INSTRUCTIONS FOR THE COMPLETION OF CERTIFICATION APPLICATION FOR MANAGED LONG TERM CARE PLANS

NEW YORK STATE DEPARTMENT OF HEALTH
October, 2012

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Bureau of Managed Long Term Care

MANAGED LONG TERM CARE PLAN APPLICATION NEW YORK STATE

FOR NYS DOH USE ONLY

_____
DATE RECEIVED

APPLICANT

STREET ADDRESS

CITY STATE ZIP C0DE

TELEPHONE NUMBER (AREA CODE)

EXECUTIVE DIRECTOR OF APPLICANT MLTCP

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER (AREA CODE)

CHAIRMAN OF THE BOARD OF APPLICANT

STREET ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER (AREA CODE)

APPLICATION TYPE: ☐ Managed Long Term Care Plan

MODEL:

PACE ☐
Medicaid Advantage Plus ☐
MLTC Partial Capitation ☐

TAX STATUS:

Privately Held ☐
Not-for-Profit ☐
Publicly Traded for Profit ☐

FEDERAL Employer ID#_____

Signature of Executive Director of APPLICANT Date:

Signature of Board Chairman of APPLICANT Date:

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

Name of Contact Person and Phone Number

DOH-793A-MLTC

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This application represents the MLTC program as it is currently structured. As the part of the Medicaid Redesign Team process, a work group has been established to evaluate the Managed Long Term Care program and recent laws that have been passed to expand enrollment. Please be aware that the program requirements may be modified as a result of this evaluation.

GENERAL INSTRUCTIONS: The Managed Long Term Care Plan (MLTCP) Certification Application is for organizations eligible to apply as a MLTCP under Article 4403-f of the New York State Public Health Law (PHL). This application is to be used for PACE, Medicaid Advantage Plus (MAP) and MLTC partial capitation applicants. Eligible applicant means an entity controlled or wholly owned by one or more of the following: a hospital as defined by section 2801 of the Public Health Law in subdivision one; a home care agency licensed or certified pursuant to article 36; an entity that has received a certificate of authority pursuant to article 44 sections 4403, 4403-a or 4408-a, or a health maintenance organization authorized under article 43 of the insurance law; or a not-for-profit organization which has a history of providing or coordinating health care services and long term care services to the elderly and disabled. The application consists of several sections. Please read the following instructions carefully.

PACE APPLICANTS: Entities applying as a PACE must complete only the following sections of the Certification Application:

- §I through III (including forms DOH-793A-MLTC, 793B-MLTC, 793C-MLTC and 794-MLTC);
- §IV, VI-VII; Marketing Strategy, Implementation Schedule and Service Delivery Network
- §VIII.C and VIII.D – In addition to the quality assurance requirements of the PACE application, 10 NYCRR §98-1.12 requires a Provider Manual, and policies and procedures for evaluating the performance of contracted providers.
- §XIII–XVI; Enrollment and Disenrollment; ADA compliance; Financial Requirements and Management Information System.

While final approval of the Certificate of Authority (COA) application is not required prior to submission, CMS has indicated it cannot accept a PACE application without a State Administering Agency Certification, which verifies the State's willingness to enter into a program agreement with the applicant. This requires the Department's review of the programmatic aspects of the application; and demonstration of adequate sources of initial capitalization as determined by the Department. Therefore, for planning purposes, we recommend that you estimate approximately six months for the following activities, which must be completed before the application can be forwarded to CMS.

- The PACE application (available at www.cms.hhs.gov/pace) must be satisfactorily reviewed by the Department.
- Adequate sources of initial capitalization must be identified and approved by the Department of Health. Projected balance sheets that support revenue and expense projections must be submitted on the forms provided by the Department, and any additional equity that may be needed must be addressed. The final documentation for the capitalization of the plan, including executed copies of all subvention certificates, and other arrangements involving subordinated loans or liabilities and actual donated capital must be in place prior to final plan certification.

  Successful PACE applicants will be issued a Certificate of Authority and will be required to enter into a three-way agreement with CMS and the New York State Department of Health (SDOH), and a separate contract with SDOH in order to begin enrolling members. The PACE model contract, which includes participation standards, can be

found on the SDOH website at: www.health.state.ny.us/health_care/managed_care/mltc.

Non-PACE MLTC APPLICANTS: Entities not applying as a PACE must complete **all** sections of this Certification Application including forms DOH-793A-MLTC, 793B-MLTC, 793C-MLTC and 794-MLTC. Successful applicants will be issued a Certificate of Authority and will be required to enter into a contract with SDOH before enrolling members. A readiness review will be conducted prior to a plan beginning enrollment. Additional programmatic requirements (eg. policies and procedures, member materials) will be required before the readiness review. Many of these are noted in the instructions below. The Medicaid Advantage Plus (MAP) and MLTC Partial Capitation model contracts, which include participation standards, can be found on the SDOH website at: www.health.state.ny.us/health_care/managed_care/mltc

ALL APPLICANTS: The application must be submitted in the following format:

- Submit application in a 3 ring binder.
- Organize application with tab dividers indentifying each section
- Clearly number all pages of the application, including attachments, with each section of the application separately numbered and identified in the Table of Contents
- Submit a Transmittal Letter. The Transmittal Letter must be signed by the Chief Executive Officer (CEO) or Chief Operating Officer (COO) or an individual who has been delegated the authority to sign for the CEO or COO and is authorized to make commitments on the organization's behalf. The Transmittal Letter must contain the following:
    - A statement attesting to the accuracy and truthfulness of all information contained in the proposal.
    - A statement that the applicant has read, understands, and is able and willing to comply with all standards and participation requirements contained in the applicable MLTC contract.
    - A statement the applicant acknowledges that, once certified, the MLTCP will provide written notice to DOH immediately upon (A) the departure, resignation or termination of any officer, member of the board, member or manager of a limited liability company or the medical director, together with the identity of the individual; and (B) the hiring of an individual to replace an individual concerning whom notice is required under (A), together with the identity of the individual hired.
- Submit a completed DOH-793A-MLTC form and include the signatures of the individuals who are authorized to submit an application on behalf of the proposed MLTCP. An original form is required. The application must be signed by the CEO and, when applicable, the general partner (partnerships), owner (proprietorship), or chairman/CEO (public applicant). Provide the name, title and telephone number of a contact person for matters related to the application.
- Submit 1 original and 3 copies of the application and 1 additional copy of the application in a word document format on CD or flash drive.

Bureau of Managed Long Term Care
Division of Long Term Care
New York State Department of Health
Room 1911, Corning Tower
Empire State Plaza
Albany, New York 12237-0062

I. ORGANIZATION AND MANAGEMENT OF PROPOSED MLTCP

A. Organizational Structure

Describe in detail the organizational structure of the proposed MLTCP. Identify the legal entity that will be responsible for the MLTCP. An organizational chart should be included with explanations of the lines of authority. Include in this description, an explanation of the relationship between the holding company and the proposed MLTCP, if such an arrangement will exist. If the entity is related to a larger system, include in the organizational chart where the entity lies within the larger system. Provide the following documents (as applicable) relative to the proposed MLTCP and the holding company, including all attachments, with any explanations necessary to clarify their meaning or use:

1. If a corporation, Certificate of Incorporation and Corporate Bylaws for the proposed MLTCP;
2. If a limited liability company (LLC), Articles of Organization and Operating Agreement for the proposed MLTCP;
3. Legal documents (as specified under Items 1 and 2) , for the holding company as defined by Part 98-1.2 (j) if applicable; and
4. Any other legal documents relating to the proposed MLTCP.

For entities applying as a PACE, the PACE center clinic and the PACE organization may be operated out of the same corporation if the services of the clinic will be limited to PACE participants. If the clinic will also serve non-PACE participants (e.g. the general public or enrollees in another managed care product), then the clinic must be a separately incorporated entity. Clinic services provided outside of the PACE corporation must be based on contracts between the clinic and the plan and contain explicit payment terms.

B. Management of the MLTCP

Provide a list of the names, addresses and official positions of the members of the board of directors, members or managers of an LLC, officers, controlling persons, owners or partners and medical director of the proposed MLTCP. If the application will be a controlled MLTCP as defined by SubPart 98-1 of Title 10 of the New York Compilation of Codes, Rules and Regulations (10 NYCRR), this information is also required for the holding company. Identify the management staff, including positions budgeted but not yet filled. Describe in detail the responsibilities of all key management staff, workload estimates and salaries.

All management functions that are delegated, such as claims payment, quality assurance and utilization review, require a management agreement that must be approved by the Commissioner of Health prior to implementation pursuant to §98-1.11(j) of 10 NYCRR. If a management contractor(s) will be used, applicants must provide the following:

- A chart showing the name of the proposed management contractor and the type of authority to be delegated; and

- A copy of the proposed agreement with each management contractor identified above, consistent with the requirements of §98-1.11 of 10 NYCRR.

Proposed management contracts must be annotated in the margin referring to the appropriate subdivision and paragraph in the regulations or guidelines. The proposed management contract must clearly identify the payment terms.

Note that if utilization review (UR) is delegated, the contractor performing UR must be registered with SDOH as a utilization review agent in accordance with §4901 of the PHL.

Proposed administrative services contracts, including those with related parties, must be submitted for review. Payment terms must be clearly identified.

Prior to certification, plans must submit the signed contract for the approved management and administrative agreements.

For Non PACE Applicants: All management and administrative contracts, including those between related parties, must contain explicit payment terms that reflect "prudent buyer" principles and may not be based on retroactively determined cost allocations. Explicit provisions defining the per unit charges (i.e., cost per processed claim) or other comparable reimbursement terms must be included in the contract. Any fees or charges should relate to enrollment levels, so that plans with lower than expected enrollment do not pay an excessive amount on a per member per month (PMPM) basis and plans with higher than expected enrollment gain the benefit of spreading costs over a larger enrollment base. Applicants are encouraged to establish payment arrangements on a PMPM basis.

C. Character and Competence Review

As detailed below, each director, officer, owner, or controlling person of the MLTCP, as well as the medical director, must include all personal qualifying information requested in Form DOH-793B-MLTC of this application.

If a management contractor is used, each officer, director, or controlling person of the proposed management contractor must also provide this information. Refer to §98-1.5(b)(5) and §98-1.11(h) through (s) of 10 NYCRR.

C-1. Instructions for completion of Form DOH-793B-MLTC

Form DOH-793B-MLTC should be duplicated and completed by:

- All members of the governing body, officers, directors and controlling persons. Controlling person for the purpose of this section means any person who has the ability, directly or indirectly, to direct or cause the direction of the management or policies of a corporation, partnership or other entity. Control shall be presumed to exist if any person directly or indirectly owns, controls or holds the power to vote 10 percent or more of the voting securities or voting rights of any other person, or is a corporate member of a not-for-profit corporation;
- Members or managers of an LLC;
- All owners;
- All partners of a partnership; and
- The medical director.

The affidavit at the end of form DOH-793B-MLTC must be completed by each individual. Without all signed notarized affidavits, the application will be considered incomplete. Omission of any information requested may lead to exclusion of the application for consideration for a Certificate of Authority or revocation of the certificate if such certificate is already awarded.

Form DOH-793B-MLTC requests personal disclosure of [A] Personal Identifying Information, [B] Individual Employment History, [C] Licenses, [D] Educational History, [E] History of Any Legal Actions, [F] Affiliation With Other Health Care Operations, [G] Personal Financial Involvement in the MLTCP.

Sections A-E are self-explanatory. These items must be filled out completely.

Section F. The purpose of this section is to obtain a complete list of any health care operations with which the owners, officers, directors, governing board members, controlling persons, partners or medical director of the proposed MLTCP have been affiliated within the past 10 years. Affiliation with health care operations for the purposes of this section includes serving as an officer, director, member of the management staff, stockholder of 10 percent or more of stock, or key advisor for a health care operation. Affiliations with New York State health care or health related operations will be verified through available records in the SDOH, and the performance of those operations will be reviewed. Affiliations with out-of-state health care or health related operations will be checked for compliance of those operations with the appropriate state regulatory agencies. The applicant is responsible for submitting letters to appropriate state regulatory agencies outside of New York State in order to obtain documentation that those health care operations are/were in compliance with applicable laws and regulations.

Sample Letter A and Form DOH-794-MLTC may be used to obtain this information. A copy of all information sent to other states should also be sent to the Bureau of Managed Long Term Care (BMLTC) in SDOH at the address provided in Sample Letter A. The states should be directed to send completed forms directly to BMLTC.

Section G is self-explanatory.

C-2. Instructions for Completion of Form DOH-793C-MLTC

The applicant must use Form DOH-793C-MLTC to list all health care or health related operations, institutional or non-institutional, that have been operated, owned or otherwise controlled during the past 10 years by the holding company forming the proposed MLTCP as a subsidiary, or the corporation proposing to operate the MLTCP as a separate line of business. Similarly, the applicant should complete this form for any health care or health related operations affiliated with the proposed management contractor. Include operations within NYS, as well as in other states and countries. The applicant is responsible for obtaining documentation that any health care operations located outside New York State are/were in compliance with applicable state laws and regulations.

The applicant may use Sample Letter B and Form DOH-794-MLTC to obtain adequate documentation from the appropriate state agency for a holding company or corporation proposing a MLTCP as a line of business. Sample Letter C and Form DOH-794-MLTC may be used for the same purpose for a management contractor. The applicant should

send Sample Letter B or C, as appropriate, with Form DOH-794-MLTC directly to the appropriate state agency. A copy of all information sent to other states should also be sent to the Bureau of Managed Long Term Care (BMLTC) in the SDOH at the address provided in Sample Letter B or C. The states should be directed to send completed forms directly to BMLTC. This inquiry may take a significant period of time. The applicant is encouraged to initiate this activity as soon as possible.

D. Location of Office(s)

Identify the location of the administrative office(s) including the address(es), space occupied and any details concerning expansion or actual construction of office(s), and the relationship to the holding company, if applicable.

II. GOVERNING BOARD

A. Describe the role and responsibilities of the governing authority of the proposed MLTCP.

B. Attach the bylaws of the governing board if the responsibilities of the governing board are not included in the bylaws of the corporation.

C. List the members of the governing board. Indicate whether members are residents of New York State.

- Describe how and when the requirement for enrollee or consumer representatives on the governing authority will be met. If an enrollee advisory council will substitute for governing authority membership, identify when it will be established and describe how direct input to the governing authority will be accomplished.
- State how many members are required for a quorum.
- State how often the board will meet.

III. SERVICE AREA

Describe the service area for the proposed MLTCP, identifying the counties included in the proposed service area. Include a rationale for selection of this service area.

IV. TARGET POPULATION

Submit a market analysis of the proposed service area and a plan that includes the following information.

A. Describe in detail the size and characteristics of the proposed target population to be enrolled in the MLTCP. Describe special populations to be served by the plan identifying the unique needs of the populations that will need to be addressed. Include an analysis of current operational plans and the applicants anticipated role in the market over a three year period.

B. Describe the approaches that the applicant will use to market the MLTCP to prospective members. Activities must be consistent with §98-1.19 of 10 NYCRR, Medicaid requirements and if applicable, Medicare and any other federal requirements.

C. Describe the training that will be conducted for marketing staff. Describe how the

applicant will monitor the activities of its marketing staff.

D. The following documents must be submitted and approved prior to the readiness review;
- Provider directory in the following format: Name, Address & Phone Number of the Provider, Counties Served, Wheelchair Accessibility and Languages Spoken (the complete provider directory must be submitted prior to enrollment)
- Member Handbook(s) (model handbooks are available)
- Marketing materials including brochures, advertising, radio/TV scripts, websites

V. MEDICARE INTEGRATION (MAP Only)

Medicaid Advantage Plus integrates Medicare and Medicaid covered services through one health plan.

- Describe how you will operationalize and integrate Medicare and Medicaid services for Medicaid Advantage Plus within your organization.
- How will services be authorized and transitioned between Medicare and Medicaid (i.e. home health, nursing home etc.).
- What actions will be taken to make the program appear as seamless as possible to the enrollee?
- Describe the applicant's plan for issuing member identification cards (i.e., will enrollees use a single health plan card for both Medicare and Medicaid covered services)
- Describe how the applicant's member services department will interact with Medicaid Advantage Plus members on issues related to both Medicare and Medicaid.

Provide a copy of the Model of Care submitted to CMS if the Medicare product is a Medicare Advantage Dual Eligible Special Needs Plan.

VI. IMPLEMENTATION SCHEDULE

Provide an implementation plan 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. PACE applicants should include in the timetable the Certificate of Need applications for diagnostic and treatment centers, and licensed home care services agency, if applicable, the Day Center construction/acquisition/leasing.

VII. SERVICE DELIVERY NETWORK

A. Provide a detailed description of the service delivery network including:

1. A chart identifying the proposed provider network, to be established at the time of initiation of MLTCP operation and whether the provider is a related or non-related entity. Consumers must be offered a choice for each type of provider. Plans must have a network of providers that have specialized expertise serving the target population including any special populations. Consideration will be given to development of networks based upon the availability of providers in the proposed service area. The chart below indicates the required Non-PACE MLTC and PACE provider types.

Provider Type	Non-PACE MLTC	PACE

Home Health Care*	●	●
Medical Social Services	●	●
Adult Day Health Care	●	●
Personal Care	●	●
Durable Medical Equipment**	●	●
Non-emergent Transportation	●	●
Podiatry	●	●
Dentist	●	●
Optometry/Eyeglasses	●	●
Outpatient Rehabilitation PT, OT, SP	●	●
Audiology/Hearing Aids	●	●
Respiratory Therapy	●	●
Private Duty Nursing	●	●
Nutritionist	●	●
Skilled Nursing Facilities	●	●
Social Day Care	●	●
Home Delivered/Congregate Meals	●	●
Social and Environmental Supports	●	●
PERS (Personal Emergency Response Service)	●	●
Hospital	NO	●
Diagnostic & Treatment Center	NO	●
Primary Care Physician	NO	●
Specialty Physicians See CMS PACE application for required specialist	NO	●
Emergency transportation, Laboratory, X-ray	NO	●

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

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

Note: Updated lists of providers may be provided to SDOH on a periodic basis during the review process, use Attachment 1 “Provider Network”.

2. A description of the basis and access standards for determining the adequacy of the provider network for each type of provider above.

B. Model Provider Contracts between MLTCPs and providers must be approved pursuant to NYS law and regulation. Provider Contract Guidelines can be found at: http://www.health.state.ny.us/nysdoh/mancare/hmoipa/hmo_ipa.htm.

Include copies of all proposed model contracts to be executed with the provider types specified in A above and include a description of the anticipated payment terms and amounts, (eg. the Medicaid rate, the Medicare rate, capitation, etc). Plans can submit

one or more templates with services specified in the appendices to address all provider types listed in A. A copy of Form DOH-4255, Provider Contract Statement and Certification, should be completed and attached to each proposed contract model.

C. For non-PACE applicants: All provider contracts, including those between related parties, must contain explicitly defined payment terms that reflect "prudent buyer" principles. The payment terms should be based on a defined unit of service basis such as per hour or per visit. Typical criteria for evaluating the reasonableness of the price would be the Medicaid rate.

D. Prior to certification, all MLTCP applicants must submit one signed copy of each model contract with medical service providers that specifies the payment terms and any fee schedule or other payment to be utilized for each type of provider. If the payment terms are identical for all providers of a particular type, only one copy of an executed agreement for each provider type should be submitted. The payment terms should follow the guidelines discussed above. All capitation arrangements should be separately identified. Signed contracts for all related party administrative service agreements must also be submitted.

VIII. QUALITY ASSURANCE PROGRAM

A. Provide a detailed description of the quality assurance program, including the following:

1. the responsibilities and composition of the quality assurance committee(s), the frequency of meetings and the methods for establishing agendas which demonstrate supervision and accountability.
2. a description of the medical director's role which demonstrates oversight and accountability.
3. the methods for establishing standards to be utilized for the quality assurance review.
4. a description of the lines of accountability for the quality assurance program including the role of the governing board.
5. a description of methods for identification and review of problems, the development of timely and appropriate recommendations, and the follow-up on implementation of recommendations for the resolution of problems.
6. a description of methods to be used for medical record audit including sampling techniques.
7. a description of the health care management information system that will be used to support the quality assurance program.

Attachment 5 provides guidance that has been developed for MCOs serving a general population. Your quality assurance program should address data and services that include long term care services and the health information system to support the quality assurance program. See the MLTCP model contracts, available on the NYS DOH website for additional information on the Quality Assurance Program requirement.

B. Identify the routine data reports and other data sources that will be used to identify quality assurance successes and problems.

C. Describe the procedures and standards for recruitment and selection of providers. Include a description of the procedures to be used for credentialing, follow-up and ongoing monitoring of providers. Include a description of the orientation and training for participating providers.

D. The following quality assurance documents must be submitted and approved prior to the readiness review:

1. the provider manual describing the quality assurance, utilization review procedures, and general MLTCP policies for provider participation;
2. the quality assurance manual (see Quality Assurance Guidance Attachment 5) ;
3. policies and procedures describing the MLTCP's process to evaluate the performance of contracted health care providers; and
4. policies and procedures used by the MLTCP to terminate providers.

IX. UTILIZATION CONTROL AND REVIEW SYSTEMS

Provide detailed description of the MLTCP's service authorization/utilization review plan. A MLTCP does not register with SDOH as a utilization review agent, however, the MLTCP is required to provide information specified in §4901(2) of the Public Health Law.

Note that if service authorization (utilization review) is delegated, the contractor must be registered with SDOH as a utilization review agent (PHL§4901). The "Utilization Review Agent Registration Application" is located at:
www.health.state.ny.us/health_care/managed_care/plans/index.htm

X. GRIEVANCE SYSTEMS AND MEMBER SERVICES

A. The Grievance System includes complaints, grievances, grievance appeals, action appeals and access to fair hearings and external appeals through the State Insurance Department. MLTCP applicants must provide a detailed description of the grievance system. The grievance system must include:

1. methods for educating enrollees as to the grievance system;
2. methods for handling complaints and grievances by enrollees and;
3. a description of the role of the medical director, grievance committee and governing board in the grievance process

B. The following policies, procedures and documents must be submitted and approved prior to the readiness review.

1. Policies and procedures which identify each step in the grievance process, including the appeals process. Include time frames for response and notification procedures. The requirements of Part 438 Sub Part F, the managed long term care contract and PHL 4408-a must be reflected in these policies and procedures. The policy must include the identification of MLTCP staff responsible for grievances. Provide the process and procedures that the applicant will implement to ensure that Medicaid members are afforded the opportunity to request a fair hearing upon issuance of an adverse determination of an appeal regarding a denial, termination, suspension or reduction of a service.
2. Provide a flow chart of the applicant's grievance system procedures
3. Submit the forms and notices the applicant intends to use to inform members of organization determinations and enrollee complaint appeals, action appeals and grievance rights (see Attachment 2 for listing of required member notices).
4. Provide an example of a tracking log the applicant will use.

C. Describe in detail the member services program including:

1. member rights and responsibilities;
2. educational materials to be provided;
3. member services to be provided;
4. ratio of member services representatives to members; and
5. mechanism the applicant will use to monitor Medicaid eligibility status, assist with Medicaid recertificaton and report any status change that may impact the enrollee's eligibility to the appropriate local social services district within 5 business days of knowledge of such change.

XI. ASSESSMENT OF PROSPECTIVE MEMBERS AND CARE PLANNING

Describe how the applicant proposes to conduct the initial assessment of prospective members and reassessments of existing members. Include in the description:

- the timeframe for completing the assessment after the referral is made;
- the qualifications of the staff performing the assessments;
- the criteria or other guidance provided to staff for developing the care plan;
- the process for ensuring the completeness and accuracy of the assessment forms and the appropriateness of the treatment plan;
- triggers for reassessment; and
- the instruments that will be used (in addition to the Semi-Annual Assessment of Members (SAAM), or successor, required by SDOH) to assess needs and risk level. Include specific instruments to be used to assess special populations.

For MAP only, include in the description how the applicant will permit its 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 primary care provider or without approval by the applicant. How will the applicant notify its enrollees, staff and network providers of these policies? (Family planning and reproductive health services are non-applicable for partial cap applicants).

XII. CARE MANAGEMENT

Care management is a critical component of the MLTCP. Provide a detailed description of the care management model and of how the applicant will provide care management to its members. Include the following specific information:

- The plan's approach to providing care management to its members that assures that needs are identified, linkages are made to needed services, members and relevant informal supports have input and feedback, services are monitored and care plans amended if goals are met or needs change. The overall approach should address health and long term care needs, behavioral health needs, as well as social and environmental needs. Include specific approaches for special populations.

- A functional and organizational description of care management. Indicate whether care management will be performed by the applicant's employees or under a contract agreement. If under a contract, identify the name of the contractor and describe the experience of the

contractor in performing similar care management programs and how the plan will monitor the contractor;

- What type of personnel will provide care management for the plan? What are the qualifications of the care management staff and what are the proposed ratios of care managers to members?

- How will the plan assure that all necessary disciplines are involved in the assessment, care planning and monitoring? How will communication regarding members take place between care management staff? Between plan staff and network providers? Between plan staff and non-network providers?

- Will the plan employ varying levels of care management dependent on specific health conditions or other member characteristics? If so, describe the levels and how members will be evaluated and monitored for each level.

- Describe how care managers will work with the enrollee's physician(s), informal supports and others to arrange for and monitor the provision of both covered and non-covered services, including health and long term care services, and social and environmental supports;

- The care manager's role in the development and implementation of a care management plan. Include in the description the approach to ensure that the enrollee and/or informal caregiver(s) are involved in the development of the care plan;

- The proposed process for matching care managers to specific enrollees, including policies surrounding the enrollee's choice of care manager and requesting a change in care manager;

- The proposed process to allow members access to care management 24 hours a day, 7 days a week;

- A description of the proposed care management record and

- A description of how the care management function relates to other health plan functions, including but not limited to quality assurance, utilization review and complaints and grievances; and

- Proposed process for handling service authorization requests from members and providers.
- How the plan will maximize reimbursement of and coordinate services reimbursed by Medicare and all other applicable benefits.

- How the plan will arrange and manage Medicaid covered services and coordinate non-covered services which could include primary, specialty, and acute care services

A Service Authorization policy and procedure must be submitted and approved prior to the readiness review. Include a description of each benefit and the accompanying service criteria authorization.

XIII. ENROLLMENT AND DISENROLLMENT

Describe the enrollment process. Include in the description the following:

- Eligibility criteria
- Process for identifying ineligible applicants
- Process for denial of enrollment
- Steps to be taken if application is withdrawn by the applicant
- Identify how the plan will ensure the enrollment is an informed process for the applicant
- Provide a proposed enrollment agreement
- The timeframe for completing the assessment after the referral is made
- The qualifications of the staff performing the assessments
- The criteria or other guidance provided to staff for developing the care plan
- The process for ensuring the completeness and accuracy of the assessment forms and the appropriateness of the treatment plan
- The instruments that will be used (in addition to the Semi-Annual Assessment of Members (SAAM) required by SDOH) to assess needs and risk level.

Provide a description of the disenrollment process from the plan. Include in the policy reasons for disenrollment and the procedure for voluntary, involuntary disenrollments and a spenddown/surplus policy to include disenrollment criteria for non-payment of spenddown/surplus.

Enrollment/Disenrollment policy and procedures and the forms and notices the applicant intends to use to inform members of plan actions must be submitted and approved prior to the readiness review. A general list of forms and notices is included in Attachment 2.

Applicants that are currently operating a Medicaid Advantage Plus or MLTC partial capitation program and intend to use the same processes and procedures for the new plan as approved may so indicate.

XIV. ADA COMPLIANCE PLAN

Medicaid managed care organizations (MCO) must comply with Title II of the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 for program accessibility. 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. It is recommended that MLTCPs review and use the guidelines in preparation of their ADA Compliance Plan. MLTCPs must develop an ADA Compliance Plan consistent with SDOH guidelines for Medicaid MCOs. Guidelines can be found in the Model Contract. The ADA Compliance Plan must be approved by and filed with the SDOH prior to the readiness review along with the completed ADA check list in Attachment 3.

XV. FINANCIAL REQUIREMENTS

Capital Requirements for New Plans:

MLTC Plans must have initial capital sufficient to comply with the Health Department's Regulation Part 98-1.11 escrow and contingent reserve requirements on an ongoing basis. They must fund cumulative operating losses sustained through the time the break-even point is reached and provide additional resources to cover unanticipated losses. Estimated minimum start-up capital funding must include the following: Cumulative Net Losses until month of Break-

Even PLUS 5% of medical expenses for the 12 month period after reaching financial break-even plus any additional resources for unanticipated losses.

MLTC plans must identify the source of initial capital. If the source of capital is a subordinated loan, then the loan must be in the form of a Surplus Note (Surplus Notes are issued in accordance with SSAP No. 41, see Attachment 6 for guidelines and principles). The proposed loan document must be submitted to the Department of Health for review and approval.

When determining the total initial capital needed at start-up only liquid assets are counted (excludes buildings, furniture, fixtures and equipment).

Pledges and/or donations receivable will not be counted towards start-up capital.

PACE Plans (Only)

In addition to the aforementioned capital requirements, for new PACE programs, due to the additional CMS PACE application process, there may be some instances where applicants deplete their net worth prior to opening due to delays and/or incurring preoperational costs above anticipated levels. To assure that plans maintain adequate financial resources as of the date the plan begins operations, the Certificate of Authority (COA) of PACE Plans will contain a condition that the plan must have the agreed upon net worth as of the first day of the month when the plan begins operations. To demonstrate compliance with this condition, within five days from notification by the Department that the Medicaid contract has been approved by Office of the State Comptroller (OSC) the plan must submit the following: actual balance sheet for the prior month and estimated expenses up to the first day of the month the plan begins operations (has enrollment). The date the plan begins operations should be the first of the month following two months from the notification that the OSC has approved the Medicaid contract. If the plan does not meet the initial capitalization requirement at date of operations, the plan must obtain additional equity to meet the requirement before the plan can begin operations. This information must be submitted to DOH, Bureau of Managed Long Term Care.

Reserve Requirement:

All MLTCPs are subject to the reserve and escrow requirements in 10NYCRR §98-1.11(e) and (f).

MLTC plans must maintain an escrow account, in the form of a trust account approved by the State Insurance Department (Sample language is included in Attachment 7). At the date of opening the escrow account must be equal to the greater of 5% of projected expenditures for health care services for the first calendar year of operations or $100,000. MLTC plans shall maintain a reserve, to be designated as the contingent reserve, which must be equal to 5% of its annual net premium income. The plan's minimum net worth must be the greater of the escrow requirement or the contingent reserve.

Initial Rates:

Please contact the Bureau of Managed Long Term Care at (518) 474-6965 for information regarding initial plan rates.

Applicants must provide the following financial data for the proposed MLTCP operation:

1. A detailed estimation of pre-operational expenses to be incurred by the plan prior to the date of opening and the source of funds to cover such anticipated expenditures.

2. A revenue and expense statement by month for the first 36 months of operation or break even, whichever is longer, a pro-forma balance sheet as of the date of opening and year-end for each of the projected three years. The format for the balance sheet and revenue expense statements will be provided by SDOH.

3. Describe in detail any arrangements to share financial risk with providers, including specific contract terms. Identify any stop-loss coverage or other reinsurance purchased.

Other Requirements:

The applicant must certify that it will be able to meet the reporting requirement contained in the Department's financial reports referred to as MMCOR. Submit a Chart of Accounts demonstrating that the plan's functions, activities and services undertaken and performed pursuant to the MCO's Article 44 Certificate of Authority shall be clearly distinguished from any other function, activity or service of the MCO or related parties. Include a description of the methodology the MLTC plan will use to estimate the cost of Incurred But Not Reported (IBNR) claims and claims reported but not paid. The MLTC applicant should describe its policy, including time frames, of writing off IBNR estimates after the claims run out has expired.

XVI. MANAGEMENT INFORMATION SYSTEM

The management information system must be adequate to support plan operations. Describe in detail the management information system including:

1. A description of the system to be used, identifying what functions will be performed directly by the plan versus purchased via contract by a related party or other vendor.

2. Describe the system's ability to supply data for required reports such as financial reports, network reports, reports of complaints, encounter data and quality data.

3. Describe the flow of claims and encounter information into the plan, the time frames allowed for submission of such information and the outflow of payments to the providers, and an account of the financial and medical utilization reports produced routinely (e.g., weekly, monthly, quarterly, annually) for plan management and providers. Any third party contracts for claims processing services with the payment terms specified should also be included.

4. Submit a copy of the plan's Management Information System Procedure and/or Training Manuals.

5. Descriptions of the systems used to pre-authorize services, personal care services, home care services, etc., and how such procedures are tied to the plan's claims payment system.

ATTACHMENT 1

Provider Network

Provider Type	**Provider Name**	**Address & Phone #**	**Insert County** *Example Albany*	**Insert County** *Example Sch'dy*	**Insert County** *Example Montgomery*	**Insert County** *Example Saratoga*	**Insert County** *Example Rensselear*	**Insert County** *Example Fulton*
LHCSA	*Happy Home Care*	*123 Main St Albany, NY 518-555-4321*	*X*	*X*			*X*	
LHCSA	*Care for your Loved One*	*321 Poplar Dr Sch'dy, NY 518-555-4373*	*X*	*X*	*X*	*X*	*X*	*X*
Adult Day Health Care	*Center for Adult Care*	*987 Broad St Amsterdam, NY 518-555-6016*			*X*			

ATTACHMENT 2

For applicants that meet the initial MLTC qualification, additional materials and notices to members will be required. Notices must be submitted and approved prior to the readiness review.

This list is for informational purposes and may not be all inclusive. Refer to the model contract for additional reference to notice requirements.

Partial and MAP Notices

Enrollment
Enrollment Ineligibility notice
Proposed Denial of Enrollment notice to applicants
Denial of Enrollment notice
Notice to referral sources indicating plan action on a specific referral
Acknowledgement of application withdrawal to applicant
Enrollment Agreement
Member ID card
Spenddown/Surplus Notice

Disenrollment
Confirmation of Voluntary Disenrollment Request
Voluntary disenrollment form for member signature
Notice of Voluntary Disenrollment
Notice of Intent to involuntary disenrollment
Notice of involuntary disenrollment

Service Authorization
Notification to member of authorized service plan
Notice of Service Authorization request
Denial of Expedited Service Authorization request

Grievance/ Grievance Appeal
Acknowledgement Notice
Denial of Expedited Request for Grievance and Grievance Appeal
Notice of Extension for Grievance and Grievance Appeal
Grievance Decision
Non consideration of grievance appeal (late filing)
Grievance Appeal Decision

Action/ Notice of Action
Non-consideration of appeal (late filing)
Acknowledgement Notice
Denial of Expedited review request
Notice of Plan Initiated Extension Taken
Appeal Decision

ATTACHMENT 3

Indicate the section and page number in the ADA Compliance Plan.

ADA Compliance Activities	Section & Page #
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 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.	
Care Management: MCO has adequate care 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. Care 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.	

ATTACHMENT 4
NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Bureau of Managed Long Term Care

MANAGED LONG TERM CARE PLAN APPLICATION

DISCLOSURE INFORMATION FOR CHARACTER AND COMPETENCY REVIEW PERSONAL QUALIFYING INFORMATION

(See Instructions for Completion of MLTCP Certification Application, Section I. ORGANIZATION AND MANAGEMENT, C-1)

A. *PERSONAL IDENTIFYING INFORMATION*

NAME (Last) (First) (Middle Initial)

MAILING ADDRESS

CITY STATE ZIP CODE

TELEPHONE NUMBER

( )

DATE OF BIRTH (Month / Day / Year) PLACE OF BIRTH (County / State)

CURRENT OR PROPOSED POSITION WITH MLTCP

B. *INDIVIDUAL EMPLOYMENT HISTORY*

Start with MOST RECENT employment and include employment for the last 10 years. A resume may be included but any additional information requested below and not contained in such resume should be added. Photocopy and attach additional sheets if necessary.

NAME OF EMPLOYER	
STREET ADDRESS OF EMPLOYER	
CITY STATE ZIP CODE	
DATES OF EMPLOYMENT from: to:	TYPE OF BUSINESS
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)
RESPONSIBILITIES	

REASON FOR DEPARTURE

Name: _____

B. ***INDIVIDUAL EMPLOYMENT HISTORY (CONTINUED)***

NAME OF EMPLOYER:	
STREET ADDRESS OF EMPLOYER	
CITY STATE ZIP CODE	
DATES OF EMPLOYMENT from: to:	TYPE OF BUSINESS
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)
RESPONSIBILITIES	
REASON FOR DEPARTURE	

NAME OF EMPLOYER	
STREET ADDRESS OF EMPLOYER	
CITY STATE ZIP CODE	
DATES OF EMPLOYMENT from: to:	TYPE OF BUSINESS
NAME OF SUPERVISOR OR REFERENCE	TELEPHONE NUMBER (area code)
RESPONSIBILITIES	
REASON FOR DEPARTURE	

Name: _____

C. *LICENSES*

Type of License (including specialty)	Institution Granting License and Address	Date Received	Date of Expiration

D. *EDUCATIONAL HISTORY* *(High School and Subsequent Education)*

Institution	Address	Dates Attended	Degree	Date Received

Name: _____

E. ***HISTORY OF ANY LEGAL ACTIONS***

1. Have you ever changed your name or used an alias?

☐ YES ☐ NO

NOTE: If "YES," attach an explanation including other names(s), date(s) and the reason(s) for each change.

2. Except for minor traffic violations, have you ever been indicted or been convicted or had a sentence imposed or suspended, or been pardoned of a conviction for any crime?

☐ YES ☐ NO

3. Are there any criminal actions pending against you?

☐ YES ☐ NO

4. Have you ever been named as defendant in any civil action or proceeding in which there was an issue of moral turpitude, including, but not limited to fraud or breach of fiduciary responsibility?

☐ YES ☐ NO

NOTE: If "YES," to 2, 3, or 4, attach explanation(s) including the date of the action or proceeding, place (county of the filing), the civil docket number, if available, and the disposition of the case, if any.

5. Have you ever been an officer, director, trustee, management employee or controlling stockholder of a company which, while you occupied any such position or served in any such capacity with respect to it:

a. became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?

☐ YES ☐ NO

b. was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?

☐ YES ☐ NO

c. suffered the suspension or revocation of its certificate of authority or license to do business in any state?

☐ YES ☐ NO

d. was denied a certificate of authority or license to do business in any state?

☐ YES ☐ NO

NOTE: if "yes", to any of the above, attach an explanation.

6. During the last 10 years, have you been refused a professional occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period ever been suspended or revoked?

☐ YES ☐ NO

7. Have you ever been named as a defendant in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of, or to prevent the violation of, any securities, insurance or health law or regulation?

☐ YES ☐ NO

NOTE: If "YES," to number 6 or 7 above, attach an explanation.

8. Have you ever been in a position that required a fidelity bond?

☐ YES ☐ NO

a. If "YES", were any claims made against the bond?

☐ YES ☐ NO

b. Have you ever been denied a fidelity bond or had such fidelity cancelled or revoked?

☐ YES ☐ NO

Name: _____

E. *HISTORY OF ANY LEGAL ACTIONS (continued)*

If "YES" was the response to any question in Section E-8, complete the following chart.

DATE OF ACTION	LOCATION
TYPE OF ACTION	CASE IDENTIFICATION
PERSONS AND/OR FACILITIES INVOLVED	
FURTHER DETAILS (Attach additional pages, as necessary)	

Name: _____

F. *AFFILIATION WITH OTHER HEALTH CARE OPERATIONS*
(See General Instructions, I. ORGANIZATION AND MANAGEMENT, C-1 (F))

1. For the past 10 years, have you owned or operated any health care or health related operations or held a management position or had any affiliations through board membership with health care or health related operations in New York, in the USA or in other countries?

☐ YES ☐ NO

NOTE: If "YES," complete the following chart:

Name & Address of Health Care Operation/ Type of Health Care (e.g. Nursing Home, Home Care Agency, Hospital, etc.)	Affiliation Dates From/To	Nature of Affiliation with Facility (e.g. owner, board member)	Licensing Agency	License Number
TYPE:				
TYPE:				
TYPE:				
TYPE:				
TYPE:				
TYPE:				
TYPE:				
TYPE:				

Name: _____

F. *AFFILIATION WITH OTHER HEALTH CARE OPERATIONS* *(continued)*

2. Are/were these facilities in compliance with applicable laws and regulations during your affiliation?

☐ YES ☐ NO

NOTE: If "NO," complete the following:

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name and address)

STEPS TAKEN BY FACILITY TO REMEDY VIOLATION

HAS SUSPENSION OR REVOCATION SINCE BEEN TERMINATED AND ACCREDITATION RESTORED? ☐ YES ☐ NO

NOTE: If "NO", explain below.

Name: _____

G. *PERSONAL FINANCIAL INVOLVEMENT IN MLTCP*

1. Financial Support for the Proposed MLTCP

Has the applicant, owner, all members of a partnership or officers, directors and controlling persons of for-profit and not-for-profit corporations or other business corporations provided capital for use in owning, organizing or operating the proposed MLTCP? (Controlling person means any person who has the ability, directly or indirectly, to direct or cause the direction of the management or policies of a corporation, partnership or other entity.)

☐ YES ☐ NO

NOTE: If 'YES" provide the following:

- Attach a personal financial statement for each individual providing financial support from personal finances for the proposed MLTCP.
- Make clear the percent of the business which each person controls, and document its value.
- Lessors are to attach documents showing their financial ability to fulfill any construction obligations.
- Any additional information pertinent to determination of either the applicant's financial capabilities or the project's feasibility must also be attached.
- For a change in ownership control, submit affidavits from both the applicant and the party from which the operational interest is being acquired. Interest, for the purposes of this section, means right, title or share in a facility, participation in any advantage, profit and responsibility from or for the facility.

2. Stock Ownership or Stock Options

Do you or a relative own stock or options to purchase stock in the proposed MLTCP, the holding company or any subsidiaries of the holding company? Relative, for the purposes of this section, includes each parent, child, spouse, brother or sister whether such relationship arises by reason of birth or adoption.

☐ YES ☐ NO

NOTE: If "Yes," complete the stock ownership and stock option form below:

STOCK OWNERSHIP/STOCK OPTIONS FORM

NAME	POSITION	ORGANIZATION

Name and Type of Business	Class of Security	# of Shares or Options	% of Total Shares or Options	Market Value	Owner	If pledged, To Whom

Name: _____

3. Transactions with the Proposed MLTCP or Holding Company

Have any transactions involving money, extension of credit, loans, notes, bonds or mortgages occurred or are such transactions anticipated between the proposed MLTCP and you or any of your relative(s), or between the holding company and you or any of your relatives(s)?

☐ YES ☐ NO **NOTE:** If "Yes", complete the Disclosure of Transactions Form below identifying such transactions

DEFINITIONS:

RELATIVE, for the purposed of this section, includes each parent, child, spouse, brother or sister, whether such relationship arises by reason of birth or adoption.

TRANSACTION, for the purposes of this section, is any business transaction or series of transactions which during any one fiscal year, represents 5 percent of the total annual operating expenses of any of the parties to the transaction. Transactions include any sale or leasing of any property. Salaries paid to employees for services provided in the normal course of their employment are not included in this definition. No single transaction of less than $500 need be reported.

DISCLOSURE OF TRANSACTIONS FORM

PARTIES INVOLVED IN TRANSACTION

TYPE OF TRANSACTION

VALUE OF TRANSACTION

_____ PERCENT OF OPERATING COSTS/ _____ DOLLARS

_____ PERCENT INTEREST RATE/ _____ DOLLARS

REASON FOR TRANSACTION

METHOD OF REPAYMENT

PARTIES INVOLVED IN TRANSACTION

TYPE OF TRANSACTION

VALUE OF TRANSACTION

PERCENT OF OPERATING COSTS/ DOLLARS

PERCENT INTEREST RATE/ DOLLARS

REASON FOR TRANSACTION

METHOD OF REPAYMENT

(Attach additional sheets if necessary)

AFFIDAVIT

State of

County of

I, _____ being duly sworn, deposes and says I am a
NAME (Last, first, middle initial)

proposed _____ of
POSITION

_____.
ORGANIZATION/CORPORATION

I certify that I have provided all the information requested in the MLTCP Certification Application, Sections A-G, including a complete list of any and all hospitals, nursing homes, clinics, health maintenance organizations, home care agencies or other providers of health care with which I was affiliated within the past 10 years as an operator, owner, director, partner, medical director or stockholder with 10 percent or more total shares.

I certify, under penalty of perjury, that if no names of such health care operations have been provided, I have had no such affiliations in the past 10 years and that the information contained herein is accurate, true and complete.

Signature _____ Date _____

Subscribed and sworn to before me this

_____ day of _____, 20___

Name of Notary Public

Signature of Notary Public

DISCLOSURE OF AFFILIATIONS WITH OTHER HEALTH CARE OPERATIONS

BY A HOLDING COMPANY, CORPORATION OR LIMITED LIABILITY COMPANY PROPOSING AN MLTCP AS A LINE OF BUSINESS, OR MANAGEMENT CONTRACTOR

(SEE General Instructions, I. ORGANIZATION AND MANAGEMENT, C.2)

List all health care or health related operations, institutional or non-institutional, that have been operated, owned or otherwise controlled during the past 10 years by the corporation or limited liability company proposing to operate the MLTCP, or the holding company forming the proposed MLTCP as a subsidiary. Management contractors must list all health care or health care related operations affiliated with the management contractor. Include all health care operations, whether located in NYS, or other states or countries. Refer to the General Instructions (as referenced above) regarding the applicant's responsibility for documentation of compliance of health care operations outside of New York State.

Name and Address of Operation	Type of Health Care Provided	Date Licensed	Name and Address of Contact Person in State Regulatory Agency

(Attach additional sheets if necessary)

1. Are all the operations listed above in compliance with applicable state laws and regulations? ☐ YES ☐ NO

NOTE: If "No," attach an explanation including the date and nature of the violation, the plan of correction or other resolution.

DISCLOSURE OF AFFILIATIONS WITH OTHER HEALTH CARE OPERATIONS BY A HOLDING COMPANY, CORPORATION PROPOSING AN MLTCP AS A LINE OF BUSINESS, OR MANAGEMENT CONTRACTOR

2. Has the holding company, corporation or management contractor ever been subjected to financial penalties or suspension or revocation of its operating certificate or license because of failure to comply with provisions governing the conduct and operation of the facility(ies)?

☐ YES ☐ NO

NOTE: If "Yes," complete for each violation.

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

STEPS TAKEN TO REMEDY VIOLATION

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Bureau of Managed Long Term Care

REGULATORY COMPLIANCE STATEMENT

INSTRUCTIONS: To be completed as indicated and returned by the regulatory agency DIRECTLY to the NYS Department of Health, Bureau of Managed Long Term Care, Empire State Plaza, Room 1911, Albany, NY 12237

A. **TO BE COMPLETED BY PROPOSED MLTCP:**

IDENTIFYING INFORMATION

NAME OF PROPOSED MLTCP:

NAME OF INDIVIDUAL/ENTITY UNDER REVIEW:

DATES OF AFFILIATION: From: / / To: / /

HEALTH CARE OPERATION TO BE REPORTED ON Name and Address: Type of operation:

B; TO BE COMPLETED BY REGULATORY AGENCY REGARDING HEALTH CARE OPERATION

NAME OF PERSON REPLYING (Last, First, Middle Initial)

TITLE TELEPHONE NUMBER ( )

OFFICE NAME/ADDRESS

CITY STATE ZIP CODE

During the stated period, was/is this health care operation in compliance with appropriate state regulations?

☐ YES ☐ NO If "NO", please explain:

During the stated period, to your knowledge, did/do regulators in your state have any concerns about the management or performance of this health care operation? ☐ YES ☐ NO If “YES”, please explain:

During the stated period, did/do regulators in your state have any concerns about the quality of health care provided by this health care operation? ☐ YES ☐ NO If "YES", please explain:

ADDITIONAL COMMENTS CAN BE MADE ON THE BACK OF THIS FORM

Signature:_____ Date:

Other Comments:

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF MANAGED LONG TERM CARE

ATTACHMENT TO
MLTCP CERTIFICATION APPLICATION
REGARDING OUT-OF-STATE
CHARACTER AND COMPETENCE REVIEWS

SAMPLE LETTER A
Character and Competence Reviews on an Individual

Dear_____

(NAME OF MLTCP) is applying for a Certificate of Authority to operate a Managed Long Term Care Plan in New York State. As part of the certification process, a 10 year character and competence review must be conducted for owners, members of the governing board, officers, directors, controlling persons, partners and the medical director who have been affiliated with other health care operations during the past 10 years. This review is to ascertain whether the health care operation named below was in compliance with all appropriate regulations in the states in which they operate.

According to the disclosure forms submitted, (NAME OF INDIVIDUAL) was affiliated with the following health care operations(s) in your state:

NAME OF OPERATION	DATES OF AFFILIATION

Please complete the enclosed Statement of Regulatory Compliance *with respect to the above named health care operation* at your earliest convenience. Without the review, (NAME OF PROPOSED MLTCP) cannot successfully complete the application process. Return the completed Form (DOH-794-MLTC) to the following address:

Bureau of Managed Long Term Care
New York State Department of Health
Room 1911, Corning Tower
Empire State Plaza
Albany, New York 12237

Sincerely,

Enclosure

SAMPLE LETTER B
For Holding Companies

Dear _____

(NAME OF CORPORATION), through its wholly owned subsidiary, (NAME OF PROPOSED MLTCP), is applying for a Certificate of Authority to operate a Managed Long Term Care Plan. As part of the certification process, a character and competence review must be conducted to ascertain that other health care operations owned or operated by (NAME OF CORPORATION) during the past 10 years are in compliance with all appropriate regulations in the states in which they operate.

According to the disclosure forms submitted, the following health care operations within your state have been owned or operated by (NAME OF CORPORATION) during the dates provided:

NAME(S) OF OPERATION	DATES OF OWNERSHIP/OPERATION BY THIS CORPORATION

Please complete the enclosed Statement of Regulatory Compliance *with respect to the above named health care operation* at your earliest convenience. Without this review, (NAME OF PROPOSED MLTCP) cannot successfully complete the application process. Return the completed form (DOH-794-MLTC) to the following address:

Bureau of Managed Long Term Care
New York State Department of Health
Room 1911, Corning Tower
Empire State Plaza
Albany, New York 12237

Sincerely,

Enclosure

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF MANAGED LONG TERM CARE

ATTACHMENT TO
MLTCP CERTIFICATION APPLICATION
REGARDING OUT-OF-STATE
CHARACTER AND COMPETENCE REVIEWS

SAMPLE LETTER C
For Management Contractors

Dear _____

(NAME OF MLTCP) is applying for a Certificate of Authority to operate a Managed Long Term Care Plan in New York State. (NAME OF MANAGEMENT CONTRACTOR) is seeking to provide management services through a management contract. As part of the certification process, a character and competence review must be conducted to ascertain that other health care operations managed by (NAME OF MANAGEMENT CONTRACTOR) are in compliance with all appropriate regulations in the states in which they operate. According to the disclosure forms submitted, the following health care operations within your state have been managed by (NAME OF MANAGEMENT CONTRACTOR) during the dates provided.

NAME(S) OF OPERATION	DATES OF OWNERSHIP/OPERATION BY THIS MANAGEMENT CONTRACTOR

Please complete the enclosed Statement of Regulatory Compliance *with respect to the above named health care operation* at your earliest convenience. Without this review, (NAME OF PROPOSED MLTCP) cannot successfully complete the application process. Return the completed form (DOH-794-MLTC) to the following address:

Bureau of Managed Long Term Care
New York State Department of Health
Room 1911, Corning Tower
Empire State Plaza
Albany, New York 12237

Sincerely,

Enclosure

ATTACHMENT 5
QUALITY ASSURANCE GUIDELINES

The following is an example of a suggested format to assist the applicant in completing the Managed Care Organization (MCO) application as it relates to quality assurance components. It should be noted that the guidelines were not developed specifically for the Managed Long Term Care Plan (MLTCP). The guidelines should be used for general guidance only and should not be construed as meeting all NYS requirements. Data sources such as the SAAM must be incorporated for the MLTCPs.

THE ROLE OF THE MEDICAL DIRECTOR

- The medical director is responsible for supervising the day-to-day operations of the quality assurance program. The medical director reports on a regular basis to the executive director and the board of directors on quality assurance activities.

- The medical director's responsibilities include:
  - Convene and chair the Quality Assurance Committee.
  - Convene and chair the Credentialing/Recredentialing Committee.
  - Monitor quality improvement activities to ensure that measurements, evaluations and corrective action plans are implemented on a timely basis.
  - Ensure that quality assurance reports are distributed to the board of directors, the Quality Assurance Committee, senior staff and other appropriate parties, i.e., IPA groups, ancillary providers, affiliated hospitals.
  - Provide oversight in the development and monitoring of provider corrective action plans.
  - Participate in the education of providers regarding the role of quality assurance in the delivery of health care.
  - Sanction non-compliant providers.
  - Oversee and direct the implementation of the annual quality assurance/quality improvement plan.

RESPONSIBILITIES OF THE QUALITY ASSURANCE COMMITTEE

- Review all sources of input (grievances, complaints, member satisfaction surveys, feedback from providers, marketing staff, member service staff and local county social service staff, medical records reviews, etc.) to identify problems or potential problems for continuous quality improvement intervention.

- Compile data and prepare reports for presentation and utilization by the medical director.

- Identify areas needing correction.

- Monitor corrective action plans and their effectiveness.

COMPOSITION OF THE QUALITY ASSURANCE COMMITTEE

- Composition of the committee will include representatives of core services provided by the MCO. The committee will be chaired by the medical director.

  Members of the committee include:
  - medical director
  - quality assurance manager or equivalent
  - physician providers representing various practices that include: family practice, internal medicine, obstetrics/gynecology, pediatrics and ancillary providers

  and may also include:
  - marketing director
  - provider relations director or equivalent

In addition to the Quality Assurance Committee, the plan may also have subcommittees or ad hoc committees that may represent ancillary or specialty services to address administrative sanctions and quality of care issues. These committees will report to the medical director.

QUALITY ASSURANCE COMMITTEE MEETING FREQUENCY

- At least monthly during the first year of operation.

QUALITY ASSURANCE COMMITTEE MEETING AGENDA

- Will be established through various sources including member complaints, provider complaints, medical record review results, etc.

METHODS FOR ESTABLISHING STANDARDS TO BE UTILIZED FOR THE QUALITY ASSURANCE REVIEW

- Quality assurance standards will be developed by those professionals and professional groups who are the most familiar with current practices and standards, i.e., the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, JCAH, New York State Dept. of Health, etc. At a minimum, the MCO will monitor QARR indicators, as well as indicators required by the State Department of Health for Medicaid managed care contractors.

- As part of the quality assurance program evaluation, the MCO staff and the quality assurance committee will evaluate the health problems of the membership served, the quality of care provided and determine the areas to be studied in subsequent years.

- The quality assurance director or committee will perform a quarterly analysis of the quality indicators and report the findings to the medical director.

LINES OF ACCOUNTABILITY FOR THE QUALITY ASSURANCE PROGRAM

- A schematic chart showing the above or a narrative is acceptable. Ensure the board of directors is included and reflects oversight by the board.

CREDENTIALING AND RECREDENTIALING PROCESS

The following elements should be included in the description of your credentialing and recredentialing processes. The application version of this policy and procedure may be different from any examples included here.

- Credentialing committee
  Describe the functions of and procedures of the committee and the participants of the committee.

- Application process
  - List the types of providers to be credentialed.
  - Develop appropriate credentialing and recredentialing criteria for each type of provider to be credentialed.
  - Describe the plan's application process. Submit a narrative and/or a schematic chart.
  - Describe the primary source verification process.

- Primary source verification

  The following are examples of the items included in the application process and the acceptable verification sources for physicians.

  1. Valid state license
     - State of New York Department of Education
     - Hospital designated as primary admitting facility, if the primary admitting facility has verified the licensure with the State Department of Education and provides the MCO with written statement indicating date of last verification and date of registration renewal.

  2. Current registration (biennial)

  3. Clinical privileges in good standing at the primary admitting facility
     - Written documentation from admitting facility with date of appointment; scope of privileges; any restrictions; date for recredentialing; and recommendations.

  4. Valid DEA certificate
     - Inspection of certificate or facsimile.

  5. Graduation from medical school
     - Written documentation from medical school
     - AMA physician master file
     - ABMS Compendium

  6. Residency program

- Written documentation from residency program
- ABMS Compendium

7. Board certification
   - Written documentation from specialty school
   - ABMS Compendium

8. Professional claims history
   - As reported on application
   - Claims history for past two years verified with carrier
   - Claims history as reported in National Practitioners Data Bank (NDPB)

9. National Practitioner Data Bank review

10. Information from NYS Department of Education

11. Medicaid or Medicare sanction activity

♦ Recredentialing Policy

The following is an acceptable example of a policy for recredentialing.

1. Purpose

   To ensure that providers maintain their licensure and clinical privileges and have an acceptable malpractice claims history

2. Policy

   A. All providers who are required to be credentialed will be recredentialed every two years at a minimum.

   B. The credentials committee is responsible for reviewing, and then approving or denying an application for recredentialing.

C. The following must be verified from primary sources (see Policy and Procedure for Credentialing for valid primary sources).

1) License to practice
2) Valid biennial registration
3) Clinical privileges in good standing at the primary admitting facility
4) Valid DEA certificate
5) Board certification status
6) Professional liability claim history
7) NPDP inquiry
8) FSMB inquiry
9) Medicaid/Medicare sanction activity

D. There is an onsite office review for primary care, OB/GYN and all volume specialist providers.

E. There is a review of data relating to the provider including

1) Member complaints
2) Results of quality reviews
3) Utilization management performance
4) Member satisfaction surveys

F. The credentials committee reports its recredentialing decisions to the quality improvement committee for its review and approval.

G. Describe procedures available to providers for the appeal of negative credentialing/recredentialing decisions.

ROUTINE DATA REPORTS AND OTHER DATA SOURCES THAT WILL BE USED TO IDENTIFY QUALITY ASSURANCE PROBLEMS

♦ The following is an example of an acceptable format:

A continuous monitoring program readily identifies areas for improving clinical quality. Important aspects of care are monitored on a regular basis to ensure that quality care is delivered to MCO members.

POLICY

1. The quality assurance committee will review and propose clinical quality indicators on an annual basis.

A. At a minimum, the MCO will monitor the indicators required by the NYS Department of Health for Medicaid managed care contractors.

B. As part of the annual quality assurance program evaluation, the MCO staff and quality assurance committee will evaluate the health problems of the population served, the quality of the care provided, and will determine the service and care areas to be reviewed for the subsequent year.

2. The quality assurance manager performs a quarterly analysis of the quality indicators and reports the findings to the quality improvement committee.

3. The medical director is responsible for implementing the quality monitoring program.

4. The initial clinical quality indicators are as listed below.

   A. General clinical
      1) Hospital readmission rate
      2) Infant immunization rate
      3) PAP smears on a timely basis
      4) Mammogram on a timely basis
      5) Prostatic examinations on a timely basis

   B. Adult medicine
      1) Rate of hospitalization for diabetic ketoacidosis
      2) Rate of hospitalization for asthma
      3) Rate of referral of diabetics for retinal exam

   C. Pediatrics
      1) NICU admission rate
      2) Rate of hospitalization for asthmas
      3) Well child visits and routine pediatric services and tests specified in the annual NYS Department of Health managed care Quality Assurance Reporting Requirements (QARR)

   D. OB/GYN
      1) Prenatal care visit rate
      2) Cesarean section rate
      3) Maternal complication rate
      4) Hysterectomy rate
      5) Low and very low birth weight rates

   E. Surgery
      1) Rate of hospitalization after outpatient surgery
      2) Rate of complication after inpatient surgery
      3) Rate of conversion of laparoscopic cholecystomy to open cholecystomy
      4) Rate of fine needle breast biopsy vs. open biopsy for breast lesions

F. Mental health/substance abuse
   1) Readmission rate for inpatient alcohol/substance abuse program
   2) Rate of repeat detoxification program
   3) Rate of ambulatory follow-up after hospitalization for major affective disorders

G. Emergency care
   1) Rate of use of walk-in/emergency room
   2) Rate of use of out-of-plan emergency rooms

H. Provider activity
   1) Credential denial rate
   2) Recredential denial rate
   3) Provider suspensions
   4) Provider terminations
   5) Other provider sanctions
   6) Follow-up on missed appointments
   7) Primary care physician (PCP) follow-up on specialist referrals

DATA SOURCES AVAILABLE TO THE QUALITY ASSURANCE PROGRAM

Data collection is of paramount importance in a comprehensive quality management program. These are many of the commonly utilized sources. Please be specific with the sources you will include.

- Data are collected from multiple sources including:
  - Policy and procedure manuals of
    a. MCO
    b. Provider offices
  - Medical records
  - Utilization reports; including emergency room visits
  - Incident reports
  - Financial reports
  - Claims data
  - Pre-certification and concurrent review notes
  - Lab, X-ray and other diagnostic test reports
  - State, county and city health department reports
  - Member surveys
  - Provider surveys
  - Prescriptions and reports from pharmaceutical third party
  - Complaints/grievances
  - Performance indicators (QARR)
  - Administrators
  - Observations by members of quality improvement committee
  - Performance audits (peer review)
  - Procedure audits (medical record documentation)
  - Patient satisfaction surveys
  - Special purpose studies (focused reviews and outcome studies)

METHODS TO BE USED FOR MEDICAL RECORD AUDIT THAT INCLUDES SAMPLING TECHNIQUE

The following is an example of an approved policy and procedure for a general medical record audit. Your own criteria may be different from this example.

- Medical Record Documentation Audit
  - Quality assurance staff will review ten medical records each year for each primary care and OB/GYN physician until the physician attains a passing grade for two years in a row. For physicians who attain a passing grade, the quality assurance staff will review five medical records each year.
  - The passing grade will be set by the quality assurance committee, based on the first year's experience and the judgment of the committee members.
  - Each medical record is reviewed for the following items:
    1. Patient identification on each page.
    2. There is a personal/biographical database that includes patient's address, home and daytime telephone numbers, emergency contact person, and parent or guardian if patient is a minor.
    3. All entries are dated and legible.
    4. The author is identified for all entries.
    5. There is a complete and up-to-date problem list.
    6. Medication allergies and adverse reactions are prominently noted.
    7. For patients 14 and over, there is notation concerning use of tobacco, alcohol and controlled substances.
    8. There is a complete history (medical and social) and physical.
    9. There is a plan for return visits or other follow-up noted after each visit.
    10. If a consult is requested, there is a medical record entry by or note from the consultant.
    11. There is a completed immunization record for all children 18 and under or a note that immunizations are up-to-date.
    12. There is a completed growth chart for children under 14.

- The quality assurance director compiles the rating or score for each physician and presents the information to the medical director.

- The medical director reviews the ratings and addresses specific documentation problems with the plan's physicians and requests them to submit a corrective action plan.

- Additional charts will be audited six months after the corrective action plan has been implemented.

- The quality assurance coordinator submits an analysis of the medical record documentation review to the quality improvement committee each year.

- Results of the medical record review will be placed in the provider's credentialing file for review and consideration in measuring performance for the recredentialing process.

PROVIDER MANUAL

The Provider Manual addresses the following:

- Credentialing/recredentialing
- Responsibilities of primary care physician
- Responsibilities of specialty physician
- Child/Teen health program guidelines
- Scheduling appointments/waiting times/missed appointments
- Emergency services
- Mental health
- Authorization procedures for the following:
  - Pre-certification of non-emergency inpatient admissions
  - Emergency and urgent admissions
  - Out-of-area hospital admissions
  - Outpatient surgical procedures
  - Outpatient referral guidelines
  - Outpatient diagnostic tests
  - Sterilization and hysterectomy
  - Home health care
  - DME
  - Nutrition
  - Referrals to consultant physicians
  - Referrals to non-participating physicians
  - Referrals for preventive care
  - Laboratory and diagnostic procedures
- Routine physical examinations
- HIV counseling and testing
- Family planning and reproductive services
- Prescription drug program
- Billing and claims procedures
- New member information
- Handling member problems
- Medical records

- Quality assurance procedures
- Enrollment and disenrollment procedures
- Member handbook
- Referral provider directory
- Covered services and non-covered services
- Physician change procedures

QUALITY ASSURANCE MANUAL

- The information described previously in the quality assurance/quality improvement system will be incorporated into the quality assurance manual which, at a minimum, will address the following:
  - Quality assurance program description including the quality improvement organizational structure
  - Annual program evaluation
  - Quality Assurance Committee composition and function
  - Credentialing and recredentialing policies and procedures
  - Clinical quality indicators (annual QARR)
  - Risk management
  - Incident report form
  - Primary care physician office reviews
  - Medical record documentation audit policies and procedures
  - Medical record documentation review form
  - Monitoring access
  - Data sources
  - Member satisfaction
  - Member satisfaction survey
  - Quality of care incident investigation
  - Corrective actions development and monitoring
  - Sanctioning policies and procedures
  - Complaint/grievance and appeals procedures for enrollees and providers
  - Standards development procedures

METHODS FOR ENSURING ACCESSIBILITY, ACCEPTABILITY AND CONTINUITY OF CARE FOR ENROLLEES

The following is an acceptable outline to assess accessibility of care for enrollees.

- Access to care will be monitored at least quarterly utilizing 1. random telephone calls to providers and 2. provider access surveys.

    1. 24-hour physician availability telephone calls
       Staff will make four after-hour calls in an attempt to reach a provider and will record the following information.
        A. the number of rings before answering service responds
        B. the time for physician to call back

    2. Provider access survey
       A report for each major delivery site is compiled quarterly and measures the following:
        A. Number of days to obtain appointment for baseline complete physical exam (adult).
        B. Number of weeks to obtain routine appointment (adult)
        C. Number of weeks for well child visit (pediatrics)
        D. Number of weeks for routine appointment (pediatrics)
        E. Number of weeks to obtain OB/GYN appointment
        F. Number of weeks to obtain specialty appointment
        G. Time to be seen for acute illness (urgent care)

- Information supplied by the providers will be validated by a random review of scheduling system or appointment logs.

- The Quality Assurance Manager
    - Reviews and analyzes the access surveys and conducts the validation studies.
    - Reports findings and makes recommendations for corrective actions, if appropriate, to the quality assurance committee.

- The Quality Assurance Committee
    - Reviews the findings and recommendations of the quality assurance manager.
    - Recommends corrective action plan, if appropriate.
    - Monitors the implementation and outcomes of corrective actions plans.

METHODS FOR MONITORING PATIENT SATISFACTION

- Member satisfaction will be evaluated through:
    - Annual member satisfaction survey
    - Review of disenrollment data
    - Review of complaints and grievances

- Member Satisfaction Survey
  - Describe who reviews the member satisfaction survey.
  - Describe what is done with the results of the survey and how it interacts with the quality assurance process.

The following is an outline of a member satisfaction survey instrument. The survey should be written/spoken in languages understandable to the MCO consumer.

MCO MEMBER SATISFACTION SURVEY:

The survey is designed to obtain information from MCO members in three areas:

- Satisfaction with services provided by MCO
- Satisfaction with services of MCO providers
- Knowledge and satisfaction with plan features and services

[The following subjects have been modeled on those commonly used in patient satisfaction surveys. They may be modified for multi-cultural member populations. The satisfaction survey should be adjusted, as appropriate, to the members of the MCO.]

- Evaluation of access, amenities, and health care services of MCO providers
  - Overall evaluation
  - Evaluation of experience during a recent visit
- Evaluation of pharmacy services, dental services, as applicable
  - Use of and satisfaction with MCO services
  - Member services
  - 24–hour medical hotline
- Knowledge of managed care and MCO program features
- Accessibility
  - Accessibility to your primary physician
  - Accessibility to specialists
- Effectiveness of MCO communication and outreach efforts
  - New member welcome session
  - MCO Newsletter
  - MCO special events
- Overall satisfaction with MCO

TELEPHONE SURVEY FIELDING PROCEDURES:

This survey type is not mandatory, but if utilized, the following applies.

- Telephone surveyor may be part of the MCO staff or recruited from outside the plan, which could reduce the risk of bias.
  - The survey should be conducted in the appropriate language of the member.
  - If telephone surveys are utilized, describe the procedures utilized and the information collected.
- Attach the telephone member satisfaction survey form.

SAFEGUARDS TO BE USED TO PREVENT UTILIZATION CONTROL FROM ADVERSELY AFFECTING QUALITY ASSURANCE IN THE MCO

Utilization review and activities are geared to prevent unnecessary services and, therefore, avoidable costs. Rigorous utilization controls, however, might prevent members from getting needed services. Quality assurance moderates utilization controls in the following ways:

- Quality and utilization relationship
  - The reporting system is monitored for indications of inadequate service to members.
  - Policy governing member benefits and corporate administrative decisions are influenced by input from the medical director, whose first responsibility is assuring quality, not cutting costs.
  - The auditing of clinical records seeks evidence of poor quality of care without respect to the number of visits or use of other services.
  - Member education and grievance procedures safeguard against the dangers of excessive utilization controls.
  - The MCO gives priority to quality assurance activities by functionally centralizing all medical management in this division. Utilization review activities of other divisions are limited to the analysis of costs and other trend factors. Information which reveals patterns of practice of providers is referred to the quality assurance division for determination.
  - Utilization review promotes quality treatment by helping to assure that medically necessary care is rendered in the setting most appropriate to the member's health needs. In this way, members will utilize the less traumatic, less anxiety producing alternatives to acute care hospitalization. Such review may help avoid illnesses which result from over doctoring and overusing services.
  - The MCO reviews denial of treatment to identify patterns associated with the provision of care.
  - Utilization review criteria and pre-authorization guidelines are reviewed and evaluated on an ongoing basis.

Attachment 6
SURPLUS NOTES
(SSAP No. 41)

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for issuers and holders of surplus notes.

SUMMARY CONCLUSION

Issuers of Surplus Notes

2. Reporting entities sometimes issue instruments that have the characteristics of both debt and equity. These instruments are commonly referred to as surplus notes, the term used herein, but are also referred to as surplus debentures or contribution certificates. These instruments are used for various reasons, included but not limited to:

    a. Providing regulators with flexibility in dealing with problem situations to attract capital to reporting entities whose surplus levels are deemed inadequate to support their operations;

    b. Providing a source of capital to mutual and other types of non-stock reporting entities who do not have access to traditional equity markets for capital needs;

    c. Providing an alternative source of capital to stock reporting entities, although not for the purpose of initially capitalizing the reporting entity.

3. Surplus notes issued by a reporting entity that are subject to strict control by the commissioner of the reporting entity's state of domicile and have been approved as to form and content shall be reported as surplus and not as debt only if the surplus note contains the following provisions:

    a. Subordination to policyholders;

    b. Subordination to claimant and beneficiary claims;

    c. Subordination to all other classes of creditors other than surplus note holders; and

    d. Interest payments and principal repayments require prior approval of the commissioner of the state domicile.

4. Proceeds received by the issuer must be in the form of cash or other admitted assets having readily determinable values and liquidity satisfactory to the commissioner of the state of domicile.

5. Interest shall not be recorded as a liability nor an expense until approval for payment of such interest has been granted by the commissioner of the state of domicile. All interest, including interest in arrears, shall be expensed in the statement of operations when approved for payment. Unapproved interest shall not be reported through operations, shall not be represented as an addition to the principal or notional amount of the instrument, and shall not accrue further interest, i.e., interest on interest.

6. As of the date of approval of principal repayment by the commissioner of the state domicile, the issuer shall reclassify such approved payment from surplus to liabilities.

7. Costs of issuing surplus notes (e.g., loan fees and legal fees) shall be charged to operations when incurred.

8. Discount or premium, if any shall be reported in the balance sheet as a direct deduction from or addition to the face amount of the note. Such discount or premium shall be charged or credited to the statement of operations concurrent with approved interest payments on the surplus note and in the same proportion or percentage as the approved interest payment is to the total estimated interest to be paid on the surplus note.

Holders of Surplus Notes

9. Investments in surplus notes meet the definition of assets as defined in *SSAP No. 4--Assets and Nonadmitted Assets* and are admitted assets to the extent they conform to the requirements of this statement.

10. Surplus notes shall be accounted for in accordance with SSAP No. 26—Bonds, excluding Loan-backed and Structured Securities (SSAP No.26). Holders of surplus notes shall value their investment in surplus notes as follows:

a. Rated Notes

i. If the notes have been rated by a Nationally Recognized Statistical Rating Organization (NRSRO) and have a designation equivalent of NAIC 1, then amortized cost shall be used. If there is more than one NRSRO rating, the lowest rating equivalent shall be used for purposes of this valuation procedure;

ii. The *Purpose and Procedures Manual of the NAIC Securities Valuation Office* contains a listing of NAIC equivalent NRSRO designations as well as a listing of insurers that meet the requirements of i above.

b. Non-Rated Notes

i. If the notes are not NRSRO rated or have an NAIC designation equivalent of NAIC 2 through 6, then value as follows:

(a) At its outstanding face value, notwithstanding the payment of interest and/or principal, when the notes were issued by a reporting entity whose capital and surplus (excluding surplus notes included therein) is greater than or equal to the greater of 5% of its admitted assets (excluding separate accounts) or

$6,000,000. The valuation shall be calculated using the most recently filed statutory financial statements of the entity that issued the notes;

(b) By applying a "statement factor" to the outstanding face amount of the capital or surplus notes, notwithstanding the payment of interest and/or principal when the notes were issued by a reporting entity whose capital and surplus (excluding surplus notes included therein) is less than or equal to the greater of 5% of its admitted assets (excluding separate accounts) or $6,000,000. The "statement factor" is equal to the total capital and surplus, including surplus notes, less the greater of 5% of admitted assets (excluding separate accounts) or $6,000,000 divided by the capital or surplus notes. The valuation should be calculated using the most recently filed statutory financial statements of the entity that issued the notes. Should the result of the "statement factor" yield a product less than zero, the surplus notes shall be carried at zero and not a negative amount.

Surplus debenture(s) must not be valued in excess of the lesser of the value determined above or amortized cost and are to be reported as other invested assets. If the notes are issued by an entity which is subject to any order of liquidation, conservation, rehabilitation or any company action level event based on its risk-based capital, then the valuation is at zero, notwithstanding any previous payments of interest and/or principal. The admitted asset value of a surplus note shall not exceed the amount that would be admitted if the instrument was considered an equity instrument and added to any other equity investments in the issuer held directly or indirectly by the holder of the surplus note. If the calculated value (after application of paragraph 10.b.i.(b)) is less than the outstanding face value, then that amount shall be accounted for as a nonadmitted asset.

11. Only interest that has been approved by the issuer's domiciliary commissioner shall be accrued as income by the holder of surplus notes in a manner consistent with SSSAP No. 26.

Disclosures

12. The notes to the financial statements of a reporting entity that issues surplus notes shall disclose the following as long as the surplus notes are outstanding:

    a. Date issued;

    b. Description of the assets received;

    c. Holder of the note or if public the names of the underwriter and trustee;

    d. Amount of note;

    e. Carrying value of note;

    f. The rate at which interest accrues;

    g. Maturity dates or repayment schedules, if stated;

h. Unapproved interest and/or principal;

i. Interest and/or principal paid in current year;

j. Total interest and/or principal paid on surplus notes;

k. Subordination terms;

l. Liquidation preference to the reporting entity's common and preferred shareholders;

m. The repayment conditions and restrictions

13. In addition to the above, a reporting entity shall identify all affiliates that hold any portion of a surplus debenture or similar obligation (including an offering registered under the Securities Act of 1933 or distributed pursuant to rule 144A under the Securities Act of 1933), and any holder of 10% or more of the outstanding amount of any surplus note registered under the Securities Act of 1933 or distributed pursuant to Rule 144A under the Securities Act of 1933.

Relevant Literature

14. This statement adopts the NAIC *Purposes and Procedures of the Securities Valuation Office*, "Procedures for Valuing Surplus Debentures." This statement rejects AICPA Practice Bulletin No. 15, *Accounting by the Issuer of Surplus Notes,* which requires surplus notes to be accounted for as debt and that interest be accrued over the life of the surplus note, irrespective of the approval of interest and principal payments by the insurance commissioner.

Effective Date and Transition

15. This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No.3—*Accounting Changes and Corrections of Errors.* The provisions of paragraph 3, which are required for an instrument to qualify as a surplus note, apply to all surplus notes issued or amended after December 12, 1991. Surplus notes issued on or before December 12, 1991, shall not be required to meet the provisions of paragraph 3 in order to be accounted for as a surplus note.

Attachment 7
SAMPLE DEED OF TRUST

THIS INDENTURE, made this day of , in the year , between: (name of the MCO) , a corporation organized under the laws of New York (hereinafter called the "Company"), and (name of bank or trust company located in New York State), a corporation organized under the laws of (hereinafter called the "Trustee"):

WITNESSETH:

WHEREAS, under and pursuant to the provision of Section 98-1.11(f) of the Regulations of the New York State Health Department (10 NYCRR 98-1) a Managed Care Organization is required to maintain in the State of New York trusteed assets for the security of all its enrollees and the enrollee's health care service claim obligations and to appoint a trustee of such assets;

THEREFORE, to ensure that the laws and regulations of the State of New York shall be fully complied with:

KNOW ALL MEN BY THESE PRESENT

FIRST: The Company has appointed (Bank or Trust Company), a Corporation having trust powers as its lawful Trustee.

SECOND: The Trustee and its lawfully appointed successors is and are authorized and shall have power to receive such securities and property as the Company from time to time may transfer or remit to or vest in said Trustee or place in such Trustee's hands or under said Trustee's control, and to hold, invest, reinvest, manage and dispose of the same for the uses and purposes and in the manner and according to the provisions contained herein.

THIRD: Legal title to such securities and property and their proceeds shall be vested in the Trustee and its lawfully appointed successors, who shall hold the same as a fund in trust for the Company's enrollees and the enrollee's health care service claim obligations.

FOURTH: All such trusteed assets at all times shall be maintained as a trust fund, separate and distinct from all other assets, and shall be continuously kept within the State of New York.

FIFTH: The Trustee is authorized and empowered with the general or specific written direction of the Board of Directors of the Company to sell or collect any security or property in the said trust fund, and to invest and reinvest the proceeds thereof in such securities or property as are or may be from time to time permitted by the laws of the State of New York, and subject to the limitations therein contained.

SIXTH: Subject to the approval required by the NINTH paragraph hereof, the Trustee is

authorized and empowered, with written direction as provided in paragraph FIFTH hereof, to furnish funds, securities or other property out of such trust fund (a) for the payment of moneys due to enrollees; (b) for the payment of enrollees health care service obligations, or (c) for remittance or transfer to the Company.

SEVENTH: The Trustee shall continuously maintain a record at all times sufficient to identify the assets of the trust fund and shall no later that April 30th of each year furnish a statement to the Superintendent of Insurance of the State of New York, and the Commissioner of Health of the State of New York, identifying the assets that are held in trust as of the thirty-first day March of such year, including the estimated fair market value of such assets.

EIGHTH: The Trustee is authorized and empowered, with the written direction as provided in paragraph FIFTH hereof, to pay or deliver any or all income, earnings, dividends (except stock dividend) or interest accumulations of the securities or property of such trust fund to such Company and accept receipt therefor.

NINTH: No withdrawal of any assets of such trust fund other than as specified in paragraph EIGHTH hereof shall be made or permitted by the Trustee without the written approval of the Superintendent of Insurance of the State of New York, except as follows:

a) For the purposes of substituting other assets permitted by law and at least equal in market value to those withdrawn, upon any general or specific written direction of the Company.

b) For the purposes of transferring such assets to the Superintendent of Insurance of the State of New York as the official liquidator or rehabilitator pursuant to an order of a court of competent jurisdiction.

TENTH: The Trustee may resign, by written resignation, effective not less than ninety (90) days after receipt by the Company, and the Company may remove the Trustee at any time, without assigning any cause therefor, provided that no such resignation or removal shall be effective until a successor Trustee has been appointed and has qualified and such appointment has been approved the Superintendent of Insurance of the State of New York. In case of a vacancy caused by such a resignation or removal of a Trustee, or for any other cause, the Company shall appoint a new Trustee, and all of the powers of the Trustee named herein shall survive and continue in the successor trustee, and every new trustee shall succeed to, take and have all the estate, rights and powers which belonged to or were held by its predecessor, and be charged with like obligations as was its predecessor. But the Trustee shall not be liable nor responsible for any loss to its said trust fund unless the same be caused by its neglect or willful malfeasance.

ELEVENTH: The Company may at any time hereafter modify or vary the trusts, conditions and powers herein before declared, imposed or conferred in such manner as it shall deem fit and as shall be according to law, provided the rights of its enrollees shall not thereby be affected or impaired. No such modification or variation shall be effective unless approved in writing by the Superintendent of Insurance of the State of New York.

TWELFTH: The Trustee may accept a certificate or other writing signed as provided in paragraph FIFTH hereof as prima facie evidence of any of the following: (a) that the securities or properties mentioned in any such certificate or other writing comply with the limitations imposed by Section 98-1.11(f) of the Regulations of the New York State Department of Health (10 NYCRR 98-1) and (b) that the securities and properties mentioned in such certificate or other writing are of the market value specified therein.

THIRTEENTH: The Trustee hereby accepts the trust above created and declared upon the terms above expressed and signifies its acceptance thereof by joining in execution of these presents.

This deed of trust and all amendments thereto shall not be effective unless approved in writing by the Superintendent of Insurance of the State of New York.

This Indenture shall take effect on the day on which it is approved by the Superintendent of Insurance of the State of New York and is filed in his office.

IN WITNESS WHEREOF, the company has caused this instrument to be signed by its President and attested by its Secretary and its corporate seal to be affixed, at this day of , , and the Trustee as evidencing its acceptance of the trust hereby created, has caused this Instrument to be signed by its Trust Officer and attested by its Secretary, at NY, this day of

BY: _____

ATTEST: _____

BY: _____

ATTEST: _____