

## **16. MCO SELECTION POLICIES**

### **Overview**

This chapter describes the process currently used by New York State to qualify managed care organizations (MCOs) for participation in The Partnership Plan. This process is used to qualify MCOs to participate in the Medicaid managed care (MMC) and Family Health Plus (FHPlus) programs

Appendix 16-1 of this document includes a description of the process used by the State in 1995 to select managed care organizations for participation in The Partnership Plan. The Appendix includes a discussion of the MCO application process (RFI/RFP release and proposal submission), followed by a detailed description of the methodology employed by State, New York City, and county representatives to evaluate MCO proposals. Technical and price proposal submissions and evaluations are described separately. The Appendix also includes a description of the final contracting activities undertaken with MCOs selected through the procurement.

### **MMC/FHPlus MCO Qualification Process**

The current qualification process is a non-competitive process through which eligible managed care organizations are qualified to provide services in both the Medicaid managed care (MMC) and Family Health Plus (FHPlus) programs. The plan must demonstrate its ability to comply with programmatic standards to be qualified.

#### ***Eligible Organizations***

The qualification process is open to all MCOs, [Health Maintenance Organizations (HMOs), and Prepaid Health Services Plans (PHSPs)], in the State certified by the New York State Department of Health under Article 44 of the New York State Public Health Law. MCOs may apply to serve MMC and FHPlus members in any county in which the plan is certified to operate. Qualification applications are accepted on a continuous basis. MCOs may apply to participate in the MMC and FHPlus programs at the same time, but MCOs must qualify or be currently approved to participate in the MMC program, in order to become qualified to participate in the FHPlus program.

#### ***Qualification Application***

The MMC/FHPlus Qualification Application consists of a Program Proposal, a Network Proposal, a Business Proposal and an on-site Readiness Review evaluation. For MCOs wishing to participate in New York City, there is also a New York City Addendum.

#### ***Program Proposal***

The Program Proposal contains required forms and the documentation of the MCO's ability to comply with programmatic standards. The MCO demonstrates this ability by responding to a series of questions about how the applicant will provide services to MMC/FHPlus members.

The questions focus on areas of particular concern to the Medicaid and Family Health Plus program. These include: member services, case management of populations with chronic illnesses and physical disabilities, compliance with C/THP (EPSDT) Program, coordination with public health agencies, mental health and chemical dependence treatment services, compliance with reporting requirements, and HIV care and treatment.

When an MCO seeks to operate in NYC, it must also satisfy the requirements found in the NYC Addendum. The Addendum identifies NYC required forms and asks applicants to respond to questions specific to operation in NYC.

### ***Network Proposal***

MCOs must have a comprehensive network for each county in which it proposes to operate. The network must include sufficient provider numbers and types to deliver the services identified in the benefit packages of the MMC/FHPlus MCO Model Contract to its target population and to meet accessibility standards.

Similar to commercial networks, the MCO must demonstrate a comprehensive provider network, which includes, but is not limited to: primary care, specialty care, hospitals, home health care agencies, physical therapy providers, occupational therapy providers, speech therapy providers, optometry, mental health and chemical dependence providers, allied health professionals, ancillary providers, durable medical equipment (DME) providers, etc. A list of all the required core provider types is available from the Bureau of Managed Care Certification and Surveillance. Family Planning and Dental Services are optional services in both programs.

MCOs must submit documentation about contracts with the FQHCs operating in each county. In addition to FQHCs, MCOs must provide evidence of contracts with presumptive eligibility providers and AIDS Designated Centers.

Networks are submitted electronically through the Provider Network Data System (PNDS).

If new or amended provider agreements or management contracts are proposed in relation to the MMC and FHPlus programs, the contracts and/or amendments must be submitted to SDOH for review and approval pursuant to SDOH Guidelines.

### ***Business Proposal***

The business proposal consists of an operating plan and premium proposal. The business proposal contains the following: enrollment projections by county and region, reinsurance election, rate proposals for each region in which the plan proposes to operate, using the SDOH methodology for developing the rate, and Revenue and Expense and Balance sheet projections.

Premiums are developed based on the MCO's specific assumptions about cost and utilization and include an analysis of the applicant's prior experience (when available) and the experience of other MCOs. In all cases, premiums must be approved by CMS and be adjudged by SDOH to be cost effective.

## ***Qualification Application Evaluation***

### ***General***

The State conducts a comprehensive and impartial evaluation of all proposal components. The evaluation is conducted by SDOH Division of Managed Care and Program Evaluation (DMCPE) and its New York City/county partners.

SDOH evaluates the qualification application based on the information contained in the documents submitted and on any additional material obtained through on-site visits. The various components of the qualification application are assessed to determine if the MCO has demonstrated the ability to provide services to Medicaid recipients in accordance with the guidelines in the MMC/FHPlus Model Contract.

Program proposals, Network Proposals, Business Proposals, and the NYC Addendum (if applicable) are evaluated separately. MCOs must be successful in all evaluations and in the on-site readiness review to be considered for a contract award.

### ***Program Proposal Evaluation***

The Program Proposal is evaluated by SDOH staff from the Division of Managed Care and Program Evaluation and other Units within the Department with expertise in the programmatic area addressed by the question and any submitted materials. Areas of expertise and SDOH staff responsible for that area are identified in the chart below.

Reviewers evaluate the responses to the questions about programmatic compliance using an evaluation tool. The tool provides the reviewer with guidance about what should be included in an acceptable response. The reviewer rates the response as satisfactory or unsatisfactory. Throughout the evaluation process, the State notifies the applicant in writing of any areas in which the applicant is deficient, and the applicant is given the opportunity to amend the document.

<b>Bureau</b>	<b>Area of Expertise</b>
Bureau of Managed Care Certification and Surveillance (BMCCS) (518) 474-5515 or 473-4842	MCO Operational Requirements Program Proposal Provider Network Evaluation Provider/Management Services Contract Requirements Complaint Process Onsite Readiness Review Fair Hearing Process

<b>Bureau</b>	<b>Area of Expertise</b>
Bureau of Program Quality Information and Evaluation (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 (BPP) (518) 473-0122	Public Health Welfare Reform ADA Compliance FQHC's FHPlus Benefit Package Issues
Bureau of Intergovernmental Affairs (BIGA) (518) 486-9015	LDSS issues Enrollment Broker Services Enrollment/Disenrollment policies Member Handbook Guidelines Marketing Guidelines Model Contract

### ***Network Evaluation***

Networks are evaluated by OMC staff to determine if they contain sufficient numbers and types of providers to ensure member choice and geographic access.

### ***Business Proposal***

The premium proposal is reviewed to ensure the rates are reasonable and conform to all applicable State and federal laws.

MCO revenue and expense projections and actual and projected balance sheets are reviewed to assess that the MCO has adequate capital to meet any start-up deficits, provisions for adverse selection and to 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 MCO's escrow deposit and capital.

### ***On-site Readiness Reviews***

Upon successful evaluation of the applicant's program, business and network proposals, an on-site review of the MCO is required. The purpose of this review is to verify that the applicant is compliant with all participation standards and is prepared to begin enrollment. The review also will consist of an evaluation of training of member services staff, capability of the management

information system, the ability to communicate electronically with appropriate State agencies and/or their agents, the ability to report data on the SDOH Provider Network Data System, (PNDS), and the ability to meet SDOH encounter and quality assurance reporting requirements and validation of network.

### ***Notification of Evaluation Results***

Applicants will be notified of the outcome of the evaluation(s) in writing. The State reserves the right to specify special terms and conditions that the applicant must accept prior to entering into a contract.

### ***Contracting Requirements***

MCOs must agree to comply with the operational and financial standards contained in the MMC/FHPlus Model Contract. The Model Contract can be found at [http://www.nyhealth.gov/health\\_care/managed\\_care/pdf/mafhpcontr05.pdf](http://www.nyhealth.gov/health_care/managed_care/pdf/mafhpcontr05.pdf). Successful applicants will be required to execute the MMC/FHPlus Model Contract in effect at the time of the contract award, in order to participate in the program.

For MMC, outside NYC and for FHPlus statewide, the contract is between the State and the MCO. For MMC in NYC, the contract is between NYC and the MCO.

### ***MCO Readiness***

As new MCOs enter the Medicaid managed care program, the State continues to verify the readiness of the organization to serve Medicaid beneficiaries under The Partnership Plan using the same three tiered approach instituted in 1996 and described on page 16 -13.

### ***Plan Enrollment Capacity - 2006***

In June 2005, NYS managed care regulations, (Part 98-1.11 Title 10 NYCRR), were amended. Revisions were made to managed care plan solvency standards and monitoring requirements. The amendment phases in a more stringent contingent reserve requirement and imposes stricter guidelines for escrow accounts.

The plan's financial capacity is based on conforming with the new requirements. If the plan meets the statutory requirements for the year, the plan may enroll up to its network capacity. If the plan is not in compliance, the plan must develop a plan of correction (POC) that is acceptable to the Health and Insurance Departments in order to continue to enroll up to its network capacity.

### ***Medicaid Advantage Qualification Process***

An MCO certified in the State as a managed care plan under Article 44 of the State's Public Health Law and which participates in Medicare Advantage, will be allowed to qualify to participate in offering the Medicaid Advantage product for the dual eligible population. Plans are required to go through a qualification process similar to the one used for Medicaid managed

care and Family Health Plus. The qualification process is described in Chapter 29 of the Operational Protocol.