NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS
DIVISION OF MANAGED CARE

# Managed Care Organization (MCO) Service Area Expansion Application

NAME OF APPLICANT

MAILING ADDRESS (Number and Street)

CITY STATE ZIP CODE

TELEPHONE NUMBER (with Area Code)

NAME OF EXECUTIVE DIRECTOR OF MCO (Last, First, Middle Initial)

MAILING ADDRESS (Number and Street)

CITY STATE ZIP CODE

TELEPHONE NUMBER (with Area Code)

NAME OF CHAIRMAN OF THE BOARD OF MCO (Last, First, Middle Initial)

MAILING ADDRESS (Number and Street)

CITY STATE ZIP CODE

TELEPHONE NUMBER (with Area Code)

| **MANAGED CARE PROGRAM AFFECTED: (MORE THAN ONE PROGRAM MAY BE SELECTED)** | **MCO TAX STATUS:** |
|---|---|
| ☐ COMMERCIAL | ☐ PUBLICLY TRADED FOR PROFIT |
| ☐ MEDICAID | ☐ PRIVATELY HELD FOR PROFIT |
| ☐ FAMILY HEALTH PLUS | ☐ NOT FOR PROFIT |
| ☐ HIV SPECIAL NEEDS | |
| ☐ MEDICARE | **Federal Employer Identification Number:** |
| ☐ MEDICAID ADVANTAGE | |
| ☐ CHILD HEALTH PLUS | |
| ☐ MEDICAID ADVANTAGE PLUS (MAP) | |
| ☐ MLTC PARTIAL CAP | |

Signature of Executive Director of MCO Date

Signature of Board Chairman of MCO Date

Signature and Title of Individual Executing Application (If different from Executive Director) Date

**GENERAL INSTRUCTIONS FOR ALL PROGRAM TYPES**: A complete application will consist of an executed application form, a written proposal which responds to all applicable questions as noted within this document, as well an electronic submission of provider network data, as applicable. Number all pages of the application, including attachments, in consecutive order. Begin the written response for each question by providing the question number and a restatement of the question. Submit all requested information except where exceptions are identified by the Department in this application form. The application should be submitted at least 90 days before the proposed implementation date.

## I. PLANNING AND IMPLEMENTATION SCHEDULE

Provide a time line that lists projected dates of completion for the following key activities as applicable:

- the desired date of regulatory approval;
- the anticipated date of beginning marketing and enrollment activities;
- the hiring and training of any new staff resulting from this service area expansion; and
- the establishment of any new offices resulting from this service area expansion.

## II. SERVICE AREA

The service area is comprised of and limited to entire county or borough.

**A.** Provide a chart representing the proposed expansion service area by program type (i.e., Commercial, Medicaid, Family Health Plus, Child HealthPlus, HIV Special Needs Plan, Medicaid Advantage, MAP, MLTC Partial Cap) and by county/borough.

## III. ORGANIZATION AND MANAGEMENT

**A.** Are any changes proposed to the existing organizational structure of the MCO as a result of this expansion?

☐ Yes ☐ No If yes, provide a description of the proposed changes to the MCO's organizational structure.

**B.** The applicant is to submit for review and approval any management and administrative contracts that are proposed for implementation as a consequence of this expansion.

## IV. OFFICES AND STAFFING

**A.** Identify the location of any additional office(s) resulting from this proposed service area expansion. Include the address(es), space occupied and any details concerning expansion or actual construction of office(s).

**B.** Identify by title, job description and location, any new staff positions to be added as a result of the proposed service area expansion.

**C.** If no additional offices or staff are contemplated, include an analysis of the ability of existing offices and staff to provide adequate service to enrollees within the proposed expansion service area.

## V. MARKETING STRATEGY

**A.** Commercial and HIV SNP:

**(1)** Describe in detail the marketing strategy including the proposed time frames for marketing the proposed MCO to the public

**(2)** Attach a copy of the member handbook and provider directory that will be distributed to new enrollees in the expansion area.

**B.** Medicaid, Family Health Plus, Medicaid Advantage, MAP, MLTC Partial Cap:

**(1)** Submit the Medicaid and/or Family Health Plus, MAP or MLTC Partial Cap marketing plan and materials, member handbook, and provider directory applicable to the proposed expansion counties.

**(2)** Medicaid Advantage MCOs are required to submit a marketing plan if they are marketing **only** the Medicaid Advantage product.

## VI. BENEFIT PACKAGE

**A.** Commercial - Are any changes to the currently approved benefit packages contemplated as a result of this proposed service area expansion?

☐ Yes ☐ No If yes, identify the specific services to be added or deleted and provide the following, as applicable:

- a copy of the proposed group or group remittance subscriber contract;
- a copy of the proposed certificate of coverage;
- a copy of the proposed conversion contract;
- a copy of the proposed individual open enrollment contract; and
- a copy of any proposed rider.

**B.** Medicaid, Family Health Plus, Medicaid Advantage - On a county-specific basis, note whether the following **optional** benefits will be offered. (For a multiple-county expansion application, attach a chart depicting this information.)

☐ Dental ☐ Family Planning ☐ Emergency Transportation ☐ Non-emergency Transportation

For both Medicare and Medicaid Advantage expansions serving members residing in New York City, dental and non-emergency transportation benefits are required and are not optional.

## VII. SERVICE DELIVERY NETWORK

Commercial, Medicaid, Family Health Plus, Child Health Plus and HIV Special Needs MCOs are required to assemble a comprehensive service delivery network in each county when such health care services are available**.** The network must include primary care, specialist and ancillary providers as identified on the attached list of core provider types. Sufficient numbers of providers to support the proposed enrollment are required, however, the network must contain a minimum of three primary care providers and at least two of each of the required specialist types. In addition, a contract with a sufficient number of hospitals in the county is required. If a provider type is not available within the county, the MCO must provide an explanation as to how enrollees will access the required services, and that such access is consistent with the normal patterns of care for residents of the expansion service area. Medicaid Advantage MCOs, if utilizing a Licensed Home Health Agency to provide private duty nursing services, must contract with a Certified Home Health Agency (CHHA).

MAP and MLTC Partial Cap networks must include a sufficient number of providers to provide long term care services to support the proposed enrollments. Attachment 2 provides a listing of required network provider types.

- Provide the provider network for MAP, MLTC Partial Cap or Medicaid Advantage using the template in Attachment 3 for the proposed service area expansion.

**A.** Separately, by program type, for each proposed expansion county, provide the following:

- an electronic submission via the Department's secure web site (Health Provider Network Data System) of all providers, by specialty with names and addresses, who have signed MCO contracts approved in form and content by the department. **(not applicable for MAP or MLTC Partial Cap)**

- a map of each expansion county displaying the location(s) of hospitals, primary care providers (pediatricians, internists, family practitioners, general practitioners), OB/GYNs and certified nurse midwives. A key, differentiating the aforementioned providers should accompany each map. If

one site has multiple providers, indicate such on the maps, by practice specialty. For major metropolitan areas, zip-coded maps should be utilized. For suburban and rural counties, county maps may suffice. If data points of a given map are too numerous or too tightly grouped to effectively display the locations of providers, submit additional maps which further break down the above provider groupings by provider type. **(not applicable for MAP or MLTC Partial Cap)**

**B.** Are the health care provider contracts that will be used for the expansion in compliance with the Department's MCO and IPA contracting guidelines and approved by the Department?

☐ Yes ☐ No

If no, submit any new provider contracts for departmental review and approval.

**C.** Will the MCO contract with any new Independent Practice Association(s) (IPA) for the delivery of services in the expanded service area?

☐ Yes ☐ No

If yes, for each IPA provide the IPA name, together with a description of services to be provided and a statement describing the status of the IPA filing with the Department of Health and Department of State as well as the applicable contracts.

## VIII. GRIEVANCES, APPEALS AND MEMBER SERVICES (Not applicable to Medicare only expansions)

Are there any changes contemplated to the currently approved grievance and appeals policies and procedures for the proposed service area?

☐ Yes ☐ No

MCOs must submit a detailed description of any revisions to the MCO grievance and appeals process and/or procedures and any changes to the Member Services Program including any revisions to member handbook(s). The grievance process for each program may differ; refer to the appropriate model contract for grievance procedures specific to the program. Changes to a member handbook requires submission of the document with revisions highlighted.

## IX. QUALITY ASSURANCE SYSTEM (Not applicable to Medicare only expansions)

Are there any changes contemplated to the currently approved Quality Management Program as a result of this proposed service area expansion?

☐ Yes ☐ No If yes, provide a description of modifications to the Quality Management Program.

## X. UTILIZATION CONTROL AND REVIEW SYSTEMS (Not applicable to Medicare only expansions)

Are there any changes to the Utilization Review process or policies and procedures as a result of this proposed service area expansion?

☐ Yes ☐ No

If yes, describe in detail any changes to the utilization review process or policies and procedures.

The utilization review process for each program may differ; refer to the appropriate model contract for utilization review procedures specific to the program.

## XI. MANAGEMENT INFORMATION SYSTEM (Not applicable to Medicare only expansions)

Are any changes to the management information system contemplated as the result of this proposed service area expansion?

☐ Yes ☐ No If yes, describe in detail these changes, and indicate whether the MCO can continue to comply with State and federal reporting requirements.

## XII. FINANCIAL ARRANGEMENTS

### A. Commercial and Medicare

**(1) Provide the following financial data for the proposed service area expansion (this data is to be submitted in both hard copy and in an electronic spreadsheet format):**

- monthly enrollment* projections by age, sex and payor group for three years;
- the cost of providing all services in the comprehensive benefit package;*
- the cost of operations (personal and non-personal);*
- identification of monthly and cumulative deficits up to the break even point;*
- methods to repay any indebtedness;
- revenue by month by source and operating costs in detail by month*; these revenue and expense projections should be for no less than 36 months or until break even is reached, whichever is later, and be presented on a gross dollar and per member per month basis covering the expansion area and statewide;
- projected quarterly balance sheets for a three year period; and
- documentation of accounts and assets as required for capitalization, reserves and deposits.

* If members will be offered a point of service option, provide this data in total, as well as separately for traditional MCO and in-network point of service coverages.

If the proposed rates for the new service area are different from all or part of the MCO's current service area the MCO must demonstrate that its proposal adheres to the requirements of the Insurance Department's Regulation 62 (11 NYCRR 52.42[d]) which states:

1. Each regional component is geographically distinct and separate from every other regional component.

2. Each regional component provides substantially the full range of basic health services to its members without extensive referral between components of the organization for such services and without substantial utilization by any two regional components of the same health facilities. The separate community rate for each regional component of the MCO must be based on the different cost of providing health services in the respective regions.

**(2) Provide a premium rate request including an explanation of the methodology utilized. In addition, provide responses to the following, if applicable:**

- provide actuarial justification of the requested premium rates for the proposed service area, including morbidity assumptions used, expected loss ratio(s), administrative expenses, broker commissions, contribution to reserve and surplus, etc.;
- provide a comparison of the requested rates for the proposed service area with the corresponding premium rates currently being charged for the existing service area and justify all variances;
- for point of service contracts, describe how the out-of-network benefits will be provided and include actuarial justification separately for premium rate components attributable to in-network and out-of-

network benefits; and

- describe how the out of network coverage will be rated for individuals, small groups and large groups (e.g., community rated, experience rated, other).

**(3) Is the MCO in the process of preparing a rate adjustment application for its existing service area?**

☐ Yes ☐ No

If yes, describe how the application will impact on the rates for the proposed service area.

**(4) Describe in detail any arrangements by the MCO to share financial risk with other parties for the purpose of the proposed expansion, including:**

- risk-sharing with physicians and other providers;
- arrangements for insurance coverage for the costs of catastrophic and out-of-area care to enrollees; and
- provisions for insolvency protection through legal arrangements, lines of credit or any other means.

**(5) Attach any proposed agreements with insurers or any other parties, other than provider contracts already submitted, for the purpose of sharing financial risks.**

**(6) Provide any legal document relating to the leasing of computer hardware and software, other equipment and real estate or contracts with consultants for computer hardware and software.**

**B. <u>Medicaid and Family Health Plus</u>**

**Provide the following data for the proposed service area expansion:**

- monthly enrollment projections by age, sex and payor group for three years; and
- projected quarterly balance sheets and income statements for a three year period covering the expansion area and statewide.

**C. <u>Medicaid Advantage, MAP and MLTC Partial Cap</u>**

**For the proposed service area expansion:**

- for information regarding rates, contact the Bureau of Managed Long Term Care at 518-474-6965 or on-line at http://www.MLTCFISC@health.state.ny.us;
- provide monthly enrollment projections, annual balance sheets and income statements for a three year period covering both the expansion area and statewide on forms provided by the Department of Health. (to obtain forms, contact the Bureau of Managed Long Term Care at 518-474-6965).

**Submit a signed, original application and additional copies as indicated:**

- **Commercial/Medicare/Medicaid Advantage: original and 5 copies**
- **Medicaid/Family Health Plus: original and 4 copies**
- **HIV Special Needs: original and 5 copies**
- **MAP, MLTC Partial Cap original and 3 copies**

**Attachment 1**
**CORE LISTING OF REQUIRED PROVIDERS BY PROGRAM TYPE**
ALL PROVIDER TYPES ARE REQUIRED EXCEPT WHERE INDICATED

| PROVIDER TYPE | COMMERCIAL | CHILD HEALTH PLUS | MEDICAID | FAMILY HEALTH PLUS | HIV SPECIAL NEEDS |
|---|---|---|---|---|---|
| **Primary Care** | | | | | |
| Family Practice | ● | ● | ● | ● | ●** |
| Internal Medicine | ● | ● | ● | ● | ●** |
| General Practice | ● | ● | ● | ● | ●** |
| Pediatrics | ● | ● | ● | NO | ●** |
| Nurse Practitioner* | ● | ● | ● | ● | NO |
| **Obstetric/Gynecology** | | | | | |
| OB/GYN | ● | ● | ● | ● | ● |
| Nurse Midwife | ● | ● | ● | ● | ● |
| **Behavioral Health** | | | | | |
| Child Psychiatry | ● | ● | ● | NO | ● |
| Psychiatry | ● | ● | ● | ● | ● |
| Psychology | ● | ● | ● | ● | ● |
| Social Work | ● | ● | ● | ● | ● |
| **Specialist Care** | | | | | |
| Allergy/Immunology | ● | ● | ● | ● | ● |
| Anesthesiology | ● | ● | ● | ● | ● |
| Cardiology | ● | ● | ● | ● | ● |
| Chiropractic | ● | NO | NO | NO | NO |
| Colon Rectal Surgery | ● | ● | ● | ● | ● |
| Dermatology | ● | ● | ● | ● | ● |
| Endocrinology and Metabolism | ● | ● | ● | ● | ● |
| Gastroenterology | ● | ● | ● | ● | ● |
| General Surgery | ● | ● | ● | ● | ● |
| Geriatrics | ● | NO | NO | NO | NO |
| Infectious Disease | ● | ● | ● | ● | ● |
| Neonatal-Perinatal Medicine | ● | ● | ● | ● | ● |
| Nephrology | ● | ● | ● | ● | ● |
| Neurology | ● | ● | ● | ● | ● |
| Neurological Surgery | ● | ● | ● | ● | ● |
| Oncology/Oncology-Hematology | ● | ● | ● | ● | ● |
| Ophthalmology | ● | ● | ● | ● | ● |
| Optometry | ● | ● | ● | ● | ● |
| Orthopaedics | ● | ● | ● | ● | ● |
| Otolaryngology | ● | ● | ● | ● | ● |
| Pediatric Surgery | ● | ● | ● | NO | ● |
| Physical Medicine & Rehabilitation | ● | ● | ● | ● | ● |
| Plastic Surgery | ● | ● | ● | ● | ● |
| Podiatry | ● | ● | ● | ● | ● |
| Pulmonary Medicine | ● | ● | ● | ● | ● |
| Rheumatology | ● | ● | ● | ● | ● |
| Thoracic Surgery | ● | ● | ● | ● | ● |
| Urology | ● | ● | ● | ● | ● |
| **Dental** | OPTIONAL | ● | OPTIONAL | OPTIONAL | OPTIONAL |
| General Dentistry | ● | ● | ● | ● | ● |
| Pedodontics | ● | ● | ● | NO | ● |
| Oral surgery | ● | ● | ● | ● | ● |

**Attachment 1**
**CORE LISTING OF REQUIRED PROVIDERS BY PROGRAM TYPE**
ALL PROVIDER TYPES ARE REQUIRED EXCEPT WHERE INDICATED

| PROVIDER TYPE | COMMERCIAL | CHILD HEALTH PLUS | MEDICAID | FAMILY HEALTH PLUS | HIV SPECIAL NEEDS** |
|---|---|---|---|---|---|
| **Ancillary/Tertiary Care** | | | | | |
| Audiology | ● | ● | ● | ● | ● |
| Durable Medical Equipment | ● | ● | ● | ● | ● |
| Hospice | ● | ● | NO | ● | NO |
| Home Health Care | ● | CHHA | CHHA | CHHA | CHHA |
| I/P Hospital | ● | ● | ● | ● | ● |
| Medical Laboratory | ● | ● | ● | ● | ● |
| Pathology | ● | ● | ● | ● | ● |
| Pharmacy | ● | ● | NO | NO | NO |
| Radiology | ● | ● | ● | ● | ● |
| Residential Health Care Facility | ● | NO | NO | NO | NO |
| Therapies: | | | | | ● |
| Physical | ● | ● | ● | ● | ● |
| Occupational | ● | ● | ● | ● | ● |
| Speech | ● | ● | ● | ● | ● |
| I/P Chemical Dependency | ● | ● | ● | ● | ● |
| Detoxification Services | ● | ● | ● | ● | ● |
| O/P Chemical Dependency | ● | ● | NO | ● | ● |
| I/P Mental Health | ● | ● | ● | ● | ● |
| O/P Mental Health | ● | ● | ● | ● | ● |
| **Traditional Medicaid Providers** | | | | | |
| Federally Qualified Health Center | NO | NO | ● | NO | NO |
| Presumptive Eligible Providers | NO | NO | ● | NO | NO |
| AIDS Designated Center | NO | NO | ● | ● | ● |

***Nurse Practitioners can be primary or specialty care providers**

****HIV SPECIAL NEEDS plan requires primary care providers to be HIV specialists for adult and pediatric providers.**

## Attachment 2

**Provider types required for MAP, MLTC Partial Cap and Medicaid Advantage**

| **Provider Type** | MAP | MLTC Partial Cap | Medicaid Advantage |
|---|---|---|---|
| Home Health Care* | ● | ● | CHHA |
| Medical Social Services | ● | ● | NO |
| Adult Day Health Care | ● | ● | NO |
| Personal Care | ● | ● | NO |
| DME** | ● | ● | ● |
| Non-emergent Transportation | ● | ● | ● *(Optional Outside NYC)* |
| Podiatry | ● | ● | NO |
| Dentist | ● | ● | ● *(Optional Outside NYC)* |
| Optometry/Eyeglasses | ● | ● | ● |
| Outpatient Rehabilitation PT, OT, SP | ● | ● | ● |
| Audiology/Hearing Aides | ● | ● | ● |
| Respiratory Therapy | ● | ● | ● |
| Private Duty Nursing | ● | ● | ● |
| Nutritionist | ● | ● | NO |
| Skilled Nursing Facilities | ● | ● | NO |
| Social Day Care | ● | ● | NO |
| Home Delivered/Congregate Meals | ● | ● | NO |
| Social and Environmental Supports | ● | ● | NO |
| PERS | ● | ● | NO |

*Home Care including Nursing, Home Health Aide, Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP)

**DME including Medical/Surgical, Enteral and Parenteral Formula, Hearing Aid Batteries, Prosthetic, Orthotics, and Orthopedic Footwear

Attachment 3

Provider Network
(MAP, MLTC Partial Cap, Medicaid Advantage)

| County | Specialty | Provider Name/ Group Name /Entity Name | Address | City | State | Zip | Phone Number | Wheelchair Accessible | Language |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |