Application for Participation in Medicaid Advantage

NYS Department of Health

Office of Managed Care

January 2007

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Section I. Overview of Medicaid Advantage

A. General Description

Medicaid Advantage is a Medicaid managed care program designed for individuals eligible for Medicare and Medicaid. Building on the strengths of the well established Medicare Advantage Program and the state's Medicaid managed care program, this program allows dual eligibles who meet eligibility criteria to enroll in the same health plan for most of their Medicare and Medicaid benefits. Enrollment is voluntary.

Plans that participate in the program will offer dually eligible persons a uniform Medicare Advantage Product and a supplemental Medicaid Advantage Product. The Medicaid Advantage Product covers certain benefits not covered by Medicare and beneficiary cost sharing (co-pays/deductibles, and Part C premiums, if any) associated with the uniform Medicare Advantage Benefit product. Health plans receive two monthly premiums: a Medicare Advantage Premium from CMS, and a payment from NYS that covers any Medicare supplemental premium and the premium for the Medicaid Advantage services provided.

Some Medicaid services will continue to be available to Medicaid Advantage enrollees on a fee-for-service basis. The Medicaid Advantage participation standards, including the uniform Medicare and Medicaid Advantage benefit packages, are found in the Medicaid Advantage Model Contract and Chapter 29 of the New York State Operational Protocol. Both of these documents are available on line at the SDOH website: http://www.health.state.ny.us/health_care/managed_care/mcmain.htm.

Questions about the Medicaid Advantage program may be directed to (518) 474-5515.

B. Eligible Populations

Participation in the Medicaid Advantage Program and enrollment in a health plan's Medicaid Advantage Product is voluntary for all eligible persons. To be eligible to enroll in the Medicaid Advantage Program individuals must:

- have full Medicaid coverage or full Medicaid coverage with Qualified Medicare Beneficiary (QMB) eligibility;
- have evidence of Medicare Part A & B coverage; or be enrolled in Medicare Part C ;
- reside in the service area of the plan and local social service district of fiscal responsibility;
- be 18 years of age or older;
- enroll in the same plan's Medicare Advantage Product; and
- otherwise not be ineligible to enroll in the Medicaid Advantage Program.

Individuals not eligible to enroll in the Medicaid Advantage program are those traditionally excluded by State statute from participating in Medicaid managed care or those not eligible to enroll in a Medicare Advantage Plan.

C. Medicaid Advantage Benefit Package

Enrollees in Medicaid Advantage are entitled to all Medicaid services they would normally get under the State Medicaid Plan, either through a health plan's Medicare and Medicaid Advantage products, or through Medicaid fee-for-service.

The Medicaid Advantage Product includes certain Medicaid covered services and benefits, and the cost of beneficiary cost sharing (co-pays and deductibles) and the supplemental Part C premium, if any, associated with the CMS approved uniform Medicare Advantage Product.

Currently, Medicaid Advantage covered services include: inpatient mental health in excess of Medicare's 190 day lifetime limit; non-Medicare covered home care; and private duty nursing services. Non-emergency transportation and dental services are also required to be included in the Medicaid Advantage Benefit package in New York City. In other areas of the state, non-emergency transportation and dental services may be offered at plan option, and will be made available to enrollees through either the health plan or Medicaid-fee-for-service.

Other Medicaid services that are not included in the Medicaid Advantage Benefit package will be covered for enrollees through Medicaid fee-for-service.

D. Health Plan Participation Requirements

To participate in the Medicaid Advantage Program a health plan must:

1. Be Licensed Under Article 44 of New York State Public Health Law as a Managed Care Organization (MCO)
2. Be approved by CMS as a Medicare Advantage Plan in the service area proposed for Medicaid Advantage
3. Be qualified by the SDOH to participate in Medicaid Advantage
4. Offer the standardized Medicare Advantage Benefit Package specified by the SDOH

Section II. Application Process

In order to qualify to participate in Medicaid Advantage, health plans must complete and submit an application to the SDOH for review and approval. The application consists of three parts: a program application; a premium proposal submission and a transmittal letter. Applicants proposing to serve one or more NYC boroughs must also respond to the NYC Addendum attached to this application.
Pursuant to State Finance Law §§139-j and 139-k, a procurement application for participation in the Medicaid Advantage Program includes and imposes certain restrictions on communications between a Governmental Entity and an Offerer/bidder

during the procurement process. An Officer/bidder is restricted from making contacts regarding the procurement during the time period commencing with submission of the application and ending with the final award and approval of the Procurement Contract by the Governmental Agency, and the Office of the State Comptroller and/or the Centers for Medicare and Medicaid Services if applicable ("restricted period") with other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff will be identified in a letter that will be sent to the Bidder/offerer by the New York State Department of Health upon receipt of the application. During the restricted period, New York State Department of Health employees will be required to obtain certain information when contacted by the Bidder/offerer and to make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection of the contract award, and in the event of two findings within a four (4) year period, the Offerer/bidder is debarred from obtaining governmental procurement contracts. Further information about these requirements can be found on the Office of General Services website at: http://www.ogs.state.ny.us/aboutOGs/regulations/defaultAdvisoryCouncil.html and at the New York Temporary State Commission on Lobbying website at http://www.nylobby.state.ny.us.

A. Program Application

The program application consists of several questions contained in Attachment I of this document. Not all applicants will need to complete all questions. The questions that need to be completed by the applicant depend on whether the applicant is already qualified to participate in New York State's Medicaid Managed Care Program and whether the applicant has previously completed a full Article 44 certification process or an abbreviated process to serve only Medicare enrollees in New York State. The section below describes each type of applicant and the questions that must be completed (indicated by an "X"):

Type 1: Applicant is approved by the Centers for Medicare and Medicaid Services to participate in Medicare Advantage and is certified under Article 44 of New York State Public Health Law and has been qualified by the SDOH to serve Medicaid enrollees

Type 2: Applicant is approved by the Centers for Medicare and Medicaid Services to participate in Medicare Advantage and is certified under Article 44 of New York State Public Health Law to serve the commercial enrollees but has not been qualified by SDOH to serve Medicaid enrollees

Type 3: Applicant is approved by the Centers for Medicare and Medicaid Services to participate in Medicare Advantage and is certified under Article 44 of New York State Public Health Law to serve only the Medicare population. The applicant has not completed the full Article 44 certification process.

	Type 1	Type 2	Type 3
Question 1 Service Area	**X**	**X**	**X**
Question 2 Organization	**X**	**X**	**X**
Question 3 Staffing	**X**	**X**	**X**
Question 4 Implementation Schedule	**X**	**X**	**X**
Question 5 Networks	**X**	**X**	**X**
Question 6 Change in Member Eligibility Status	**X**	**X**	**X**
Question 7 Special Services and Populations		**X**	**X**
Question 8 Marketing	**X**	**X**	**X**
Question 9 Medicare/Medicaid Integration	**X**	**X**	**X**
Question 10 Member Materials and Rights			**X**
Question 11 Organization Determinations and Grievance Systems	**X**	**X**	**X**
Question 12 Fair Hearings		**X**	**X**
Question 13 Quality Management			**X**
Question 14 Operational Data Reporting		**X**	**X**
Question 15 ADA Compliance		**X**	**X**

Medicaid Advantage participation standards are contained in the Medicaid Advantage Model Contract and Chapter 29 of the New York State Operational Protocol. Both of these documents are available online at the SDOH website at: http://www.health.state.ny.us/health_care/managed_care/mcmain.htm.

B. Premium Proposal

All applicants must submit a Medicaid Advantage Premium Proposal in accordance with the instructions and work sheets issued by the SDOH's Bureau of Managed Care Financing. SDOH approval of the Medicaid Advantage premium will be contingent upon CMS approval of the corresponding Medicare Advantage Plan A/B Bid submitted with the Medicaid premium proposal.

C. Transmittal Letter

All applications must be accompanied by a transmittal letter signed by Chief Executive Officer (CEO) or Chief Operating Officer (COO) or an individual with the authority to sign for the CEO or COO and make commitments on the organization's behalf. The transmittal letter must include:

- A statement attesting to accuracy and truthfulness of all information in the submission;

- A statement that the applicant has read, understands, and is able and willing to comply with all standards and participation requirements contained in the Medicaid Advantage model contract;
- A statement that the applicant has reviewed the NYC Addendum, if applicable, and understands and agrees to conform its operations to meet these standards;
- A statement that the applicant is or is applying to become an entity determined to be an eligible Medicare Advantage Organization under 42 CFR 422.503 in the service area for which it is requesting qualification to participate in the Medicaid Advantage Program; and that the applicant intends to offer the standard Medicare Advantage Product as described in Appendix K of the Medicaid Advantage contract to Medicaid Advantage enrollees.

Applicants must submit four bound and one unbound copy of the program application, transmittal letter and NYC Addendum, if applicable, to the Office of Managed Care at the following address. Premium proposals should be submitted in accordance with the instructions in the Premium Proposal.

Bureau of Managed Care Certification and Surveillance
New York State Department of Health
Office of Managed Care
Empire State Plaza
Corning Tower Building --- Room 2019
Albany, New York 12237

Section III. Additional Information Regarding Provider Networks and Subcontracts

A. Provider Networks

Networks for Medicaid only services covered by the plan's Medicaid Advantage product must be approved by the SDOH's Bureau of Managed Care Certification and Surveillance. The SDOH will defer to Medicare approved networks for Medicare covered services and will only review provider networks for the delivery of Medicaid Only covered services such as private duty nursing, dental, and non-emergency transportation services (when included in the plan's Medicaid Advantage product).

Plans that participate in Medicaid Advantage will be required to report providers of Medicaid only covered services to the HPN on a quarterly basis.

B. Subcontractor/Provider Agreements

If new or amended provider agreements or management contracts are required in relation to the Medicaid Advantage program, they must be submitted to SDOH for review and approval.

- Provider agreements for Medicaid only services must be in accordance with the

Department's Provider Contracting Guidelines for Medicaid managed care. These guidelines can be found at http://www.health.state.ny.us/nysdoh/mancare/hmoipa/hmo_ipa.htm.

- Provider contracts which transfer financial risk to providers may also be subject to review by the NYS Insurance Department under state regulation.

- Management contracts not previously approved by the SDOH must be submitted in accordance with Subpart 98-1 and guidelines issued by the Department.

Section IV. Pre-Operational Requirements

Prior to starting enrollment in Medicaid Advantage, successful applicants will be required to complete the following activities:

A. Marketing Plans, Marketing and other Enrollment Materials

Plans must have a SDOH approved Medicaid Advantage marketing plan if using dedicated marketing staff to primarily market Medicaid Advantage. Marketing and enrollment materials including brochures, advertising, sales scripts, enrollment/disenrollment forms, member handbooks and member notices must follow approved models and be approved by SDOH's Bureau of Intergovernmental Affairs and the CMS Regional Office prior to use.

B. Encounter Data

Participating health plans must submit monthly encounter data through the State's Fiscal Agent, Computer Services Corporation (CSC). Plans must establish a Provider Transmission Supplier Number and an active eMedNY exchange, FTP or VPN account with CSC.

Participating plans are expected to develop processes for capturing, storing and reconciling MEDS II encounter data response reports. Plans also must establish access to the MEDS Home Page on the HPN and join the e MEDS II Listserve discussion forum (MEDS_L).

C. Provider ID

Health plans must complete an application to obtain a eMedNY Provider Identification (ID) to offer the Medicaid Advantage product. The application may be obtained from the SDOH"s Office of Medicaid Management's Rate Based Provider Unit. This

requirement applies to all plans including those that already have a provider ID for the Medicaid managed care program.

D. Provider Electronic Transmissions

After receiving a new Provider ID, health plans must establish the capacity to engage in electronic transmissions with the State's Fiscal Agent, Computer Sciences Corporation (CSC) using their new ID. Plans may download the provider electronic transmission forms they need to complete to establish appropriate access from the CSC website at: http://www/emedny.org.

E. Plan Code and Benefit Package Code

Participating plans must be assigned a new Medicaid Advantage Plan Code and Benefit Package Code by SDOH. Plans also may wish to request a new HPN Account Identification (ID) for staff to access Medicaid Advantage rosters and daily reports.

F. Contract Execution

Participating plans must have an executed Medicaid Advantage contract with the SDOH for service areas outside of New York City; or with the New York City Department of Health and Mental Hygiene, for service areas in New York City. Executed contracts must be approved by CMS before they are effective. Contracts with the SDOH must also be approved by the Office of the State Comptroller.

Attachment I

MEDICAID ADVANTAGE PROGRAM PROPOSAL

Applicant Name _____

Date of Application _____

1. Service Area

List the counties and New York City boroughs in which the applicant proposes to offer Medicaid Advantage and the time frame for participation in each county or group of counties. For service areas outside New York City, applicants should also indicate whether or not they will provide optional dental and non-emergency transportation services as part of their Medicaid Advantage benefit package.

2. Organization

a) Identify the legal entity that will be responsible for Medicaid Advantage. State whether this is the same legal entity that contracts with CMS for Medicare Advantage. If not, explain the relationship between the two entities.

b) Identify all entities that will be involved in the administration of Medicaid Advantage, including management contractors. Briefly describe the roles of each entity.

3. Staffing

a) Identify by title and job description any new staff positions to be added to enable the applicant to satisfy the requirements of the Medicaid Advantage Program. If you are not proposing to add new staff, please provide an explanation of how existing staff will administer this new product line.

b) Identify individuals that will have lead responsibility for administering Medicaid Advantage including at minimum the medical director, and those responsible for utilization management, finance, marketing, management information systems and regulatory compliance and quality improvement.

4. Implementation Schedule

Provide an implementation schedule outlining the major steps that the applicant will take to prepare its organization for participation in Medicaid Advantage. The implementation schedule must include the following components and proposed target dates for completion of each component.

a. Network development and subcontracting, as applicable
b. Premium proposal submission
c. Secure HPN Account

d. Complete MIS changes to meet reporting requirements (financial data, encounter data (MEDS), QARR/HEDIS, networks, complaints, etc)
e. Staff hiring, if applicable, and training.
f. Provider manual updates and training.
g. Development of Medicaid Advantage marketing and other member materials including:
   - Provider directory
   - Member handbook(s)
   - Enrollment/disenrollment forms
   - Membership/ID cards
   - Marketing materials (brochures, advertising, radio/TV scripts)
   - Prior authorization/ concurrent review forms
   - Notices necessary to implement Medicaid Advantage Grievance System requirements (complaint and appeal process, appeal actions and access to state fair hearings
   - Integrated /Summary of Benefits
h. Medicaid Advantage Model Contract execution

5. Network Development and Subcontracting

a) If applicant is proposing to use its existing contracted provider network to provide Medicaid Advantage members the following Medicaid covered services, private duty nursing, and dental non-emergency transportation, check here _____ and complete the network attestation in Attachment II. Also, provide a copy of the proposed notice to providers informing them about their obligation under their existing contract to provide services to Medicaid Advantage members.

b) If applicant **is** proposing to enter into any new contracts with providers for any of the following Medicaid covered services, private duty nursing, dental, and non-emergency transportation, check here ____, and provide the following:

- a copy of the contract(s) for SDOH review and approval.
- a list showing the name, address, telephone number, type of service and county of participation for each new provider
- a completed attestation in Attachment III.

Note: If applicant is proposing to use its already contracted network and add new providers, check both 5(a) and (b) above and complete and submit both attestations.

c) Identify any new management contracts the applicant proposes to implement in relation to the Medicaid Advantage program. Submit any new contracts to the SDOH for review and approval.

d) Explain how the applicant will monitor and maintain networks to ensure adequate access and availability of Medicaid Advantage covered services for the enrolled population.

6. Ability to Identify Changes in Member's Eligibility Status

The applicant must report to the appropriate LDSSs any change in status of its enrollees which may impact the enrollee's eligibility for Medicaid or Medicaid Advantage within 5 business days of knowledge of such a change including a change in their Medicare Advantage enrollment status. Describe the mechanism the applicant will use to monitor any change in status of its enrollees in order to meet this operational requirement. State the type of data that will be reviewed and the periodicity of the reviews.

7. Special Service Provisions and Populations

a) Describe how the applicant will permit its Medicaid Advantage enrollees to exercise their right to obtain family planning and reproductive health services from either the Contractor, if Family Planning and Reproductive Health Services are provided by the Contractor, or from any appropriate Medicaid enrolled non-participating family planning provider, without a referral from the Enrollee's PCP or without approval by the applicant, as defined in Appendix C of the Medicaid Advantage Contract. How will the applicant notify its enrollees, staff and network providers of these policies?

b) In the context of contract requirements, describe how the applicant will identify the needs of and case manage the delivery of services to enrollees with the following:

- complex or chronic medical conditions.
- mental health services and/or chemical dependency treatment
- HIV/ AIDs

Include the following in the response:

- the qualifications of case management staff
- the mechanisms used to monitor the effectiveness of case management.
- how persons are identified for case management, including the identification of any assessment tools used
- how the applicant proposes to coordinate physical health services and mental health and/or chemical dependency services
- how the applicant will ensure that treatment protocols for members who are HIV+ or have AIDS are consistent with federal government clinical standards and with the NYS DOH AIDS Institute Clinical Standards for Adult Care.

c) Describe how the applicant will coordinate the delivery of Medicare/Medicaid Advantage covered services with other services available to the member on a Medicaid fee for service basis, and with other community and social services available in the applicant's service area.

8. Marketing

Describe the approaches that the applicant will use to market Medicaid Advantage to dual eligibles consistent with the Medicaid Advantage Marketing Guidelines in Appendix D of the Medicaid Advantage Contract. Describe the training that will be conducted for marketing staff. Describe how the applicant will monitor the activities of its marketing staff.

9. Medicare and Medicaid Integration

Medicaid Advantage integrates Medicare and Medicaid covered services through one health plan. Describe how you will operationalize Medicaid Advantage within your organization to make the program appear as one benefit to the enrollee. In particular, describe the applicant's plan for issuing member identification cards (ie., will enrollees use a single health plan card for both Medicare and Medicaid covered services) and how the applicant's member services department will interact with Medicaid Advantage members on issues related to both Medicare and Medicaid.

10. Member Materials and Member Rights

Describe in detail your member services program including:

- how staff will be trained on the member rights and responsibilities outlined in Article 4408 of the PHL
- educational materials to be provided
- ratio of member services representatives to members
- hours of operation
- language translation services
- the establishment of a 1 800 number for members
- how the plan will address the needs of persons with visual, hearing, speech, physical or developmental disabilities.

11. Organization Determinations, Actions and Grievances Systems

a) Explain the applicant's grievance system procedures and how they will be available to Medicaid Advantage enrollees, including the processes and procedures that the applicant will implement to comply with requirements for organization determinations, action appeals, complaints and complaint appeals, as defined in Section 14 and Appendix F of the Medicaid Advantage Contract.

b) Provide a flow chart of the applicant's Medicaid Advantage grievance system procedures.

c) Applicant must submit the forms and notices it intends to use to inform members of organization determinations and enrollee complaint appeals, action appeals and grievance rights as part of the Medicaid qualification application.

12. Fair Hearings

a) Discuss the process and the procedures that the applicant will implement to ensure that Medicaid members are afforded the opportunity to request a fair hearing regarding a denial, termination, suspension or reduction of a service determined by the applicant to be a benefit or a benefit other than those solely covered by Medicare.

b) Discuss the process and procedures for offering "aid continuing" of disputed services pending a fair hearing. The applicant must submit the notices it intends to use.

13. Quality Management

a) Describe the applicant's quality assessment and improvement program. Include a description of the structure of the quality program, process of evaluation, and the outcomes of those assessments.

b) Describe applicant's your quality assessment and improvement program integrates information from clinical and administrative functions such as complaints/grievances/appeals, medical /utilization management, provider relations, etc. to identify problems and implement appropriate corrective actions as needed.

c) Applicants not currently operational in NYS for other than Medicare must submit HEDIS or QARR results from other states in which it operates. If the applicant does not collect HEDIS or CAHPS data in other states, describe the process used to measure, benchmark and improve quality and consumer satisfaction performance.

14. Operational Data Reporting

a) Describe the applicant's plan for collecting and reporting operational data pursuant to Medicaid Advantage program reporting requirements as defined in Section 18 of the Medicaid Advantage Contract (financial, networks, complaints, encounter, quality data, etc.)

b) How will the applicant verify the accuracy of data reported by its providers? Discuss any data validation activities the applicant performs including medical record audits.

15. ADA Compliance

Applicants are required to comply with Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 for program accessibility. Applicants shall review their current compliance activities and provide the SDOH with the completed checklist found in Attachment IV.

Attachment II
Question 5 (a)

PROVIDER NETWORK ATTESTATION AGREEMENT

I, _____, the Chief Executive Officer of _____ hereby attest, under penalty of perjury, that the current provider network for the counties of _____as submitted to the Department of Health via the Health Provider Network will be used for the provision of Medicaid covered services to Medicaid Advantage members, if the plan has contracted to provide the benefit in the county. The network includes healthcare providers who are obligated by contract to provide services to the dually eligible population for the following services:

_____ Dental

_____ Private Duty Nursing

_____ Non-emergency transportation

_____
Chief Executive Officer

_____
Date

Notary Signature and Seal

ATTACHMENT III
QUESTION 5(B)

NEW PROVIDER ATTESTATION AGREEMENT

I, _____, the Chief Executive Officer of _____ hereby attest, under penalty of perjury, that _____ has executed a contract with each of the providers listed in response to Question 5(b) of the Medicaid Advantage Program application submitted to the Department of Health on (date) and that such providers are obligated to provide the services indicated to dually eligible persons enrolled in Medicaid Advantage.

_____
Chief Executive Officer

_____
Date

Notary Signature and Seal

ATTACHMENT IV

Medicaid Advantage Qualification
ADA Compliance Activities Update

In accordance with Appendix J of the Medicaid managed care contract, all participating Medicaid managed care organizations must comply with Title II of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 for program accessibility.

I, or my designee, has reviewed (health plan name)_ current ADA compliance activities

I certify that the information provided below is correct.

_____
(Signature CEO or Designee)

_____
(Printed Name and Title)

Name of person with primary responsibility for ADA compliance:

_____
Title:

_____

Telephone number:

_____

E-mail address:

_____

Place an **X** in the column to indicate that your health plan currently has a satisfactory ADA compliance plan in effect.

ADA Compliance Activities	A Current Satisfactory Compliance is in Effect
Pre-enrollment Marketing and Education: MCO has made pre-enrollment marketing and education staff, activities and material available to persons with disabilities.	
Members Services Department: MCO has member services	

ADA Compliance Activities	A Current Satisfactory Compliance is in Effect
functions that are accessible to and usable by people with disabilities.	
Identification of Individuals with Disabilities: MCO has satisfactory methods/guidelines for identifying members with disabilities and determining their needs. These guidelines do not discriminate against potential or current members.	
New Enrollee Orientation: MCO gives members information sufficient to ensure they understand how to access medical care through the plan. This information is made accessible to and usable by people with disabilities.	
Complaints and Appeals: MCO makes all information regarding complaint process available to and usable by people with disabilities and assures that people with disabilities have access to sites where members typically file complaints and requests for appeals.	
Case Management: MCO has adequate case management systems to identify service needs of all members including those with disabilities and ensures that medically necessary covered benefits are delivered on a timely basis. Case management systems include procedures for standing referrals, specialists as PCPs and referrals to specialty centers, out of plan referrals and continuation of existing treatment relationships without plan providers during transition period.	
Participating Providers: MCO networks include all provider types necessary to furnish the benefit package, to assure appropriate and timely health care to all enrollees including those with disabilities. Physical accessibility is not limited to entry to a provider site, but also includes access to services within the site; e.g., exam tables and medical equipment.	
Populations with Special Health Care Needs: MCO has satisfactory methods for identifying persons at risk of, or having chronic disabilities or diseases and determining their specific needs in terms of specialist physician referrals, durable medical equipment, medical supplies, home health services, etc. MCO has satisfactory systems for coordinating service delivery.	

NYC ADDENDUM

Medicaid Advantage Qualification Document

NEW YORK CITY ADDENDEM

May 2006

Participation Standards and Proposal Submission Instructions

1. Contact Person

Questions regarding the NYC Addendum may be addressed to Liane Daniels at New York City Department of Health and Mental Hygiene, Division of Health Care Access and Improvement ("DOHMH") telephone 212-. 788-5657.

2. Contract Administration

Contracts in New York City will be administered by DOHMH. The New York City model contract contains the NYC-specific program requirements. A copy of the current New York City model contract for the Medicaid Advantage program ("model contract") is available upon request from DOHMH.

3. Public Health Issues

The current NYC Guidelines for Coordination with Public Health Agencies and the current fee schedule for certain NYC Department of Health and Mental Hygiene services are contained in the model contract, Appendix N.

4. New York City Addendum Proposal Instructions

Applicants must submit <u>one</u> copy of the following documents:

- Transmittal Letter signed by the Chief Executive Officer or Chief Operations Officer
- Program Proposal
- Part A of the New York City Proposal Addendum, containing all of the components listed below.
- Part B of the New York City Addendum.

The New York City Addendum should be submitted to:

DOHMH
Division of Health Care Access and Improvement
161 William Street , 5th Floor
New York, NY 10038

The components of the New York City Proposal Addendum are as follows:

Part A

- Response to New York City-specific questions.

Part B

- Completed Vendex questionnaires.
- Division of Labor Services Supply and Service Employment Report
- Model participating provider agreements for Medicaid only services**.**

Part A

Response to New York City-Specific Questions

In this section, applicants must document their compliance with New York City program participation standards by responding to all of the questions listed below.

In general, it is anticipated that an applicant's answer to a question with respect to its operations will apply to all boroughs 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 or portions thereof.

I Public Health Issues and Priorities

Support of the New York City Take Care New York Initiative

The NYC DOHMH "Take Care New York" initiative prioritizes actions to help individuals, health care providers, and New York City as a whole to improve health. The initiative focuses on preventable causes of illness/death and sets an agenda of 10 key areas for intervention that represent health problems that present a large disease burden; have been proven amenable to intervention and public action; and can be addressed through coordinated action by City agencies, public-private partnerships, health care
providers, businesses and individuals.

The initiative includes the following goals for providers and plans:

a. Ensure that members have a primary care provider from whom they receive continuous primary and preventive care.
b. Screen members for tobacco use and help smokers quit.
c. Screen members for risk factors for cardiovascular disease and assist all members in reducing their risk factors for CVD.
d. Screen members for HIV infection per DOHMH recommendations and counsel members on how to reduce their risk for HIV infection; ensure that HIV-infected members receive appropriate care.
e. Screen members for depression and ensure appropriate follow up for those with depression.

f. Screen members for chemical dependence, and refer members with problems involving chemical dependence to appropriate care; ensure the availability within network of PCPs who can prescribe buprenorphine.
g. Ensure that members are appropriately screened for colon, cervical and breast cancer.
h. Ensure that members receive age- appropriate immunizations.
i. Screen members for domestic violence.

1. Describe the following:

a. how the applicant will educate members on diseases and conditions included in the TCNY initiative .
b. how the applicant will monitor receipt by members of counseling and preventive services included in the TCNY initiative, and how the applicant will follow up with members who have not received preventive services at recommended intervals.
c. how the applicant will ensure that its providers can access clinical guidelines on prevention and management of diseases and conditions of public health importance.
d. For one condition included in the TCNY initiative, how the applicant will design disease and case management programs. Include in this description how the applicant will monitor the effectiveness of disease and case management programs based on patient outcomes.

Mandated Reporting

2. Identify the person(s) in your organization who will assist providers in disease/condition reporting for mandated disease**s** to the NYC Department of Health in accordance with public health law and regulations. Describe how the applicant will educate providers about reporting of diseases and conditions specified in the New York City Health Code.

Collaboration with District Public Health Offices

3. DOHMH has identified, through Community Health Surveys, neighborhoods that have had persistent, across the board problems with community health and demonstrate sharp disparities when compared with other parts of the City in preventable illnesses such as asthma, diabetes , heart disease , lead poisoning, cancer, and HIV. For applicants proposing to provide services in East and Central Harlem, the South Bronx North and Central Brooklyn, describe strategies for community and population-based interventions for addressing these health conditions in these neighborhoods and how the effectiveness of these interventions will be measured.

II Emergency Preparedness

1. Describe the applicant's emergency preparedness protocols, including
a. ability to communicate electronically with network providers via e-mail and/or facsimile, as well as by telephone, during emergencies;
b. ability to communicate with members during emergencies;
c. designation of staff members who will serve as liaisons with NYC DOHMH during emergencies, and methods for keeping DOHMH updated on contact information for such liaisons.

Part B

Instructions for Part B Documents

A) A packet of the following forms necessary to the New York City Addendum will be mailed to you upon request by the Division of Health Care Access and Improvement, 212-788-5657:

- Division of Labor Services Supply and Service Employment Report

The instructions for the Supply and Service Employment Report state that reports are due upon acceptance of a proposal. Notwithstanding this instruction, all Employment Reports are due on the proposal due date.

B) You must also complete New York City Vendex forms and submit these forms directly to:

- Mayor's Office of Contract Services
  VENDEX UNIT
  253 Broadway, 9th Floor
  New York, NY 10007.

Subcontractors whose aggregate business in the City in the preceding 12 months totals $100,000 or more, or for whom their contract with applicant is valued in excess of $100,000 must also complete Vendex Questionnaires. Subcontractors who are providers of medical services are exempt from this requirement.

In order to inform DOHMH that the questionnaires were sent to MOCS, the vendor must complete the **Submitted VENDEX memorandum** and return it to:

- Eric Zimiles
  DOHMH, Division of Health Care Access and Improvement
  225 Broadway, 17th Floor, Room 8
  New York, NY 10007

Vendex forms, including *Vendor Questionnaire, Principal Questionnaire, Certification of No Change, and Submitted Vendex Memorandum,* along with

guidelines for completing the forms, are available on the Web at the following address:

http://www.nyc.gov/vendex

C) Pursuant to New York City Standard Clauses, please submit one copy of model participating provider agreements for Medicaid only services. (See Appendix R of the Medicaid Advantage Contract)