interest of the member.

2.7.10.3 Children with Special Health Care Needs

Children with special health care needs are those who have or are suspected of having a serious or chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that generally required by children. MCOs will be responsible for performing all of the same activities for this population as for adults (see above Section 2.7.10.2). In addition, MCOs must have in place for these children:

- ! Satisfactory methods for interacting with school districts, child protective service agencies, early intervention officials, and behavioral health and developmental disabilities service organizations for the purpose of coordinating and assuring appropriate service delivery.
- ! An adequate network of pediatric providers and sub-specialists, and contractual relationships with tertiary institutions, to meet their medical needs.
- ! Satisfactory methods for assuring that children with serious, chronic, and rare disorders receive appropriate diagnostic work-ups on a timely basis.

- ! Satisfactory arrangements for assuring access to specialty centers in and out of New York State for diagnosis and treatment of rare disorders. A listing of specialty centers is available from the Bureau of Managed Care Program Planning.
- ! A satisfactory approach for assuring access to allied health professionals (Physical Therapists, Occupational Therapists, Speech Therapists, and Audiologists) experienced in dealing with children and families.

2.7.10.4 MR/DD Population

Persons with mental retardation and/or other developmental disabilities (MR/DD) will be eligible to enroll into MCOs on a voluntary basis, as described in Section 1.3. Initially, the MR/DD managed care population will consist of ADC, ADC-related, and Home Relief beneficiaries. However, the State has released SSI health-only rates and opened MCO enrollment to the SSI-MR/DD population. It is anticipated that this change will result in the enrollment of more seriously impaired individuals into MCOs.

With the release of SSI health-only rates, the State issued separate guidelines for the designation of selected MCOs as well-qualified to serve members with MR/DD. To receive this designation, interested MCOs must demonstrate that their networks include providers experienced in serving patients with MR/DD, and that other MCO components have also been structured to meet the special needs of the MR/DD population. While the well-qualified MCOs will be so identified to the families of MR/DD clients, all participating MCOs will be required to enroll and serve any eligible MR/DD individuals who select them.

2.7.10.5 Persons Requiring Ongoing Mental Health Services

The State expects to enroll significant numbers of persons with ongoing or chronic mental health service needs into MCOs. These individuals, while not diagnosed as SPMI, may have relatively significant needs for mental health services.

Accordingly, MCOs must have in place all of the following for their members with chronic or ongoing mental health service needs:

- ! Inclusion of all of the required provider types listed in Section 2.6.8.
- ! Capacity to provide culturally and linguistically appropriate services, including therapy services in languages other than English, to the extent reasonable and practical given provider capacity in the MCO's service area.
- ! Satisfactory methods for identifying persons requiring such services and encouraging self-referral and early entry into treatment.
- ! Satisfactory case management systems to ensure all required services--including emergency services--are furnished on a timely basis.

- ! Satisfactory systems for coordinating service delivery between physical health, substance abuse, and mental health providers.

MCOs also must participate in the local planning process for serving persons with mental illness to the extent requested by the LDSS.

2.7.10.6.1 Persons Requiring Substance Abuse Services

As with users of mental health services, the State expects to enroll significant numbers of persons with chronic and serious alcohol and substance abuse problems. While substance abuse treatment (other than methadone maintenance) is included in the basic benefit package for all beneficiaries, the State expects MCOs to take additional measures to ensure that individuals with such problems--particularly pregnant women--receive effective and cost-efficient care. Specifically, MCOs must have in place all of the following:

- ! Provider networks containing all of the required provider types listed in Section 2.6.8, including experienced treatment providers licensed by the New York State Office of Alcohol and Substance Abuse Services (OASAS).
- ! Capacity to provide culturally and linguistically appropriate services, including therapy services in languages other than English, to the extent reasonable and practical given provider capacity in the MCO's service area.
- ! Satisfactory methods for identifying persons requiring such services and encouraging self-referral and early entry into treatment. In the case of pregnant women, having methods for referring to OASAS for appropriate services beyond the MCO's benefit package (e.g., halfway houses).
- ! Satisfactory systems of care (provider networks and referral processes) sufficient to ensure that emergency services (including crisis services) can be provided in a timely manner.
- ! Satisfactory case management systems to ensure all required services--including emergency services--are furnished on a timely basis.
- ! Satisfactory systems for coordinating service delivery between physical health, substance abuse, and mental health providers.

MCOs also must participate in the local planning process for serving persons with drug and alcohol addictions, to the extent requested by the LDSS.

2.7.10.6.2 Welfare Reform Alcohol and Substance Abuse services

MCOs are not responsible for the provision and payment of alcohol and substance abuse treatment services ordered by the local district and provided to Medicaid managed care enrollees who have been:

- ! assessed as unable to work by the LDSS, and are mandated to receive ASA services as a condition of eligibility for Public Assistance or Medicaid, or,
- ! determined to be able to work with limitations (work limited) and are simultaneously mandated by the district into ASA treatment pursuant to work activity requirements.

While these services may not be part of the benefit package, the PCP retains the responsibility for coordinating the care of enrollee.

For those Medicaid managed care enrollees who are not currently receiving ASA services through their MCO, LDSS mandated Welfare Reform Alcohol and Substance Abuse services, which are covered by Medicaid and provided by an OASAS-licensed Medicaid enrolled provider, will be reimbursed on a fee-for-service (FFS) basis. Welfare Reform Alcohol and Substance Abuse services that may be ordered by the LDSS, and may be reimbursed FFS include: uncomplicated inpatient detoxification services, inpatient rehabilitation services, alcohol clinic services, alcohol day rehabilitation services, medically supervised substance abuse services (1035 facility services) and methadone maintenance treatment services (MMTP). (Please be aware that alcohol day rehabilitation, 1035 facility services and MMTP are not included within the prepaid benefit package, and are available on a fee-for-service basis. Accordingly, if these services ARE NOT ordered by the LDSS as a condition of Public Assistance or Medicaid eligibility, then the provider would bill Medicaid FFS in accordance with general Medicaid billing practices.)

MCOs retain responsibility for the provision and payment of medically complicated inpatient detoxification services in acute hospital settings.

If an MCO is already providing ASA treatment and the district is satisfied with the level of care and the treatment plan, then the MCO will continue to be responsible for the provision and payment of the services.

2.7.10.7 HIV+ Population

HIV+ persons will be permitted to enroll voluntarily into MCOs at the start of this program. Following approval of the Section 1115(a) waiver, enrollment will remain voluntary for persons with HIV.

At the same time, managed care networks will be established specifically to serve the HIV+ population (Special Needs Plans). The State expects to have contracts with such networks in place by mid-2000. Once the contracts have been executed, pregnant women and children also will be required to enroll either in a mainstream MCO or a Special Needs Plan (SNP).

To adequately address the HIV prevention needs of uninfected members, as well as the special needs of HIV+ individuals who do enroll in managed care, the State will require MCOs to have in place all of the following:

- ! Methods for promoting HIV prevention to all MCO enrollees. HIV prevention

information, both primary (targeted to uninfected members), and secondary (targeted to those members with HIV), should be tailored to the member's age, sex, and risk factor(s) and must be culturally and linguistically appropriate. All MCO members should be informed of the availability of both in-MCO HIV counseling and testing services, as well as those available from the New York State and New York City-operated anonymous counseling and testing programs.

- ! Satisfactory methods for encouraging self-referral and early entry into treatment. Special attention should be paid to identifying HIV+ women and engaging them in routine care in order to promote antiretroviral therapy during pregnancy.
- ! Satisfactory case management systems to ensure that all necessary services are furnished on a timely basis.

MCOs also are strongly encouraged to include traditional HIV providers, such as AIDS designated centers, in their networks and to establish linkages with HIV clinical educational programs as a means of obtaining the most current treatment guidelines and standards. The State intends to evaluate MCO proposals to ensure a high level of expertise in treating persons with HIV disease by meeting or exceeding all of these standards.

2.7.10.8 Native Americans

2.7.10.8.1 Introduction

This section describes New York State's plan for patient management and coordination of services furnished to Medicaid-eligible Native Americans. It also describes options for, and responsibilities of, urban American Indian and tribal providers. It concludes by discussing the State's monitoring protocol for assessing the impact of The Partnership Plan on health service delivery to the Native American beneficiary population.

2.7.10.8.2 Patient Management and Coordination of Services

Under The Partnership Plan, Native Americans will be allowed to enroll in MCOs on a voluntary basis. Beneficiaries will be given the option to join an MCO at time of eligibility determination under the same timeframes and family unit rules as other voluntary groups, or at time of open enrollment. If a Native American beneficiary elects to enroll in managed care, his/her enrollment will be governed by the same guaranteed eligibility and lock-in provisions as apply to other voluntary groups.

Although Native American enrollees will be governed by program lock-ins, they will retain the right to self-refer to an urban American Indian or tribal provider for MCO-covered services. LDSS staff will inform Native Americans of their self-referral options at time of enrollment. The Tribes also will educate Native American beneficiaries about their self-referral rights.

The manner of payment for self-referral services will be dependent on whether the urban American Indian/tribal provider is part of the MCO network. Specifically:

- ! If the urban American Indian/tribal provider is not part of the MCO's network, the provider will submit claims directly to the State and will be reimbursed fee-for-service. The State will track these claims and recoup from the MCO the amount paid through a year-end audit, thereby ensuring that New York and HCFA do not pay for the same service twice (once through capitation and once through a claim submittal).

In the event the urban American Indian/tribal provider determines that a client requires a referral to a private provider (i.e., physician or nurse practitioner) for additional care, payment for the referral service will occur as follows:

- ! If the private provider participates in the MCO's network, the MCO will be responsible for paying the provider in accordance with provider/MCO contract terms. The MCO will be permitted to require prior authorization for the referral, as long as it is not a "free access" service such as HIV counseling/testing.
- ! If the private provider is not part of the MCO's network, the provider will submit claims directly to the State and will be reimbursed fee-for-service. The State again will track these claims and recoup in order to ensure that duplicative payments do not occur.
- ! If either the urban American Indian/tribal provider, or a non-participating private provider determine that a client requires hospitalization, the provider will be required to refer the client back to the MCO. The only exception will be for medical emergencies (see below).

Emergency room payment policies for Native Americans will be the same as for other clients enrolled in managed care. Specifically:

- ! If the hospital participates in the MCO's network, the MCO will be responsible for paying the hospital in accordance with hospital/MCO contract terms.
-
- ! If the hospital is not part of the MCO's network and an initial triage reveals the visit to be non-emergent, the MCO will be responsible for paying the hospital a triage fee in accordance with State law. The MCO also may authorize the hospital to furnish non-emergency services, in which case it will be responsible for payment of those services as well.
- ! If, using prudent layperson standards, a true emergency is determined, the MCO will be responsible for payment of necessary emergency services, whether or not prior notification was made.

2.7.10.8.3 Provider Participation

Urban American Indian and tribal providers will be encouraged to participate in MCO

networks, to the extent they wish to do so. To facilitate their participation, these providers will be permitted to restrict their services to Native American beneficiaries only. Providers who elect not to participate in MCO networks will be expected to coordinate the care they furnish to MCO enrollees with MCO PCPs. For their part, MCO PCPs and specialists will be required to advise the urban American Indian/tribal providers about the course of treatment rendered pursuant to a referral, subject to confidentiality rules.

2.7.10.8.4 Monitoring Impact

Because of their voluntary enrollment status and self-referral rights, the State foresees no issues for Native Americans in terms of reduced accessibility to IHS/tribal providers and services. The State's monitoring efforts for Native Americans therefore will be focused on measuring health outcomes and service utilization patterns among MCO enrollees. The service use analysis will include a profiling of the out-of-MCO self-referral rates of Native Americans, based on claims paid fee-for-service by the State.

2.7.10.8.5 Education

Department of Health staff have worked cooperatively with a variety of tribal representatives and others as appropriate to create an informational instrument/brochure to assist Medicaid eligible Native Americans to understand their voluntary Medicaid managed care enrollment options.

2.8 Member Services Function

MCOs must operate a Member Services function during regular business hours. At a minimum, the Member Services department should be staffed at a ratio of at least one Member Service Representative for every 4,000 MCO members (all members Commercial and Medicaid). Member Services staff must be responsible for the following:

- Providing enrollees with information necessary to make informed choices about treatment options and to effectively utilize health care resources
- Explaining MCO rules for obtaining services and assisting members to make appointments.
- Assisting members to select or change PCPs.
- Fielding and responding to member questions and complaints, and advising members on the availability of the State's formal complaint process.

MCOs with both Medicaid and non-Medicaid enrollment are encouraged to identify and train dedicated staff within the unit to deal with requirements of the Medical Assistance program.

Member Services sites and functions will be made accessible to, and usable by, people

with disabilities. (Examples of methods for compliance with ADA and Section 504 accessibility requirements include, but are not limited to: physical accessibility of parking, entrances/exits, common areas used by enrollees; availability of auxiliary aids/ services, technology (e.g. TTY/TDD), interpreters, etc. for communication-impaired members; alternative formats for written material (e.g. Braille, large print, readers, audio tapes); training for staff in disability-related issues.

2.9 Languages Other than English

MCOs must make available written marketing and other informational materials (such as enrollee handbooks) in languages other than English whenever at least 5 percent (5%) of potential Partnership Plan enrollees in a MCO's service area speak a language other than English as a first language. In addition, verbal interpretation services must be made available to enrollees who do not speak English as a primary language. Interpreter services must be offered in person, when practical, but otherwise may be offered by telephone. MCOs must have mechanisms in place to communicate effectively with enrollees who are vision or hearing impaired, e.g., the services of an interpreter, including sign language assistance for enrollees who require such assistance, telecommunication devices for the deaf (TDD), etc., according to the Americans with Disabilities Act standards.

2.10 Provider Services Function

MCOs must operate a Provider Services function during regular business hours. At a minimum, Provider Services staff must be responsible for the following:

- ! Assisting providers with prior authorization and referral protocols.
- ! Assisting providers with claims payment procedures.
- ! Fielding and responding to provider questions and complaints.

2.11 Quality Improvement and Medical Management

2.11.1 Internal Quality Improvement Program/Quality Assurance Plan

MCOs must have internal quality assurance programs and written quality improvement or assurance plans (QIPs/QAPs) for monitoring and improving the quality of care furnished to members. Such plans must be submitted to the State Department of Health for prior approval and must address all of the following:

- ! Description of Quality Assurance committee structure.
- ! Identification of departments/individuals responsible for QAP implementation.
- ! Description of the manner in which network providers may participate in the QAP.

- ! Credentialling/re-credentialling procedures (see 2.11.2 for further information).
- ! Standards of care (see 2.11.3 for further information).
- ! Standards for service accessibility.
- ! Medical records standards.
- ! Utilization review procedures (see 2.11.4 for further information).
- ! Quality indicator measures and clinical studies (see 2.11.5 for further information).
- ! QAP documentation methods.
- ! Description of the manner in which QA/QI activities are integrated with other management functions.

2.11.2 Credentialling/Recredentialling

MCOs must institute a credentialling process for their providers that includes, at a minimum, obtaining and verifying the following information:

- ! Evidence of valid current license and valid DEA certificate, as applicable.
- ! Names of hospitals, HMOs, PHPs, and medical groups with which the provider has been associated.
- ! Reasons for discontinuance of such associations.
- ! Level of malpractice coverage.
- ! Any pending professional misconduct proceedings or malpractice actions and the substance of the allegations.
- ! The substance of any findings from such proceedings.
- ! Any sanctions imposed by Medicare or Medicaid.
- ! Names and relevant information of providers who will serve as on-call designees for the provider (applies to non-staff/group models only). MCOs must ensure that all on-call providers are in compliance with MCO credentialling standards, including any nonparticipating providers serving in this capacity.
- ! Attestation of provider as to validity of information provided.
- ! Information from other MCOs or hospitals with which provider has been associated regarding professional misconduct or medical malpractice, and associated

judgments/settlements, and any reports of professional misconduct by a hospital pursuant to NY State Public Health Law Section 2803-E.

- ! Review of provider's physical site of practice.
- ! Review of provider's capacity to provide services, based on practice size and available resources.
- ! National Practitioner Data Bank profile.
- ! Data necessary for MCO to submit network data via the Health Provider Network (HPN).

MCOs also must recredential their providers at least once every two years. During such recredentialing, MCOs should re-examine the items covered during the initial credentialing, as well as:

- ! Complaints lodged against the provider by MCO members.
- ! Results of chart audits and other quality reviews.

2.11.3 Standards of Care

MCOs must develop or adopt practice guidelines consistent with current standards of care, as recommended by professional specialty groups such as the American Academy of Pediatrics, the U.S. Task Force on Preventive Care, the New York State Child/Teen Plan (C/THP) standards for provision of care to individuals under age 21, the New York State Prenatal Care Standards for Managed Care Plans, the US DHHS Center for Substance Abuse Treatment, and the AIDS Institute Clinical Standards for Adult and Pediatric Care. Copies of these standards are available from the Bureau of Quality Management and Outcomes Research.

Benefit package services provided by MCOs must comply with all standards of the State Medicaid Plan established pursuant to Section 363-a of the State Social Services Law and regulations and must satisfy all applicable requirements of the State Public Health and Social Services Law and regulations. MCOs further must assure, in accordance with Article 44 of the Public Health Law, that persons and entities providing care and services on their behalf in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such persons or entities, satisfy all applicable licensing, certification, or qualification requirements under New York law and that the functions and responsibilities of such persons and entities in providing benefit package services do not exceed those permissible under New York law.

2.11.4 Utilization Review Procedures

MCOs must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning,

physician profiling, concurrent and retrospective review of both inpatient and ambulatory claims meeting predefined criteria. MCOs should develop their policies and procedures to comply with Article 49 of the Public Health Law. MCOs also must develop procedures for identifying and correcting patterns of over- and underutilization on the part of their enrollees (particularly children).

2.11.5 Quality Indicator Measures and Clinical Studies

2.11.5.1 Quality Indicator Measures

The State defines quality measures for MCOs in its Quality Assurance Reporting Requirements (QARR) document. The most recent QARR is available from the Bureau of Quality Management and Outcomes Research. MCOs must comply fully with QARR standards and must incorporate into their QA programs updated QARRs as produced by the State. (see also Section 2.13.1.4).

2.11.5.2 Clinical Studies

The MCO will be required to participate in up to four (4) SDOH sponsored focused clinical studies annually. The purpose of these studies will be to promote quality improvement within the MCO.

The MCO will be required to conduct at least one (1) internal focused clinical study each year in a priority topic area of its choosing, from a list to be generated through the mutual agreement of the SDOH and the MCO's Medical Director. The purpose of these studies will be to promote quality improvement within the MCO. SDOH will provide guidelines for the studies' structure. Results of these studies will be provided to the SDOH and the LDSS.

2.11.6 Medical Director's Office

MCOs must designate a Medical Director with responsibility for the development, implementation, and review of the internal quality assurance plan. The Medical Director's position need not be full time but must include sufficient hours to ensure that all Medical Director responsibilities are carried out in an appropriate manner. MCOs also may use assistant or associate Medical Directors to help perform the functions of this office.

The Medical Director must be licensed to practice medicine in the State of New York and must be board-certified in his or her area of specialty. The specific responsibilities of the Medical Director must include, but need not be limited to the following:

- ! Overseeing the MCO's Quality Assurance Committee.
- ! Overseeing the development and revision of clinical standards and protocols.
- ! Overseeing the MCO's prior authorization/referral process for non-primary care services.

- ! Participating in the management of the MCO's C/THP program.
- ! Overseeing the MCO's recruiting, credentialing, and recredentialing activities.
- ! Reviewing potential quality of care problems and overseeing development and implementation of corrective action MCOs.
- ! Serving as a liaison between the MCO and its providers.
- ! Serving as a liaison between the MCO and local public health representatives.
- ! Being available to the MCO's medical staff on a daily basis for consultation on referrals, denials, and complaints.
- ! Serving on an advisory committee to be established by the State, for purposes of coordinating program implementation and ensuring consistency among MCOs in interpreting contract and program provisions.
- ! In New York City, the Medical Director is required to work at least half time for the MCO in this capacity and full-time for all MCOs with more than 50,000 members.

Records Retention and Audits

MCOs must maintain, directly or through their providers, records related to services provided to enrollees, including a separate medical record for each enrollee. Such records must be retained at least 6 years from date of service or 3 years from age of majority, whichever is longer.

2.11.8 Confidentiality

MCOs must ensure that all individually identifiable information relating to Medicaid enrollees is kept confidential pursuant to Article 27(f) of the State Public Health Law, Section 3313 of the State Mental Hygiene Law, the provisions of Section 369 of the State Social Services Law, 42 U.S.C. Section 1396a(a)(7) [Section 1902(a)(7) of the Federal Social Security Act], 42 CFR Part 2 and other regulations promulgated thereunder. Such information may be used by the MCO or its providers only for a purpose directly connected with performance of the MCO's obligations under this program. The provisions of this section will survive the termination of a MCO's participation in the Medicaid managed care program and will remain in effect as long as the MCO maintains any individually identifiable information relating to Medicaid beneficiaries.

2.11.9 External Monitoring and Evaluation

New York State DOH and DSS, the United States Department of Health and Human Services through the Health Care Financing Administration (HCFA), the LDSS, and their representatives shall each have the right, during the MCO's normal operating hours, and at

any other time an MCO function or activity is being conducted, to monitor and evaluate, through inspection or other means, the MCO's performance and that of its network providers. This includes, but is not limited to, assessments of the quality, appropriateness, and timeliness of services provided to Medicaid enrollees, as well as focused clinical studies of acute and chronic health conditions determined to be of high priority to SDOH. This also includes the performance of periodic medical audits and collection of management data to be conducted at least once per year.

2.12 Marketing

2.12.1 General

The State places a high priority on ensuring that Medicaid beneficiaries are able to make informed choices when selecting an MCO in which to enroll. The State also is committed to enforcing consistent guidelines with respect to what MCOs may and may not do as part of their marketing practices. Accordingly, all MCOs must abide by the marketing guidelines issued by the New York State Department of Health when marketing to Medicaid beneficiaries (these guidelines do not apply to marketing activities directed at other payor groups). These guidelines include:

- ! MCO marketing activities may not discriminate on the basis of a potential member's health status, prior health service use, or need for future health care services.
- ! MCOs may not engage in marketing practices that mislead, confuse, or defraud eligible persons, the public, or any governmental agency.
- ! MCOs may not engage in door-to-door solicitations of potential Medicaid enrollees.
- ! Marketing in emergency rooms or treatment areas is prohibited. Unsolicited marketing shall not take place in waiting areas.
- ! MCOs are encouraged to sponsor or participate in promotional events and health fairs. However, if information is to be disseminated concerning the Medicaid managed care program, it must be approved by the State or LDSS before the event. At no time may MCOs seek out or specifically target likely Medicaid beneficiaries as part of their health fair promotional activities.
- ! MCOs may not purchase or otherwise acquire mailing lists from third-party vendors. Once a Medicaid eligible has initiated contact with an MCO, he or she can be added to the MCO's database for future mailings.
- ! MCOs may accept and respond to telephone inquiries from potential members. However, MCOs may not conduct cold call telephone solicitations.
- ! MCOs and their marketing representatives may not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, MCOs may only: 1) make reference in marketing materials and activities to benefits/services offered under

the program; 2) offer only nominal gifts, valued at no more than \$5.00, with such gifts being offered whether or not the recipient intends to enroll; and 3) offer individuals already enrolled in the MCO incentives valued at no more than \$50.00 in any twelve-month period.

- ! MCOs may use radio, billboards, newspapers, and other forms of mass media to market to potential enrollees. All such forms of advertising must be approved in advance by the State and should be included in the MCO's marketing plan (see Section 2.12.2 below).
- ! MCOs must ensure their marketing materials are responsive to the language and cultural needs of the Medicaid population in their service area.
- ! MCOs may not pay their marketing representatives any commission, bonus, or similar compensation, unless such compensation is identified in the MCO's marketing plan and approved by the State in advance. Under no circumstances may MCOs offer financial or other kinds of incentives to marketing representatives based on the number of Medicaid recipients enrolled.
- ! MCOs must ensure that providers within their networks and other subcontractors comply fully with the above standards. As part of such compliance, providers serving potential MCO enrollees may speak to these individuals about their MCO affiliations, as long as the provider discloses all MCOs with which they are affiliated.

In some instances, including New York City, the marketing guidelines have been revised to reflect local priorities and conditions, and differ from State guidelines.

2.12.2 Marketing Plans

MCOs must develop and submit to the State and LDSS a marketing plan, consistent with the marketing guidelines issued by the New York State Department of Health, that describes the types of marketing activities to be undertaken during the course of the contract period. No marketing activities can be conducted unless described in the plan and prior-approved by the State. MCOs will be permitted to update their marketing plans at any time throughout the contract period with LDSS/SDOH approval. Further information on the format and approval process for marketing plans will be made available prior to program startup.

2.12.3 Marketing Infractions

Infractions of the marketing guidelines and policies may result in any or all of the following actions being taken by the LDSS to protect the interests of the program and its clients:

- ! If an MCO or its representatives commit a first time infraction of marketing guidelines or policies and the infraction is deemed to be unintentional and minor in nature, the MCO may be issued a warning letter.

- ! For other infractions, depending on their seriousness, the MCO may be subject to liquidated damages of \$2,000.00 per infraction and must submit a corrective action plan with a specified deadline for implementation.
- ! If a corrective action plan is not implemented by the specified deadline, or if the MCO commits further infractions, or commits an egregious first time infraction, the LDSS may, at its discretion: 1) prohibit the MCO from conducting any marketing activities for the remainder of the contract term; 2) suspend new enrollments into the MCO (other than newborns) for the remainder of the contract term; or 3) terminate the contract.

In addition to contract marketing infractions by the LDSS, the State may seek enforcement action against any MCO that violates regulatory requirements and may impose penalties of up to \$2,000.00 per violation.

2.13 Operational and Financial Data Reporting

2.13.1 Operational Data Reporting

2.13.1.1 General

The success of this managed care program is premised on the belief that beneficiaries will enjoy better access to primary care and preventive services, and will experience improved health status and outcomes as a result. The State has developed a multi-part operational data collection plan to monitor actual program performance with respect to service access and health status/outcomes. The components of the plan are described individually below. Except as otherwise specified, MCOs must prepare and submit to the State and the LDSS the required reports in an agreed media format within sixty (60) days of the close of the applicable semiannual or annual reporting period, and within fifteen (15) business days of the close of the applicable quarterly reporting period. All reporting periods shall be based on the calendar year unless otherwise specified.

SDOH will provide MCOs with instructions for submitting the reports, including time frames and requisite formats. The instructions, time frames and formats may be modified by SDOH upon sixty (60) days written notice to the MCO.

The MCO shall incorporate the findings from reports in this section into its overall Quality Assurance Program. Where performance is less than the statewide average or other standard as defined by the State, the MCO will be required to develop a plan for improving performance that is approved by SDOH and LDSS. The MCO will be required to meet with SDOH and the LDSS up to twice a year to review improvement plans and overall quality performance.

2.13.1.2 Quarterly and Annual Statements

MCOs must prepare and submit Quarterly and Annual Statements of Operations. The

instructions and format for these statements are available from the Bureau of Managed Care Financing.

2.13.1.3 Encounter Reports

MCOs must prepare and submit encounter data to SDOH or its fiscal agent, specified by the State. Instructions and formats for encounter data are included in the SDOH Medicaid Managed Care Encounter Reporting Requirements available from the Bureau of Quality Management and Outcomes Research. Failure to comply with these standards may result in the MCO being liable for liquidated damages, as defined in Section 2.17.5.

2.13.1.4 Quality of Care Performance Measures

MCOs must prepare and submit reports to SDOH in accordance with the Medicaid report specifications, instructions, and timeframes provided by SDOH as specified in the Managed Care Quality Assurance Reporting Requirements (QARR). A copy of these requirements is available from the Bureau of Quality Management and Outcomes Research. The MCO must arrange for an NCQA-certified audit of the QARR data prior to submission to the SDOH. The SDOH reserves the right to determine which measures will be audited.

2.13.1.5 Complaint Reports

MCOs must provide the State and LDSS (at the request of the LDSS), on a quarterly basis, within fifteen (15) business days of the close of the quarter, a summary of all complaints received during that quarter. MCOs also must provide a record of all complaints that have been unresolved for more than forty-five (45) days. Such records shall include the actual complaint, all correspondence related to the complaint, and an explanation of the lack of disposition. Separate reports must be produced for each borough/county in which the MCO operates.

Complaint reporting guidelines are available from the Bureau of Managed Care Certification and Surveillance. However nothing in this section is intended to limit the State's right to seek information immediately from an MCO pursuant to investigating a complaint.

2.13.1.6 Participating Provider Network Reports

MCOs must submit electronically an updated provider network report on a quarterly basis, starting with the first full quarter after the contract has been signed and executed. The MCO shall submit a notarized attestation that the providers listed in each submission have executed an agreement with the MCO. The report submission must comply with the Managed Care Provider Network Data Dictionary (available from the Bureau of Quality Management and Outcomes Research). This routine reporting requirement in no way relieves MCOs of the obligation to report material changes in network composition at the time they occur pursuant to Section 2.6.12.

2.13.1.7 Appointment Availability Studies

MCOs must conduct a county specific (or service area if appropriate) review of appointment availability, twenty-four (24) hour access availability and member satisfaction surveys annually. Results of such surveys must be kept on file and be readily available for review by the SDOH or LDSS, upon request. Guidelines for such studies may be obtained from the Bureau of Managed Care Certification and Surveillance.

2.13.1.8 Clinical Studies

The MCO will be required to participate in up to four (4) SDOH sponsored focused clinical studies annually. The purpose of these studies will be to promote quality improvement within the MCO.

The MCO will be required to conduct at least one (1) internal focused clinical study each year in a priority topic area of its choosing, from a list to be generated through the mutual agreement of the SDOH and the MCO's Medical Director. The purpose of these studies will be to promote quality improvement within the MCO. SDOH will provide guidelines for the studies' structure. Results of these studies will be provided to the SDOH and the LDSS.

2.13.1.9 PCP Auto Assignments

MCOs must submit semi-annually to the SDOH and the LDSS a report showing the percentage of PCP assignments for enrollees which were made automatically by the MCO, rather than personally selected by the enrollee. Reporting will begin with the close of the first annual reporting period, even if the contractor has not been in operation for a full six months. Semiannual period close dates are June 30th and December 31st.

2.13.1.10 Enrollee Unavailable Reports

MCOs shall submit a monthly report to the LDSS of any enrollee it is unable to contact within ninety (90) days of the effective date of enrollment through reasonable means, including by mail, and by telephone, and/or has not utilized any health care services through the MCO or its participating providers.

2.13.1.11 Independent Audit

MCOs must submit copies of all certified financial statements by independent auditors of their Plan to the SDOH and the LDSS within thirty (30) days of receipt by the MCO.

2.13.1.12 Voluntary Disenrollments

The MCO shall submit to SDOH on a quarterly basis a report of all voluntary disenrollments during the preceding quarter.

2.13.1.13 Additional Reports

The State may from time to time request other operational data reports be prepared and submitted by MCOs. The State will limit such requests to situations in which the desired data is considered essential and cannot be obtained through existing MCO reports. When such a request is made, the State generally will give MCOs ninety (90) days notice and the opportunity to discuss and comment on the proposed requirements before work is begun. However, the State reserves the right to give thirty (30) or less days notice in circumstances where time is of the essence.

2.13.1.11 Ownership of Data

Any data, information, or reports collected or prepared by MCOs in the course of performing their duties and obligations under this program will be deemed to be owned by the State of New York. This provision is made in consideration of MCOs' use of public funds in collecting and preparing such data, information, and reports. In addition, all proposals submitted in response to this document become the property of the State and will not be returned.

2.13.2 Financial Data Reporting

2.13.2.1 General

MCOs must make available all financial records and statistical data that SDOH and any other federal or State agency may require, including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received and expenses incurred under the contract. MCOs also must make available upon request appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds and to the capacity of the MCO or its subcontractors, to bear the risk of potential financial losses. MCOs must maintain all financial records and statistical data according to generally accepted accounting principles.

MCOs are evaluated using the performance measures of profit and loss, net worth and net worth per member, as well as other ratio analyses. These are indicators of an MCO's current profitability and ability to absorb short-term negative operating results or variances. Each MCO's ratios and performance standards are compared to other MCOs and to normative standards.

All MCOs must demonstrate that they meet State statutory reserve requirements and maintain minimum net worth. MCOs that do not have a contingency reserve or net worth sufficient to cover their minimum reserve requirement are considered "financially impaired" and must submit a plan of corrective action (subject to the approval of the Office of Managed Care) that demonstrates rapid correction of the impairment.

All financial and fiscal reporting requirements are available in full detail from the Bureau of Managed Care Financing.

2.13.2.2 **Standardized Reports**

The State may define specific, standardized financial reporting requirements for participating MCOs. If so, such reporting standards will be released prior to program start up.

Disclosure of Ownership

MCOs must report ownership and related information to SDOH and, upon request, to the Secretary of DHHS and the Inspector General of the United States Department of Health and Human Services, in accordance with 42 U.S.C. Section 1320a-3 and 1396b(m)(4) [Sections 1124 and 1903(m)(4) of the Federal Social Security Act].

2.13.2.3 **Physician Incentive Plan (PIP) Disclosure**

Prior to approval of a potential Managed Care Organization's contract or agreement and then annually thereafter, the MCO must supply information on any Physician Incentive Plan arrangements, as described in Federal Regulations 42 CFR 417.479 and 42 CFR 434.70 or, if no such arrangements are in place, must attest to that fact. A **Physician Incentive Plan (PIP)** means any compensation arrangement between a Managed Care Organization or one of its contracting entities and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid recipients enrolled by the MCO.

Disclosure includes whether or not referral services are included in the PIP, and if so, the type of incentive arrangements and the percent of total income at risk for referrals. 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.

If arrangements are at Substantial Financial Risk, the MCO must meet additional requirements as described in regulation, including: conduct enrollee/disenrollee satisfaction surveys; disclose the requirements for the Physician Incentive Plans to its beneficiaries upon request; and ensure that all physicians and physician groups at Substantial Financial Risk have adequate stop-loss protection. This information is also reported on the Physician Incentive Plan Disclosure report.

The content and time frame of the Physician Incentive Plan Disclosure reports shall comply with State and federal requirements and must be in the format provided by SDOH and must be approved prior to the approval of an MCO contract or agreement. Since the format varies from year to year, a current copy of the disclosure forms may be obtained by contacting the Bureau of Managed Care Financing at (518) 474-5050.

2.14 **Complaint Resolution**

2.14.1 **Complaint Resolution (Within MCOs)**

MCOs must establish a process for receiving and responding to complaints from members and providers. The process must include:

- ! The MCO has provided written notice of the complaint procedure to the enrollee if the complaint involved a denial of a referral or a determination that a request is not covered by the benefit contract.
- ! The notice advises the enrollee of the process for filing a complaint; the timeframes for resolution; the enrollee's right to designate a representative to file a complaint.
- ! The procedure is accessible to non-English speaking enrollees.
- ! Oral complaints are allowed if they involve denial of a referral or determination that a requested benefit is not covered by benefit contract.
- ! Acknowledgment forms required for oral complaints summarize the complaint and state that the enrollee must sign and return it to initiate the complaint procedure.
- ! The MCO has provided notice to the enrollee specifying what information must be provided in order to render a decision.
- ! The MCO has provided written acknowledgment of the grievance to the enrollee within 15 business days of receipt of the complaint (except in cases of imminent health risk).
- ! Complaints are resolved in accordance with the following timeframes:
 - 48 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health.
 - 30 days after the receipt of all necessary information in cases involving a denial of a referral or denial of a requested benefit covered pursuant to the enrollee's contract.
 - 45 days after the receipt of all necessary information for all other cases.
- ! MCO staff reviewing complaints include at least one (1) clinical person to review clinical complaints.
- ! In cases of risk to an enrollee's health response to the complainant or designee will be directly by telephone or a similar substitute if no telephone is available to the complainant.
- ! Written notice is made within (3) three business days of resolution for all complaints. Notice includes detailed reason(s) for the determination, including clinical reasons if applicable, and the procedures for filing an appeal that includes appropriate forms.
- ! An enrollee has at least 60 business days after receipt of the notice of complaint determination to file a written appeal.

- ! The MCO provides written acknowledgment of the appeal within 15 business days of receipt of the appeal including a contact person and what information is necessary for the MCO to render a decision.
- ! Resolution of appeals are (2) two business days after receipt of necessary information for cases involving risk to patient health and 30 business days for all others.
- ! Appeals must have been reviewed by staff at a higher level than those reviewing the original complaint. Clinical matters must have been reviewed by at least one clinical peer reviewer.
- ! Appeal determinations include the detailed reasons, including clinical, if applicable.

As part of the complaint resolution process, MCOs must maintain a log of all complaints received, the date of their filing, and current status. The logs must be made available to the State for review, upon request.

2.14.2 Complaints to the State and LDSS

The State and its LDSS partners have policies and procedures for members to file a complaint with the SDOH or LDSS at any time. MCOs will be responsible for informing enrollees of their right to file complaints, and will inform enrollees of the process for filing complaints. The complaint process also will be open to MCOs seeking to disenroll a member pursuant to the conditions described in Section 2.5.12.

2.14.3 Fair Hearings

Medicaid recipients enrolled in MCOs have fair hearing rights. MCOs are required to cooperate fully in the fair hearing process and comply with SDOH regulations (18NYCRR 360-10 and 358) and guidelines regarding fair hearings. These guidelines are available from the Bureau of Managed Care Program Planning.

2.14.4 External Appeal

Effective July 1, 1999, managed care enrollees will be able to request an external appeal when one or more covered health care services have been denied by the managed care organization on the basis that the service(s) is not medically necessary or is experimental or investigational. An enrollee (and for retroactive denials, a provider) is eligible for an external appeal when the enrollee has exhausted the MCO's internal utilization review procedures or both the enrollee and the MCO have agreed to waive internal appeal procedures. The external appeal determination is binding on the MCO, however, a fair hearing determination supercedes an external appeal determination for Medicaid enrollees.

MCO responsibilities relative to the external appeal program include, but are not limited to, the following:

- Ensuring that final denial notices include all information necessary for the enrollee to

request an external appeal, including an explanation of the enrollee's right to an external appeal, specific information concerning the health care service requested, the reason for denial and a description of the external appeal program, including an application form;

- Facilitating an enrollee's external appeal request such that the request may be filed within the required 45 days from receipt of the final notice of denial (or letter confirming that internal appeals have been waived). Facilitation includes promptly providing the enrollee's medical and treatment records and any other relevant information to the external appeal agent as well as promptly responding to any requests for information by the agent;
- In the event that additional information about a pending external appeal becomes available that, in the opinion of the external appeal agent, constitutes a material change from the information used by the MCO to make its determination, reconsidering the final MCO determination;
- Paying the appropriate fee to the external appeal agent; and
- In the event that an MCO's determination is reversed upon external appeal, providing the health care services required by the external appeal determination.

2.15 Payments to and from the MCO

2.15.1 State Capitation Payments

MCOs will be capitated for all services included in the prepaid benefit package, including dental and family planning if the MCO has elected to provide these two optional benefits. The State will make capitation payments to MCOs on a monthly basis in the following manner:

- ! MCOs will prepare and submit to the State's Medical Assistance fiscal agent each month a claim for payment for members enrolled with the MCO during the current month. The specifications for this claiming process are available from the Bureau of Managed Care Financing. Upon receipt of the claim and verification of its completeness, the fiscal agent will promptly process it for payment and use its best efforts to complete such processing within thirty (30) business days from date of receipt.
- ! MCOs will be entitled to full monthly capitation payments for each enrollee whose effective date of enrollment is the first of the month.

2.15.2 Third-Party Health Insurance

MCOs must make diligent efforts to determine whether enrollees have Third-Party Health Insurance (TPHI) and must attempt to coordinate benefits with, and collect TPHI recoveries from, other insurers. MCOs must comply with all TPHI policies regarding

enrollment and disenrollment of Medicaid recipients with TPHI coverage. MCOs will be permitted to keep TPHI recoveries for their enrollees. The State has established capitation rates that reflect the historical net Medicaid payments after other third party coverage is applied.

2.15.3 Reinsurance/Stop-Loss

The State will be making available to MCOs optional reinsurance/stop-loss coverage for inpatient hospital service costs. MCOs must purchase this coverage unless they can demonstrate that they either: 1) have comparable and satisfactory (in the State's judgment) coverage from another source; or 2) are able to self-insure.

The State's reinsurance will be structured as follows:

- ! MCOs will be solely responsible for the first \$50,000 in inpatient hospital expenses incurred by any single enrollee during a calendar year period. The dollar value of such expenses will be calculated on the basis of the rates paid to the hospital(s) by the MCO (negotiated rates) or the Medicaid payment rate for the hospital(s), whichever is less.
- ! The State will pay eighty percent (80%) of the inpatient hospital costs incurred during the full calendar year period, after the first \$50,000 and until a \$250,000 level is reached. Again, the dollar value of the enrollee's costs will be determined on the basis of the rates paid to the hospital(s) by the MCO (negotiated rates) or the Medicaid payment rate for the hospital(s), whichever is less.
- ! The State will pay one hundred percent (100%) of the inpatient hospital expenses incurred during a calendar year period beyond the \$250,000 stop-loss threshold.
- ! The State has available detailed instructions on the manner in which to submit a stop-loss claim. As part of these instructions, MCOs will be required to submit a claim for a case within one hundred eighty (180) days of the end of claims activity. The State then will seek to pay the claims within sixty (60) days of their validation. MCOs will be responsible for making all payments to providers.

2.15.3.2 Mental Health/Substance Abuse

This stop-loss is based on numbers of outpatient visits and will be part of all MCO contracts. Payment rates will be made at the MCO's contracted fee schedules. The specific stop-loss thresholds are:

- ! Twenty (20) mental health outpatient visits during a calendar year period.
- ! Sixty (60) alcohol and drug treatment outpatient visits during a calendar year period.
- ! Thirty (30) days of inpatient mental health, alcohol and/or drug treatment services in a voluntary, municipal, or licensed proprietary hospital or State-operated facility during a contract year period (any combination).

2.15.4 MCO Payments to Providers

2.15.4.1 General

MCOs will be responsible for making timely payment for medically necessary, covered services furnished by network providers when services are rendered to treat a medical emergency (including assessment and stabilization); services are rendered under the terms of the contract with the provider; or services are prior authorized.

MCOs also will be responsible for making timely payment for medically necessary, covered services to out-of-network providers when:

- ! Services are rendered to treat a medical emergency.
- ! Services are Medicaid covered court ordered services
- ! Services are provided during a stop loss period
- ! Services are prior authorized.
- ! Services are provided pursuant to Chapter 705 of the Laws of 1996.

2.15.4.2 Hospital Payments - General

MCOs may elect to reimburse hospitals for inpatient care using a negotiated rate rather than the State's Medicaid hospital inpatient rate with GME cost removed.

2.15.4.3 Hospital Emergency Room Triage Fees

MCOs must pay hospitals an assessment, or triage fee, when their members present at an emergency room with a non-emergent condition, and no services are rendered (pursuant to MCO authorization) beyond the assessment. MCOs may pay hospitals based on any negotiated rate or, in the absence of a negotiated rate, at the State's default triage fee.

The State has established specific guidelines for hospitals to follow in order to receive the triage fee, including requirements for counseling patients on proper use of emergency rooms, notification of MCOs, and encounter reporting.

The guidelines are available from the Bureau of Managed Care Program Planning.

2.15.4.4 FQHC/RHC Reimbursement

The Balanced Budget Act (BBA) of 1997 prescribed that FQHCs be reimbursed by states for their reasonable costs in providing comprehensive primary care services to managed care enrollees. In New York State, MCOs have historically been required to reimburse

FQHCs/RHCs at terms no less favorable to the FQHC/RHC than offered to other providers delivering equivalent services. HCFA has indicated that the above BBA provision applies in New York State to all counties that are not operating a mandatory Medicaid managed care program. New York State will be providing supplemental payments to applicable FQHCs operating in voluntary counties. In addition, the 1115 waiver provides for a Supplemental Transitional payment program for FQHCs and certain other comprehensive primary care providers who serve high levels of Medicaid and/or indigent populations.

2.15.4.5 Retroactive Eligibility Period

MCOs will not be financially responsible for any services rendered to a member prior to his or her enrollment, including services falling into a period of retroactive Medicaid eligibility. This provision does not apply to newborns of members, for whom enrollment is to be effective from the time of birth.

2.15.4.6 Member Cost Sharing

MCOs are expressly prohibited from collecting copayments or imposing any other cost sharing requirements on members for delivery of services included in the prepaid benefit package.

2.16 Fiscal Standards

The fiscal stability of prepaid MCOs contracted to serve Medicaid beneficiaries under this program will be monitored primarily by the State Department of Health, working in collaboration with the Department of Insurance. As part of its oversight activities, SDOH will measure MCO performance against a variety of financial ratios, including but not limited to:

- ! Current Ratio
- ! MCO Equity per Enrollee
- ! Administrative Expenses as a Percent of Capitation
- ! Net Medical Expenses as a Percent of Capitation
- ! IBNR and IBUC Levels, Including Days Claims Outstanding

If SDOH determines that an MCO faces potential insolvency, it will order corrective actions as necessary to protect the interests of members and the program. MCOs must agree to comply with corrective actions when so ordered by SDOH. In addition, SDOH works closely with the State Insurance Department to ensure solvency of Health Maintenance Organizations.

2.17 Performance Standards and Damages

2.17.1 Performance Standards

The performance standard for MCOs is defined as absolute and total compliance with the participation requirements specified in Chapter Two of this Document. MCOs will be expected to meet these performance standards in full or be subject to suspension of enrollment and other sanctions or damages in the manner described below. Unsatisfactory performance may also disqualify an MCO for future contracts or contract extensions.

2.17.2 Suspension of New Enrollment

Whenever the State or LDSS determines that an MCO is failing to meet the performance standards for this program, the State or LDSS will have the option of suspending new enrollments into the MCO. The LDSS, when exercising this option, will notify the affected MCO in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by the LDSS, or may be indefinite. It also may be limited to only a portion of the MCO's geographic service area or its provider network, depending on the exact nature of the deficiency. Finally, the LDSS may notify enrollees of the MCO's nonperformance and permit these enrollees to transition to another MCO.

2.17.3 Damages and Sanctions

In the event of a MCO's failure to meet program performance standards, the contract may establish liquidated damages in an amount not to exceed \$2500 for each business day the plan is out of compliance. Liquidated damages will be assessed against the deficient MCO in an amount equal to the costs incurred by the State or LDSS to ensure adequate service delivery to the affected members.

2.17.4 Monthly Member Reconciliation

MCOs must carry out the monthly member reconciliation tasks described in Section 2.5.13 of this Document. MCOs will be liable for the actual amount of any detected overpayments or duplicate payments identified as a result of State or federal claims reviews or as reported by providers or from other referrals, which are a result of incorrect MCO action in conducting monthly member reconciliation.

2.17.5 Data Reporting

MCOs must comply with the operational and financial data reporting requirements described in Section 2.13 of this Document. MCOs shall pay liquidated damages of \$2,500 if any required report identified in the MCO contract is incomplete, contains misstatements or inaccurate information, or is not submitted in the requested format. The MCO shall pay liquidated damages of \$500.00 for each business day in which a required report is late, except for encounter data submissions. The MCO shall pay liquidated damages of \$10,000 if its monthly encounter data submission is not received by the fiscal agent by the date specified. The LDSS shall not impose liquidated damages for a first time infraction by the MCO unless the LDSS deems the infraction to be a material

misrepresentation of fact or the MCO fails to cure the first infraction within a reasonable period of time upon notice from the LDSS.

SDOH or LDSS may extend due dates, or modify report requirements or formats upon a written request by the MCO to the SDOH or LDSS with a copy of the request to the other agency, where the MCO has demonstrated a good and compelling reason for the extension or modification. The determination to grant an extension of time shall be made by SDOH with regard to the annual and quarterly statements, complaint reports, audits, encounter data, change of ownership, clinical studies, QARR and provider network reports and by the LDSS with respect to no contact, PCP auto-assignment, and to other reports requested by the LDSS.

2.17.6 Other Damages

The objective of this standard is to provide the State and LDSS with an administrative procedure to address general program compliance issues which are not specifically defined as performance requirements listed above or for which damages due to non-compliance cannot be quantified in the manner described in Section 2.17.3.

The State or LDSS may identify contract compliance issues resulting from a MCO's performance of its responsibilities through routine contract monitoring activities. If this occurs, the State or LDSS will notify the MCO in writing of the nature of the performance issue. The State or LDSS also will designate a period of time, not to be less than ten (10) business days, in which the MCO must provide a written response to the notification and will recommend, when appropriate, a reasonable period of time in which the MCO should remedy the non-compliance.

If the non-compliance is not corrected by the specified date, the LDSS may assess liquidated damages up to the amount of \$2,500.00 per day after the due date until the non-compliance is corrected, or may take other appropriate actions.

2.17.7 Deduction of Damages From Payments

Amounts due the LDSS as sanctions may be deducted from any money payable to an MCO in the form of capitation. The LDSS may, at its sole discretion, return a portion or all of any sanctions collected as an incentive payment to MCOs for prompt and lasting correction of performance deficiencies.

2.18 Termination and Modification of MCO Contracts

2.18.1 General

This section describes the termination and contract amendment options and procedures that will be available to the State, LDSS and participating MCOs through any contract awarded pursuant to this qualification.

2.18.2 By the LDSS or State

The LDSS or State will have the right to terminate MCO contracts, in whole or in part, if an MCO:

- ! Takes any action that threatens the health, safety, or welfare of any enrollee.
- ! Has engaged in an unacceptable practice under 18 NYCRR, PART 515, that affects the fiscal integrity of the Medicaid program.
- ! Has its certification suspended or revoked by SDOH.
- ! Materially breaches the contract or fails to comply with any term or condition of the contract and does not cure its deficiency within ten (10) business days (or such longer period as specified by the LDSS).
- ! Becomes insolvent.
- ! Brings a proceeding voluntarily, or has a proceeding brought against it involuntarily, under Title 11 of the U.S. Code (the Bankruptcy Code).
- ! Meets conditions for termination as otherwise defined in the specific contract between the LDSS and the MCO.

2.18.3 By an MCO

MCOs will have the right to terminate their contracts if the State or LDSS materially breaches the agreement and fails to comply with any material term or condition of this agreement that is not cured within ten (10) business days, or such longer period as the parties may agree, of the MCO's written request for compliance.

MCOs also will have the right to terminate their contracts if they are unable to provide services because of a natural disaster and/or an act of God to such a degree that enrollees cannot obtain reasonable access to services.

2.18.4 Due to Unavailability of Funds

In the event that State, LDSS, and/or federal funding used to pay for services under this program is reduced so that payments cannot be made in full, MCO contracts will automatically terminate, unless both parties agree to a modification of the obligations under the contract.

2.18.5 Termination Procedures

Specific procedures for termination of MCO contracts will be specified in the contracts issued pursuant to this Document.

2.18.6 Contract Modifications

The LDSS and MCOs (with SDOH approval) will be able to modify the contract issued pursuant to this Document through mutual agreement, subject to approval by HCFA. Such modification may include revision of requirements to address the unique needs of certain populations (e.g., SSI beneficiaries).

2.19 County- and New York City-Specific Standards

2.19.1 County Specific Standards

The great majority of program participation standards outlined in Sections 2.1 - 2.18 of this Document will apply in an identical fashion throughout New York City and all of the other participating counties. However, there are a small number of areas in which some counties outside of New York City have chosen to specify their own standard.

The standards that will vary by county are outlined below.

2.19.1.1 Standard 1: Member-to-Provider Ratios

Counties are permitted to specify a lower member-to-provider ratio than what is described in Section 2.6.3.8 (i.e. 1:1000 instead of 1:1500).

2.19.1.2 Standard 2: Service Area

Counties may choose to allow MCOs to submit proposals for less than the entire county.

2.19.1.3 Standard 3: Covered Services

Medical transportation is included in the standard prepaid benefit package. Individual counties may remove emergency transportation, non-emergency transportation, or both from the benefit package and make other arrangements for offering this service to their clients.

2.19.1.4 Standard 4: Public Hospitals

Counties may require MCOs to contract with any JCAHO-accredited acute care public hospitals within their jurisdictions, subject to State guidelines.

2.19.1.5 Standard 5: Optional Covered Populations

Individual counties have the option of excluding Foster Care children and Homeless recipients from the managed care program.

2.19.1.6 Standard 6: Data Reporting

Counties may require MCOs to submit certain enrollment and encounter-related reports to the LDSS.

2.19.1.7 Options Selected by Counties

Appendix 4.7 identifies the options selected by each of the counties participating in the managed care program. As described in Section 3.2, MCOs wishing to participate in any of the counties outside New York City must review the options selected by those counties and agree to structure their operations accordingly.

2.19.2 New York City

New York City has defined a number of requirements for MCOs to address in a separate document entitled the New York City Addendum. As described in Section 3.2, MCOs wishing to participate in any portion of New York City must review the Addendum and agree to meet the requirements delineated within it.

In addition, MCOs must provide the New York City-specific information requested within the Addendum as part of their proposals. The specific process to be followed is described in Chapter Three.

2.20 MCO Contracts

2.20.1 Composition

The participation standards delineated in Chapter Two will be incorporated into MCO contracts awarded through this qualification. The contracts also will include or reference the standard New York State Contract Terms and Americans with Disabilities Act compliance language presented in Appendix 4.8, as well as other terms and conditions considered necessary to clarify the responsibilities of both parties.

2.20.2 Federal Approval

Under Section 1902(m)(2)(A)(iii) 42 CFR, subsection 434.71, the Health Care Financing Administration (HCFA) has final authority to approve all comprehensive risk contracts between states and MCOs in which payment exceeds one million dollars (\$1,000,000.00). If HCFA does not approve a contract awarded pursuant to this qualification, the contract will be considered null and void.

2.20.3 Conformance with State and Federal Laws and Regulations

MCOs must agree to comply with all State and federal laws and regulations, including any not specifically mentioned in this Document or in subsequent MCO contracts.

2.20.3.1 Compliance with the Americans with Disabilities Act (ADA)

MCOs may not discriminate against an individual with a disability, as defined in Title II of the Americans with Disabilities Act (1990, 42USC 12132 and the regulations contained in 28 CFR Part 35) and Section 504 of the Rehabilitation Act of 1973, in providing services,

programs, or activities. To ensure compliance with the ADA, the MCO must submit a plan (“ADA Compliance Plan”) which lists its program site(s) and describes in detail how it intends to make its services, programs and activities readily accessible to and usable by individuals with disabilities, including, but not limited to, people with visual, auditory, cognitive or mobility disabilities, at such site(s). In the event the program site is not readily accessible to and usable by people with disabilities, the MCO will include in its Compliance Plan a description of reasonable alternative means and methods that result in making the services, programs and activities accessible. The contractor must abide by the Compliance Plan and implement any action detailed in the Compliance Plan to make the services, programs and activities accessible to and usable by individuals with disabilities.

2.20.4 Subcontractors

MCOs may enter into written subcontracts for performance of program responsibilities as outlined in this Document. Subcontracts must comply with applicable State requirements of 10NYCRR Part 98 and the SDOH Provider Contract Review Guidelines. (These guidelines are available from the Bureau of Managed Care Certification and Surveillance.) By entering into a subcontract, an MCO is in no way relieved of its obligations to the State, but will remain wholly responsible for meeting all program participation requirements as outlined in this Document and any subsequent contract.

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)
 - ✓ New York City MCOs should submit in NYC Addendum
 - ✓ 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/recredentialing 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.