Dear interested party,

As you know, OPWDD has embarked on a multiyear path to transition the current fee for service system to managed care beginning October 1, 2015 when individuals with Developmental Disabilities will have the choice to voluntarily enroll into Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs).

We are pleased to release the enclosed Application for a Certificate of Authority for Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs). This comprehensive document will be used to qualify organizations that have met the criteria for becoming a DISCO and have applied to participate in the program.

Please note that this document also includes criteria that will be used to award DISCO managed care start-up grants to eligible organizations.

- For applicants that are **NOT** interested in a start-up grant, the process and timeframes for the COA application is "rolling", meaning the application may be submitted at any time in the future that the organization is ready to participate and the entire application is developed.

- For applicants that **ARE** interested in applying also for a DISCO start-up grant, while the timeframe for the full application submission is "rolling", the timeframes for applying for the grant funds (which includes criteria that will need to be met also as part of the COA process) is finite. The criteria for the grant funds are included in Attachment 10 of the COA Application.

  At the onset of the application process, those DISCO applicants who have successfully completed section Five (V) of Attachment 10 of this document (Request for Grant Applications - Managed Care Start-Up Costs for DISCOs) will be eligible to apply for DISCO startup grant funds. All terms and procedures for grant application are outlined in Attachment 10 including the window of time during the Certificate of Authority application process that start up grant applications will be accepted. All applications for grant funding must be received by the OPWDD by the November 1, 2014 deadline as outlined by the timeline in Attachment 10 of this document.

Financing, contracts and the start-up of enrollment in DISCOs are subject to approval by the Centers for Medicare and Medicaid Services (CMS). Proxy Rates for completing the Financial Requirements section will be made available and posted to this website in mid-September 2014.

APPLICATION
FOR A CERTIFICATE OF AUTHORITY
FOR DEVELOPMENTAL DISABILITIES INDIVIDUAL SUPPORTS AND CARE COORDINATION ORGANIZATION (DISCO)

NEW YORK STATE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)

August 21, 2014

Introduction

Programmatic Goals of the People First Waiver

The New York State Office for People with Developmental Disabilities (OPWDD) is committed to its mission of helping the individuals with developmental disabilities who receive its services and supports live richer lives, and creating stronger person-centered services, now and in the future. OPWDD and the Department of Health (DOH) will develop specialized managed-care organizations that meet the requirements of Mental Hygiene Law §13.40 and Public Health Law §4403-g, and have expertise in the provision of services under the auspice of OPWDD. These entities will be known as Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs). As OPWDD and DOH prepare to begin system reforms by authorizing and funding DISCOs, it is critical to ensure that each individual receives services, consistent with his or her known wishes, that are designed to achieve person-centered outcomes, to enable him or her to live in the most integrated setting appropriate to his or her needs, and to enable him or her to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings. It is equally important to ensure that each individual is given the opportunity to make informed choices, either personally or through an authorized representative, about the development of his or her person-centered plan, and is fully informed about how the system will operate to meet his or her needs.

Individuals will voluntarily opt to enroll in the DISCO. In keeping with the valued outcomes of OPWDD and the programmatic objectives of the People First Waiver, during the application process the DISCO applicant will be required to describe how it will:

- Provide Person-Centered Planning that focuses on individual outcomes for all individuals enrolled in the DISCO,
- Promote OPWDD's four valued outcomes for individuals to:
  - Live and receive services in the most integrated settings;
  - have meaningful and productive community participation, including paid employment;
  - develop meaningful relationships with friends, family, and others in their lives; and
  - experience personal health, safety and growth
- Ensure that each individual who chooses to do so can self-direct his or her services including the option for budget and employer authority.
- Maintain a well trained workforce that meets all OPWDD requirements and is culturally competent to meet the needs of the individuals seeking or receiving supports and services in the communities in which they live; and
- Cooperate with the State's Money Follows the Person (MFP) Demonstration focusing on the transition of individuals from institutional-based care to a person-centered quality system for home-based quality care.

The application process will begin in 2014 and will include a letter of intent, a formal application for Certificate of Authority followed by readiness review and a contract. The readiness review is to ensure the DISCO is ready to begin coordinating services. Throughout this document, we use the term 'enrollee' to mean the person who voluntarily enrolls in the DISCO. Where permitted an enrollee may be represented by his or her authorized representative.

At the onset of the application process, those DISCO applicants who have successfully completed section Five (V) of Attachment 10 of this document (Request for Grant Applications - Managed Care Start-Up Costs for DISCOs) will be eligible to apply for DISCO startup grant funds. All terms and procedures for grant application are outlined in Attachment 10 including the window of time during the Certificate of Authority application process that start up grant applications will be accepted. All applications for grant funding must be received by the OPWDD by the November 1, 2014 deadline as outlined by the timeline in Attachment 10

of this document.

What is a Developmental Disabilities Individual Support and Care Coordination Organization?
Managed Care operations in New York State are governed by Public Health Law Article 44, Mental Hygiene Law §13.40, Social Services Law §364-j; DOH regulations at 10 NYCRR Subpart 98-1, and federal managed care regulations at 42 CFR Part 438. OPWDD's establishment of DISCOs will comply with these statutes and regulations. In addition, OPWDD and DOH will work closely together in reviewing applications for certificates of authority, in DISCO readiness reviews and in continuing DISCO oversight.

A DISCO applicant must be controlled by one or more non-profit organizations with a history of providing or coordinating health and long term care services to persons with developmental disabilities. The expectation is that the leadership of the DISCO (board members and officers) will have extensive experience coordinating care for individuals with Intellectual/Developmental Disabilities (I/DD). Experience coordinating care for individuals with developmental disabilities will be evaluated based the member of the DISCO leadership's overseeing and operating entities that deliver Medicaid Service Coordination, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and/or HCBS waiver services that are in good standing with OPWDD.

The DISCO and all its network providers, with which it enters into provider contracts, will be required to be in compliance with all applicable State and federal licensing, certification, and other requirements. These networks must have demonstrated capacity to perform the needed services. For network providers under the jurisdiction of OPWDD, competence will be demonstrated with acceptable OPWDD survey and fiscal reviews.

The DISCO must maintain an administrative and organizational structure that supports high quality supports and services and comprehensive care coordination. The management structure should ensure effective linkages between administrative areas: Quality Management, Network Development and Contracts Management, Information Technology (Utilization Review), Enrollment / Disenrollment, Care Coordination, Accounts Receivable / Accounts Payable, and Budget, Finance and Accounting. A complete description of a DISCO's areas of responsibility will be identified in its contract with New York State that has been published separately, and may be found at http://www.opwdd.ny.gov/node/5569.

Application and Timeline
This Plan Qualification Application is being published at this time to begin the qualification process for approval of DISCO plans. The timetable for final approval of the applications and COA authorization is dependent on the approval by the Centers of Medicare and Medicaid Services (CMS) of both OPWDD's new 1915 (b) Waiver and amendments to its 1915 (c) Waiver, but it is the intent of OPWDD that DISCO contracts will be negotiated and signed for enrollments beginning approximately October 1, 2015. Questions regarding this document may be addressed to the People First Waiver Unit, at peoplefirstwaiver@opwdd.ny.gov.

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Qualification APPLICATION
FOR A CERTIFICATE OF AUTHORITY FOR A DISCO

I. REQUIRED ORGANIZATION AND MANAGEMENT OF PROPOSED DISCO

A. ORGANIZATIONAL STRUCTURE

In its application for a Certificate of Authority (COA) to be a DISCO, the potential DISCO must describe in detail its organizational structure which includes an organization chart with explanation of lines for authority. Identify the legal entity that will be responsible for the DISCO. The required forms and format are described in Attachment 1.

B. MANAGEMENT OF THE DISCO AND GOVERNING BOARD

In its application for a COA to be a DISCO, the potential DISCO must provide a list of names, addresses and official positions of the members of the board of directors, members, officers and Medical Director. The required forms and format are described in Attachments 1 and 5.

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 NYSDOH guidelines (as published at http://www.health.ny.gov/health_care/managed_care/pdf/mgmt_contract_guidelines.pdf). 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.

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

During the application process to become a DISCO, a review will be conducted to ensure that the proposed governing board and operators, and the incorporators, stockholders and members are of such character, experience, competence and standing in the community as to give reasonable assurance of their ability to conduct the affairs of the proposed DISCO in the best interests of the DISCO and in the public interest, and to provide proper care for enrollees. The character, experience, competence and standing of the operators, board members, stockholders and members will be reviewed throughout the time the DISCO is operating. Attachment 1 includes instructions for completion of required forms for the COA application.

II. GOVERNING BOARD

The DISCO applicant must provide with its application a copy of its Certificate of Incorporation and by-laws of the corporation, including any additional information necessary to provide sufficient information in determining power structure of the board. In addition, if the corporate bylaws do not include of the governing board responsibilities, then the applicant must also provide a copy of the governing board bylaws.

The Governing Board is responsible for establishment and oversight of the DISCO's policies, management and overall operation, regardless of the existence of any management contract. The board's ability to delegate certain management functions is subject to NYS regulations, 10 NYCRR §98-1.11 (i). Each board member of the DISCO must also participate in OPWDD-required abuse and incidents training within three months of becoming a board member. In keeping with the current requirements for Board Members of entities that provide Medicaid Service Coordination (MSC), this training is required onetime for each Board Member.

DISCO Governing Boards must meet to conduct the business of the DISCO at least four times per year (once each quarter) and more often if necessary. In keeping with existing DOH regulations:

- Within one year of the DISCO becoming operational, at least 20 percent of the members of its governing board must be individuals served by the DISCO or family members or advocates, **OR**
- As an alternative to or in addition to individual/advocate board membership, an advisory council may be created that has direct input to the governing board.

In its application for COA, the applicant must list the members of the governing board. Indicate whether members are residents of New York State and 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. In addition, the application must describe how many members are required for a quorum, and how often the board will meet.

III. SERVICE AREA

In its application, the potential DISCO must describe the service area, identifying the counties included in the proposed service area. Include a rationale for selection of this service area.

IV. TARGET POPULATION

Qualified individuals of all ages living in the area served by the DISCO will be eligible to enroll in the DISCO, with the authorization of OPWDD. An individual will qualify for enrollment, if he or she has a developmental disability, meets ICF/IID level of care and is Medicaid-enrolled. This includes those enrolled in both Medicaid and Medicare. Specifically, this includes individuals now receiving:

- OPWDD 1915(c) Comprehensive Waiver Services
- ICF/IID services
- OPWDD Targeted Case Management (MSC)
- Other long term support services (e.g., personal care) under the auspice of state agencies other than OPWDD.

Initially, OPWDD does not intend to enroll individuals who meet the above qualifications and who live in a skilled nursing facility, OASAS or OMH facility, a Developmental Center, or a private psychiatric hospital. However, if an individual who is already enrolled with a DISCO enters one of these settings, the DISCO will be expected to pay for the service, while working with the individual to ensure that he or she lives in the most integrated setting possible.

As part of the application for a COA, the applicant must submit a market analysis of the proposed service area and a plan that includes the following information.

- Describe in detail the size and characteristics of the proposed target population to be enrolled in the DISCO. 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.
- Describe the approaches that the applicant will use to outreach to prospective members. Activities must be consistent with §98-1.19 of 10 NYCRR, Medicaid requirements and any other federal requirements.
- Describe the training that will be conducted for marketing/outreach staff. Describe how the applicant will monitor the activities of its outreach staff.

V. 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.

VI. SERVICE DELIVERY NETWORK

As part of the COA application, the DISCO applicant must provide a chart of the proposed provider network that identifies whether a provider is a related or non-related entity. Each DISCO, consistent with the scope of the DISCO's contracted services, must maintain and monitor a network of appropriate providers that is supported by written agreements that provide for the following covered benefits. A DISCO must have a network of providers that have specialized expertise serving individuals with developmental disabilities, including any special populations. Consideration will be given to development of networks based upon the availability of providers in the proposed service area. Below are listed the covered services:

- Adult Day Health Care
- Audiology and Hearing Aids
- Care Management (provided by the DISCO)

- Clinic Social Worker
- Day Treatment
- Dentistry (including services delivered in inpatient and ambulatory surgery settings)
- Durable Medical Equipment (includes "traditional" DME, such as wheelchairs, as well as: medical/surgical supplies, enteral and parenteral formulae, orthotics, prosthetics, prescription footwear and hearing aid batteries).
- Home Care (Nursing, Home Health Aide, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Medical Social Services) (delivered by hospital-based, nursing home-based, and free-standing programs)
- Inpatient Substance Abuse Services
- Inpatient Psychiatric Services (includes services delivered in state psychiatric centers, residential treatment facilities for children, and inpatient psychiatric services delivered by public and private hospitals or by subdivisions thereof)
- Intermediate Care Facility/Developmental Disability
- Non Emergency Transportation
- Non-Medical[1] Services in Hospital-based and Freestanding Clinics certified by NYS Office of Alcohol and Substance Abuse Services (OASAS)
- Non-Medical[2] Services in Hospital-based and Freestanding Clinics certified by NYS Office of Mental Health
- Non-Medical[3] Services in Hospital-based and Freestanding Clinics certified by NYS OPWDD
- Nutrition
- Optometry/Eyeglasses
- Occupational Therapy, Physical Therapy, Speech and Language Therapy, Rehabilitation Counseling services
- Personal Care (including consumer directed personal assistance)
- Personal Emergency Response System
- Podiatry
- Private Duty Nursing
- Psychology
- Rehabilitation Option programs certified by NYS Office of Mental Health, excluding licensed residential services
- Respiratory Therapy
- Skilled Nursing Facility

In addition, services described in the OPWDD Comprehensive 1915 (c) waiver will also be included in the benefit package for enrollees also enrolled in that waiver program. The benefit package shall exclude all services authorized and delivered under the Early Intervention (EI) and School Supportive Health Services (SSHS) programs. People enrolled in a DISCO shall continue to have authorized EI and SSHS services reimbursed fee-for-service.

In its review of network capacity, OPWDD and DOH will assess the degree to which the DISCO applicant's proposed network providers are capable of delivering services in a manner that is responsive to cultural considerations of the community, and to address the specific cultural and language needs of its enrollees. See Attachment 2 for further information regarding cultural competence and Attachment 3 for the form for identifying the network providers.

[1] In this context, "non-medical" shall refer to services not delivered by a physician (including physician specialists such as psychiatrists, physiatrists, and neurologists), physician assistant, or nurse practitioner.
[2] Ditto
[3] Ditto

Model Provider Contracts between DISCOs and providers must be approved pursuant to NYS law and regulation. For informational purposes, Provider Contract Guidelines can be found at: http://www.health.state.ny.us/nysdoh/mancare/hmoipa/hmo_ipa.htm. These contract guidelines will be up-dated to reflect requirements for DISCOs. NYS will inform applicants when the new template information is available. Prior to certification, all DISCO applicants must submit one signed copy of each model contract with 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.

Continuity of Care Requirements

DISCOs must meet continuity of care standards for services under OPWDD auspices. This means a DISCO will have to pay a person's current provider of non-residential services the OPWDD rate for that service for 90 days after the person enrolls in the DISCO, and will have to pay a residential facility the OPWDD rate as long as the person lives in the facility under an approved plan of care.

VII. ENROLLMENT MONITORING AND DISENROLLMENT REPORTING

The DISCO will be required to provide certain reports in a form and format required by the State, so that the State can ensure adequate capacity and access for the enrolled population and ensure that satisfactory administrative and management arrangements are in place. Reports may include but are not limited to information on: availability, accessibility and acceptability of services; enrollment; enrollee demographics; disenrollment; enrollee health and functional status (including the Developmental Disabilities Profiles (DDP) or NYS OPWDD Coordinated Assessment System (CAS) or any other such instrument the Department of Health or OPWDD may request); service utilization; encounter data, enrollee satisfaction; outreach; grievance and appeals; and fiscal data.

The DISCO must accept persons enrolled by OWPDD or its enrollment broker into the DISCO in the order in which applications are received from OPWDD or its enrollment broker and must not discriminate on the basis of need for services, intensity of need, health status, race, color or national origin. The DISCO cannot use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

Persons enrolled in a DISCO may change enrollment at any time without cause by requesting, either personally or through an authorized representative, to be disenrolled from the DISCO.

The DISCO may also request that a person be disenrolled, but only for the reasons specified in the contract between the State and the DISCO. The DISCO will not be able to request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the DISCO seriously impairs the DISCO's ability to furnish services to either this particular enrollee or other enrollees). The DISCO must submit the request for disenrollment in writing to OPWDD. The disenrollment will not be effective until approved by OPWDD. In addition, the DISCO must assure the State that it does not request disenrollment for reasons other than those permitted under the contract.

A beneficiary will be automatically reenrolled with the same DISCO if he or she is disenrolled solely because he or she loses Medicaid eligibility for a period of 3 months or less.

VIII. INFORMATION

The DISCO must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that can be easily understood. The DISCO must also have in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the DISCO's plan. The use of all written materials that are written in twelve (12) point type at a minimum and prose written in clear, simple, understandable language at the 4th to 6th grade reading level.

The DISCO must make its written information available in those prevalent non-English languages in its service area. Languages spoken by at least 5% of the plan's target population, or 50 members, whichever is less, will be included for translation.

The DISCO must make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent.

The DISCO must notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.

The DISCO's written materials must use easily understood language and format, and must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The DISCO must inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

The DISCO must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who was seen on a regular basis by the terminated provider.

Prior to enrollment in a DISCO each enrollee and/or his or her authorized representative must sign an enrollment agreement which indicates that he or she:

- received a copy of the member handbook which included the rules and responsibilities of plan membership and which expressly delineates covered and non-covered services;
- agreed to the terms and conditions for plan enrollment stated in the member handbook;
- understood that enrollment in the DISCO is voluntary;
- received a copy of the DISCO's current provider network listing and agreed to use network providers for covered services; and
- was advised of the projected date of their enrollment.

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)

- Outreach materials including brochures, advertising, radio/TV scripts, websites

IX. UTILIZATION MANAGEMENT AND REVIEW SYSTEMS

The applicant must provide detailed description of the DISCO's service authorization/utilization review plan. In the developmental disabilities service arena, utilization review is critical to ensure that the needs of enrollees are met and that services are provided in the most integrated and appropriate setting to meet the person's needs. Specific utilization review functions can include:

- Assuring maximum system use of available community-based and integrated services, based on needs of the enrollee;
- Providing direction and linking to care coordinators, the enrollee or advocates and caregivers regarding services that promote the objectives of the People First Waiver;
- Developing and disseminating aggregate reports showing uses (and costs) of services and other characteristics along with trends;
- Recommending system, service or provider changes based on utilization data and reports.

These functions may be carried out by the DISCO or subcontracted to another entity. Note that if utilization review is delegated, the contractor performing the utilization review must be reviewed by OPWDD and subsequently must be registered with SDOH as a utilization review agent in accordance with §4901 of the Public Health Law.

X. QUALITY ASSURANCE PROGRAM

The DISCO must have a quality assurance and performance improvement program and an approved written quality plan for ongoing assessment, implementation, and evaluation of overall quality of care and services. The quality assurance and performance improvement program must identify specific and measurable activities to be undertaken by the DISCO. The DISCO's written quality plan must meet the requirements of Mental Hygiene Law §13.40, Article 44 of Public Health Law and implementing regulations and address the standards in 42 CFR 438.240 regarding quality assurance and performance improvement and must be reviewed and approved by the Commissioner of OPWDD in advance of operating approval.

The quality plan must provide for board level accountability for overall oversight of program activities and review of the QA/PI program, annual review and approval of the program, and allow for periodic feedback to the board from oversight committees. The goals and objectives for quality assurance and improvement activities should be reviewed and revised periodically, and be supported by data collection activities which focus on clinical and functional outcomes, encounter and utilization data, and client satisfaction data.

A. The applicant must 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.

The Quality Plan Guidelines for DISCOs (described in Appendix I of the DISCO contract) will include a discussion of how the DISCO will ensure adherence to applicable HCBS Waiver Assurances for enrollees who are also enrolled in the 1915 (c). The assurances are:

- Level of Care - Persons enrolled in the waiver have needs consistent with an institutional level of care
- Service Plan - Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan
- Qualified Providers - network providers are qualified to deliver services/supports
- Health and Welfare - Participants' health and welfare are safeguarded and monitored

The Quality Plan Guidelines will also explain how DISCOs will measure the achievement of Council on Quality and Leadership's Personal Outcome Measures (POMs) for a sample of the individuals they support as a means of assessing how well they are supporting individuals to achieve their desired outcomes through effective person-centered planning and coordination of care.

B. In its application, the potential DISCO must identify the routine data reports and other data sources that will be used to identify quality assurance successes and problems.

C. The applicant must also 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.

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 DISCO policies for provider participation;
2. The quality assurance manual (see Quality Assurance Guidance Attachment 6)
3. Policies and procedures describing the DISCO's process to evaluate the performance of contracted health care and habilitation? providers; and
4. Policies and procedures used by the DISCO to terminate providers.

XI. UTILIZATION CONTROL AND REVIEW SYSTEMS

Provide detailed description of the DISCO's service authorization/utilization review plan. A DISCO does not register with SDOH as a utilization review agent, however, the DISCO 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

XII. 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 Department of Health, Office of Temporary and Disability Services, and the Department of Financial Services. DISCO applicants must provide a detailed description of the grievance system. The grievance system must include:
   1. Methods for educating enrollees and authorized representatives as to the grievance system;
   2. Methods for handling complaints and grievances by enrollees and authorized representatives 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 DISCO contract and PHL 4408-a must be reflected in these policies and procedures. The policy must include the identification of DISCO 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 3 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 recertification 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.

XIII. ASSESSMENT OF PROSPECTIVE MEMBERS

OPWDD is now working on the development of a new assessment tool, the Coordinated Assessment System (CAS) and once the design and roll-out of the new tool is complete, it will be in use throughout the OPWDD service system. OPWDD will be responsible for completing an initial

assessment with individuals and their circles of support. This information will be provided to the DISCO, and the care coordinator will use this initial assessment information along with other information to assist with the development of a person-centered Individualized Service Plan (ISP) and monitoring of the ISP. The DISCO will be responsible for subsequent assessments under the oversight of OPWDD.

The DISCO will be expected to participate in the roll-out of the new assessment instrument and to ensure that the current instrument (the DDP2) is completed for all enrollees in accordance with current OPWDD written guidance regarding DDP completion. The CAS is being used in limited case studies that will help OPWDD finalize the assessment tool for wider use. OPWDD will subsequently develop a plan for rolling out the final CAS for system-wide use over several years. Once the CAS is finalized, OPWDD will define the qualifications of those who can complete assessments using the CAS and will provide the DISCO with the manual and with required training relevant to completing the CAS to ensure consistency of assessment practices.

During the application process, the DISCO applicant will be expected to describe the qualifications of the staff performing the reassessments; as well as the process for ensuring the completeness and accuracy of the assessment forms. In addition, the applicant will describe any triggers for reassessment. The DISCO must describe the functional behavior assessment tool that will be used if such an assessment is necessary in accordance with Part 633.16. If other assessment tools will be used in addition to the DDP and CAS, the applicant will need to name the tools and whether these additional instruments will be used to assess special populations.

The DISCO applicant must describe how it proposes to conduct the reassessments of existing members. Include in the description:

- 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 Developmental Disabilities Profile (DDP) or the Comprehensive Assessment System (CAS) now under development) to assess needs and risk level. Include specific instruments to be used to assess special populations.

XIV. CARE MANAGEMENT

Care management entails the development of a written care plan, using person-centered planning and having a way for the enrollee to be able to make informed choices, either personally or through an authorized representative, in the development of this plan. Care management also entails the implementation of the plan and assisting the enrollee to access services that have been identified through the plan. Care management is a critical component of the DISCO, and therefore during the application process the DISCO's approach to providing care management to its members will be assessed. The intent of this readiness review is to assure that the DISCO is prepared to work with enrollees and families, so that each person's needs are identified, linkages are made to needed services, services are monitored and care plans amended if the person's valued outcomes are met or needs change. The overall person-centered approach should address the person's desired outcomes and the long-term support services that will help the person obtain those outcomes, and his or her physical and behavioral health needs. The readiness review will also assess the methods and tools for ongoing monitoring of health and safety of enrollees. The care management system will also be evaluated for its ability to make out-of-network referrals and arrange for the continuation of existing care relationships with out-of-network providers (during a transitional period for non-

residential services), as required.

In the COA application, the potential DISCO must 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:

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. Please be aware that the parameters for delegating care management will be provided at a later date, any applicants considering such arrangements should contact the OPWDD waiver unit for guidance.

- The organizational description of care management should demonstrate how organizational firewalls and DISCO policies and procedures will support the provision of conflict free care management. Guidance is forthcoming regarding conflict free case management standards but will include requirements that family members do not serve as care managers.

- The plan's approach to providing care management to its members that assures that valued outcomes and 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 identified valued outcomes must be categorized within the broad categories identified in the Council on Quality and Leadership's Personal Outcome Measures (POMs). The Personal Outcome Measures (POMS) will be used to identify the habilitative outcomes that are most important for the person, and that the person has supports in place to assist in achieving the identified outcomes. 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.

- 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?

- The proposed methodology for employing varying levels of care management dependent on assessed need, including behavioral and health needs and the availability of and satisfaction with 24/7 residential supports. Describe the levels and how members will be evaluated and monitored for each level and the methods for assuring that changes in level of care management are implemented immediately with the changing needs of the person. In no instance will the ratio of care manager to individuals serve exceed one-to-one hundred (1-to-100).

- 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 an Individualized Service Plan (ISP) that is maintained in an electronic format. The applicant should 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

The effectiveness of the DISCO's care management provision will be assessed as a component of its on-going Quality Improvement (QI) Plan. OPWDD will conduct an annual on-site review of the effectiveness of every DISCO's care coordination function. During this review, a statistically valid sample of all individuals served by the DISCO will be selected and OPWDD will review the overall effectiveness of care coordination to produce results that reflect the person's assessed needs, communicated choices and preferences. The on-site care coordination review will include a record review, interviews with the person and their advocates/circles of support, and interviews with the DISCO personnel and staff engaged in the care coordination function. This review may also include operational and administrative elements included in the DISCO contract such as a review of the QI Plan, policies and procedures, and grievance systems.

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.

Willowbrook Class members

If a DISCO enrollee is a member of the plaintiff class in the Willowbrook litigation, the DISCO will have to ensure that all services the DISCO provides or arranges for such enrollee meet the requirements of the Permanent Injunction in the such litigation, entered in the United State District Court for the Eastern District of New York on March 11, 1993.

XV. Support of OPWDD Transformation Goals

In its application for a COA, the DISCO candidate will be asked to describe:

A. SELF-DIRECTION AND INDIVIDUALIZED BUDGETING

OPWDD is committed to making self-directed services available to all people who choose to enroll in a DISCO. As part of the application process, the DISCO will provide a description for how it will offer and promote self-direction to all enrollees, how individuals and families will be educated about self-direction and the supports that will be made available to make self-direction accessible for the largest number of individuals possible.

B. PERSON-CENTERED PLANNING

The person served by the DISCO will have an Individualized Service Plan (ISP) that is developed by the care coordinator, the person and the person's circle of support. The DISCO will use a person-centered planning process to develop the ISP. As part of the DISCO application process, the DISCO applicant must describe how person-centered planning will be provided to the enrollee and how the use of person-centered planning principles will be promoted and supported within the organization. The description should include the training that will be made available for care management staff, individuals and families. The discussion should also address how the DISCO will ensure that the person-centered planning process incorporates measurable individual outcomes that are meaningful to the person and in the areas of home, health, meaningful relationships, and meaningful employment/community activities.

C. PROMOTION OF PRODUCTIVE COMMUNITY PARTICIPATION INCLUDING COMPETITIVE EMPLOYMENT

OPWDD's vision includes supporting individuals with Intellectual and Developmental Disabilities to fully participate in their communities including employment. As part of its application, the DISCO applicant will be asked to describe the process and methods that will increase volunteerism and employment for enrollees.

XVI. ENROLLMENT AND DISENROLLMENT

The DISCO must process enrollments in the order in which they are received and must not discriminate on the basis of health status. Enrollment will be done by the OPWDD regional office or contracted enrollment broker, and prior to enrollment in a DISCO each enrollee or authorized representative must sign an enrollment agreement which indicates that the enrollee:

- Received a copy of the member handbook which included the rules and responsibilities of plan membership and which expressly delineates covered and non-covered services;

- Agreed to the terms and conditions for plan enrollment stated in the member handbook;
- Received a copy of the DISCO's current provider network listing and agreed to use network providers for covered services;
- Was advised of other plan options in the Enrollee's service area;
- Understands that enrollment is voluntary; and
- Was advised of their projected date of enrollment.

In the application for the COA, the DISCO applicant must describe the enrollment process that includes in the description the following:

- The timeframe for completing an initial face-to-face meeting after the enrollment 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

A person may opt to disenroll from the DISCO for any reason, and the disenrollment will take effect no later than the close of the month following the month in which the request was made. The DISCO may also request that an individual be disenrolled involuntarily, but OPWDD will review any such request and the disenrollment will not be effective without OPWDD approval. All due process rights must be provided to the enrollee, and services must continue until all appeals process have been concluded.

DISCO applicants in the COA application must also provide a description of the process of disenrollment from the DISCO. Include in the disenrollment policy reasons for disenrollment and the procedure for voluntary and involuntary disenrollments. Enrollment/Disenrollment policy and procedures and the forms and notices the applicant intends to use to inform members of DISCO actions must be submitted and approved prior to the readiness review.

XVII. ADA COMPLIANCE PLAN

DISCOs must comply with Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 for program accessibility. As part of the DISCO application process an ADA Compliance Plan must be submitted that describes in detail how the DISCO 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 DISCOs review and use the guidelines in preparation of their ADA Compliance Plan. DISCOs must develop an ADA Compliance Plan consistent with SDOH guidelines which can be found in the Model Contract. The ADA Compliance Plan must be approved by DOH and filed with the state prior to the readiness review along with the completed ADA check list in Attachment 5.

XVIII. FINANCIAL REQUIREMENTS

A. General Financial Requirements

DISCO entities must have initial capital sufficient to comply with Regulations under development regarding escrow and contingent reserve requirements on an ongoing basis. In keeping with existing regulations in section 98-1.11, they must fund cumulative operating losses sustained through the time the break-even point is reached and provide additional resources to cover unanticipated losses. At a minimum estimated start-up capital funding must be sufficient to fund the following: Pre-operational Expenses, Cumulative Net Losses until month of Break-Even, and an additional capital margin for unanticipated losses calculated based upon 5% of projected service expenses for the 12-month period after reaching financial break-even.

DISCO applicants must identify the source(s) 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 8 for guidelines and principles). The proposed loan document must be submitted for review and approval by the state. 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.

B. Reserve and Escrow Requirements

All DISCOs are subject to the reserve and escrow requirements in 10 NYCRR §98-1.11(e) and (f) with the exception of the initial 2 years of operations as described in the following paragraph. The DISCO is a partially capitated plan closely modeled after the New York State Managed Long-Term Care Plan (MLTCP) and will, accordingly, be afforded similar contingent reserve requirements as those in place for these plans. Specifically, three provisions will establish that:

- The contingent reserve for DISCOs will be set and maintained at 5% of net premium income (NPI). (Typically, MCOs other than Managed Long-Term Care Programs [MLTCPs] have their contingent reserve graduate to 12.5% of NPI over seven years.);

- The escrow deposit will be phased in over three years – 3%, then 4% and finally 5% of the estimated expenditures for health care services (Typically, the escrow deposit for MCOs starts at 5% and remains at 5%.); and

- The portion of the premium derived from certified residential services under the auspice of OPWDD will be at least partially excluded from the contingent reserve calculation.

DISCOs will be allowed to exclude the premium income associated with Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) from the calculation of their contingent reserve requirements. DISCOs will also be able to exclude up to 50 percent of the premium income associated with HCBS certified residential habilitation services from their contingent reserve calculation. These allowances recognize OPWDD's direct control of the number of certified residential opportunities in each region and the development of standardized regional fees for residential services. These regional fees will be the basis of establishing the per member, per month (PMPM) payment to the DISCOs and also establish the payment floor from DISCOs to their network providers.

C. Minimum Net Worth

The DISCO must maintain a minimum net worth equal to the greater of the escrow requirement or the contingent reserve.

OPWDD intends to establish risk sharing arrangements with DISCOs in order to mitigate risk for these entities. The final design will be established as part of the actuarial rate development process.

D. **Initial Rates:** Initial rates will be available and posted on the OPWDD website to allow applicants to provide the following financial data for the proposed DISCO 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.

E. 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 DISCO's Article 44 Certificate of Authority shall be clearly distinguished from any other function, activity or service of the DISCO or related parties. Include a description of the methodology the DISCO will use to estimate the cost of Incurred But Not Reported (IBNR) claims and claims reported but not paid. The DISCO applicant should describe its policy, including time frames, of writing off IBNR estimates after the claims run out has expired.

XIX. 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 availability of a full electronic record system that integrates all services on a single platform, with the following features:
    a. Electronic records are integrated into the person's electronic ISP.
    b. Program planning must include a Personal Outcome Measures based on OPWDD guidance (Attachment 7) with corresponding outcomes set by the member and his/her circle of support that are identified in the electronic ISP.
    c. Ability for alerts to be shared between network providers and the care coordinator
    d. How the individual and/or family will have access to care plan information via a web based 'portal' or through other means.

4. 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 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.

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

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

In keeping with information system policy for NYS, DISCO applicants must demonstrate how the organization will come into compliance with the current version of the Statewide Policy Guidance, which includes common information policies, standards and technical approaches governing health information exchange. It is expected that all successful DISCO applicants will come into compliance with final health information technology (HIT) requirements within 24 months of becoming operational or have a plan for doing so. Final HIT requirements include:

- Structured interoperable HIT to support a Plan of Care for every individual,
- Certified Meaningful Use EHR, allowing patient's health information and plan of care to be accessible,
- Compliance with current/future version of Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm,
- Commitment to joining RHIO/QE,
- Use of evidence based clinical decision making tools, consensus guidelines, and best practices.

Attachment 1. Application Instructions

The application process to become a DISCO will require that applicants complete a certificate of authority application as is now done for entities seeking to become Managed Long-Term Care Programs (MLTCPs) under the auspice of DOH. Entities applying as a DISCO must complete **all** sections of this Certification Application including forms DOH-793A-MLTC/DISCO, 793B-MLTC/DISCO, 793C-MLTC/DISCO and 794-MLTC/CC. These forms and detailed instructions follow.

Successful applicants will be issued a Certificate of Authority and will be required to enter into a contract with the state before enrolling members. A readiness review will be conducted prior to a DISCO beginning enrollment. Additional programmatic requirements (e.g. policies and procedures, member materials) will be required before the readiness review. Many of these are noted in the instructions below.

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 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.

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/DISCO form and include the signatures of the individuals who are authorized to submit an application on behalf of the proposed DISCO. 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.

The application must be /submitted to:

Contract Management Unit
Office for People With Developmental Disabilities
44 Holland Avenue, 3rd Floor
Albany, NY 12229

Attachment 2. Guidance Regarding Cultural Competence

Culture refers to the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, ways of interacting, roles and relationships, customs and expected behaviors, beliefs, values, practices, customs and institutions of racial, ethnic, religious, or social groups.

Cultural Competence implies having the capacity and ability to have impact by functioning effectively and efficiently as an individual and an organization to respect and affirm cultural differences within the context of the cultural beliefs, behaviors, and needs presented by the diversity of consumers and their communities.

Culture defines: how rights and protections are exercised; how health care information is received; how health problems are defined; how symptoms and concerns about problems are expressed; how disability is defined; how appropriate service providers are determined; and, how types of treatment, services and solutions are determined and provided.

How Cultural Competence will be Assessed

Applicants must submit evidence demonstrating the demographic characteristics of the population to be served, for example, U.S. Census data on the racial and ethnic characteristics of the proposed population. Based on this data, the applicant must submit a detailed plan with measurable goals and objectives demonstrating how it will arrange for and provide individuals and families of different cultures with effective understanding and respectful services, including information on self direction, in a culturally and linguistically competent manner consistent with the definition of these terms within this RFA. Such evidence may include:

- Training of DISCO staff and board members in recognizing and becoming sensitive to the cultural needs of proposed enrollees and enrollees;
- Strategies that will be used to recruit, hire and retain care coordinators who are culturally and linguistically competent specific to the diversity of the proposed population;
- Employing directly or by contract, staff responsible for grievance and appeals processes, who are culturally and linguistically competent to meet the needs of each individual enrollee filing a grievance or appeal;
- The inclusion of providers in the provider network with governance or advisory board structures that represent the cultural diversity of the proposed enrolled population;
- Provider education on cross-cultural issues;
- The use of care coordinators who are culturally and linguistically competent specific to the diversity of the proposed enrolled population;
- The training of care coordinators in recognizing and meeting cultural needs of proposed enrollees and enrollees;

Attachment 3. Provider Network

Network Adequacy Requirements

In establishing the network, the Contractor must consider several factors when evaluating the necessary size and makeup of the provider network responsible for providing services to plan enrollees. These include:

1) Anticipated volume of enrollment
2) Expected utilization of services by the population to be enrolled
3) The number and types of providers necessary to furnish the services in the benefit package
4) The number of providers who are not accepting new patients, and the geographic location of the providers and enrollees

The following table outlines minimum requirements for provider coverage in all instances; however, a contractor's network will be assessed not only on the minimum standard but also in regard to the elements noted above. An example when the minimum may be sufficient could be if the anticipated enrollment will be at a level that would only require the minimum number of providers. If the anticipated enrollment is higher, the minimum will need to be exceeded.

Please note: When the required number of providers are not available in a coverage area, the DISCO must attest in writing that enrollees have access to needed services, demonstrating how this access is available.

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Adult Day Health Care	In NYC Metro area, three (3) per county/Borough. Rest of State, Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice	NA	NA	NA
Care Management (provided by the DISCO)	NA	NA	NA	NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Clinical / Therapuetic Services •**Clinic Social Worker** •**Audiology & Hearing Aids** •**Nutrition** •**Occupational Therapy,** •**Physical Therapy,** •**Speech & Language Therapy,** •**Rehabilitation Counseling services** •**Optometry/Eyeglasses** •**Podiatry** •**Private Duty Nursing** •**Psychology** •**Respiratory Therapy**	Sufficient clinicians within each discipline to offer, within each county, choice of two clinicians accepting new Enrollees, unless the county has an insufficient number of clinicians licensed, certified or available in that county as determined by the Department. Clinical/therapeutic services may be provided in any venue: private practice, hospital-based clinic, free-standing clinic under the auspice of OPWDD, OMH, DOH or OASAS.	Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice		Enrollees with appointments shall not routinely be made to wait longer than one hour indicated	**Non-urgent** mental health or substance abuse visits with a Participating Provider (as included in the Benefit Package): within two (2) weeks of request. **Pursuant to an emergency or hospital discharge**, mental health or substance abuse follow-up visits with a Participating Provider (as included in the Benefit Package): within five (5) days of request, or as clinically necessary

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Day Treatment	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice	NA	NA	
Dentistry (including services delivered in inpatient and ambulatory surgery settings)	The network must include 2 dentists with expertise in serving special needs populations. Free Access to academic dental centers (per 364-j and mltc contract)	Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice.	At least: one (1) pediatric dentist and one (1) oral surgeon. Orthognathic surgery, temporal mandibular disorders (TMD) and oral/maxillofacial prosthodontics must be provided through any qualified dentist, either in-network or by referral. Periodontists and endodontists must also be available by referral.	Enrollees with appointments shall not routinely be made to wait longer than one hour	**Emergency care-** immediately upon presentation at service site **Non-urgent 'sick' –** 48 to 72 hours within request as clinically necessary **Routine or preventative –** within 4 to 6 weeks

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Durable Medical Equipment (includes "traditional" DME, such as wheelchairs, as well as: medical/surgical supplies, enteral and parenteral formulae, orthotics, prosthetics, prescription footwear and hearing aid batteries).	At least one (1) provider	NA	NA	NA	
Home Care (Nursing, Home Health Aide, Occupational Therapy, Physical Therapy, Speech and Language Therapy, Medical Social Services) (delivered by hospital-based, nursing home-based, and free-standing programs)	At least one agency that is accepting new Enrollees in each county, with the availability of a choice of at least Two (2) staff persons within the agency. (MMC)	NA	NA	NA	
Inpatient Substance Abuse Services	At least one (1) per region (i.e., when the DISCO spans two regions, there must be at least one contracted provider in each region). [4]	NA	NA	NA	

1. [4] For the purpose of network adequacy review, the regions are: **Capital District:** Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington. **Central New York Region:** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga and Tompkins. **Metropolitan Area:** Bronx, Kings, New York, Queens, Richmond, Dutchess, Nassau

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Inpatient Psychiatric Services (includes services delivered in state psychiatric centers, residential treatment facilities for children, and inpatient psychiatric services delivered by public and private hospitals or by subdivisions thereof)	At least one (1) per region (i.e., when the DISCO spans two regions, there must be at least one contracted provider in each region)	NA	NA	NA	
Intermediate Care Facility/Individual with Intellectual Disabilities – Developmental Center	At least one (1) per region (i.e., when the DISCO spans two regions, there must be at least one contracted provider in each region)	NA	NA	NA	
Intermediate Care Facility/Individual with Intellectual Disabilities – Community Based	Provided in state-certified setting, access based on priority need and local availability. Those not provided ICF/IID in a certified setting have needs met through alternative services in more integrated settings.				
Non Emergency Transportation	At least one (1)	NA	NA	NA	

Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester. **Western Region:** Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, and Yates.

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Personal Care (including consumer directed personal assistance)	At least one (1) PC and (1) CDPAP agency that is accepting new Enrollees in each county in its service area, with choice of at least two (2) staff persons within each agency.	NA		NA	
Personal Emergency Response System	At least one (1)	NA		NA	
Rehabilitation Option programs certified by NYS Office of Mental Health, excluding licensed residential services	At least one (1) agency that is accepting new Enrollees in each county in its service area, with choice of at least two (2) staff persons within each agency.	Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice		Enrollees with appointments shall not routinely be made to wait longer than one hour	
Skilled Nursing Facility	Two (2) that are accepting new Enrollees in each county (3 in metropolitan NYC area) in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MMC)	NA		NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Day Habilitation	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	When delivered in a certified location: Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice	NA	NA	
Live-in Caregiver (42 CFR §441.303(f)(8))	NA	NA	NA	NA	
Prevocational Services	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	When site-based program: Travel time/distance shall not exceed thirty (30) minutes/thirty (30) miles from the Enrollee's residence. Transport time and distance in rural areas may be greater than thirty (30) minutes/thirty (30) miles from the Enrollee's residence if based on the community standard for accessing care or if by Enrollee choice	NA	NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Residential Habilitation	Provided in state-certified setting, access based on priority need and local availability. Those not provided residential habilitation in a certified setting have needs met through alternative services in more integrated settings.	NA	NA	NA	
Respite	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA – service may be site-based or provided in family home	NA	NA	
Supported Employment (SEMP)	The DISCO must include all DDRO approved brokers in their network allowing the individual choice of available broker.	NA	NA	NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Agency with Choice/Financial Management Services (AWC/FMS)	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Consolidated Supports and Services	NA	NA	NA	NA	
Support Brokerage	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Assistive Technology - Adaptive Devices	At least one (1) provider – option for DISCO as provider	NA	NA	NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Community Habilitation	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Community Transition Services	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Environmental Modifications (Home Accessibility)	At least one (1) provider – option for DISCO as provider	NA	NA	NA	

Service	Number of Providers/ Ratio to participants	Time/Distance Standards	Other – specialized services	Appointment wait time Standard	Appointment Scheduling Time
Family Education and Training	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Intensive Behavioral Services	Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	
Pathway to Employment	**Once program established:** Two (2) that are accepting new Enrollees in each county in its service area for each covered service in the benefit package unless the county has an insufficient number of providers licensed, certified or available in that county as determined by the Department. (MLTCP)	NA	NA	NA	

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*
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*
Adult Day Health Care	*Center for Adult Care*	*987 Broad St Amsterdam, NY 518-555-6016*			*X*		

Attachment 4. Notices

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

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

Enrollment
Notice to referral sources indicating plan action on a specific referral
Welcome Notice
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 5
NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs
Bureau of Managed Long Term Care

MANAGED LONG TERM CARE PLAN/ DISCO APPLICATION

DISCLOSURE INFORMATION FOR CHARACTER AND COMPETENCY REVIEW PERSONAL QUALIFYING INFORMATION

(See Instructions for Completion of MLTCP/DISCO 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/DISCO

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/DISCO*

1. Financial Support for the Proposed MLTCP/DISCO

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/DISCO? (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/DISCO.
- 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/DISCO, 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/DISCO 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/DISCO 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/DISCO 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/DISCO, or the holding company forming the proposed MLTCP/DISCO 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/DISCO 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/DISCO:**

IDENTIFYING INFORMATION

NAME OF PROPOSED MLTCP/DISCO:

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/DISCO CERTIFICATION
APPLICATION REGARDING OUT-OF-STATE
CHARACTER AND COMPETENCE REVIEWS

SAMPLE LETTER A
Character and Competence Reviews on an Individual

Dear_____

(NAME OF MLTCP/DISCO) is applying for a Certificate of Authority to operate a Managed Long Term Care Plan or a Developmental Disabilities Individual Support and Care Coordination Organization 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/DISCO) 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/DISCO), is applying for a Certificate of Authority to operate a Managed Long Term Care Plan or a Developmental Disabilities Individual Support and Care Coordination Organization. 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/DISCO) 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/DISCO) is applying for a Certificate of Authority to operate a Managed Long Term Care Plan or Developmental Disabilities Individual Support and Care Coordination Organization 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/DISCO) 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

ATTACHMENT 6. ADA Compliance

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

ADA Compliance Activities	Section & Page #
Pre-enrollment Outreach and Education: DISCO has made pre-enrollment Outreach and education staff, activities and material available to persons with disabilities.	
Members Services Department: DISCO has member services functions that are accessible to and usable by people with disabilities.	
Identification of Individuals with Disabilities: DISCO 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: DISCO 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: DISCO 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: DISCO 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: DISCO 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: DISCO 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. DISCO has satisfactory systems for coordinating service delivery.	

ATTACHMENT 7. Quality Assurance Guidelines

ROLES AND RESPONSIBILITIES:

Board Governance and Quality Assurance and Improvement:

The DISCO Board is accountable for the overall oversight of program activities and the review of the QA/PI program. The Board ensures enrollee (and advocate, family member, and others of importance to enrollees) and network provider involvement in quality assurance and performance improvement activities and evaluation of satisfaction with services.

The Board ensures annual review and approval of the program. The Board ensures the establishment of review committees and periodic feedback to the board on the review process by oversight committees.

The Board establishes a quality assurance review committee(s) to:

(i) evaluate data collected pertaining to quality indicators, performance standards, and individual satisfaction and make recommendations for improvements based on ongoing data analysis;
(ii) make recommendations to the board regarding the process and outcomes of the quality assurance and performance improvement program, and
(iii) provide input related to processes to evaluate ethical decision-making including end-of-life issues.

Policies and procedures of the review committee:

(i) define qualifications of individuals participating on the committee(s);
(ii) include a method for identifying, selecting and reviewing data and information to be used in the quality assurance and performance improvement program;
(iii) integrate the findings of the grievance and appeals process;
(iv) define a process for recommending appropriate action to resolve problems identified as part of quality assurance and improvement activities, including providing feedback to appropriate staff and subcontractors; for monitoring effectiveness of corrective actions taken; and for reporting QA/PI findings to the board and OPWDD on at least an annual basis; and
(v) incorporate review of the care delivery process to include appropriate clinical professionals and paraprofessionals as well as non-clinical staff, as appropriate.

Medical Director and other DISCO Key Management Staff Responsible for Oversight, Quality Assurance, and Improvement:

The written Quality Plan includes a description of the medical director's roles and responsibilities which demonstrates ongoing quality oversight and accountability.

The written Quality Plan includes a description of the lines of accountability for the quality assurance and improvement program including the role of the governing board, the DISCO's leadership, and the roles and responsibilities of other key management staff including those responsible for the Care Coordination function.

CONTENTS OF THE QUALITY ASSURANCE AND IMPROVEMENT PLAN:

General:

The DISCOs written Quality Plan includes goals and objectives that provide a framework for quality assurance and improvement activities and discovery and corrective/remediation action both on an individual level as well as systemically across the DISCO's network. These goals and objectives are reviewed at least annually by the DISCO's senior leadership, the Board and its Quality Assurance Review Committee and revised periodically as necessary based upon this discovery, evaluation, and review.

This discovery, evaluation and review is supported by data collection activities including a focus on individualized outcome measures (including clinical, functional, and personal outcomes); encounter and utilization data; the measurement of required HCBS waiver assurances; individual satisfaction data; and may also include other appropriate and actionable quality indicators such as HEDIS measures and/or the Council on Quality and Leadership's Basic Assurance Indicators and National Core Indicators.

Quality indicators that are objective, measurable and related to the range of services provided through the DISCO and which focus on potential clinical problem areas (high volume service, high risk diagnoses or adverse outcomes) should be incorporated in the QI Plan. The methodology should assure that all services and care settings (e.g. residential, day settings, and in-home settings) are included in the scope of the quality assurance and performance improvement program.

The DISCOs Written Quality Assurance and Quality Improvement Plan describes how the DISCO will:

- Provide person-centered planning for all individuals that focuses on individual progress and outcomes in the 21 POM areas identified in the Care Coordination section of the contract (i.e., personal outcome measures) and also promote OPWDD's four outcome areas for individuals to:

  ✓ Live and receive services in the most integrated settings;
  ✓ have meaningful and productive community participation, including paid employment;
  ✓ develop meaningful relationships with friends, family, and others in their lives; and
  ✓ experience personal health, safety and growth

- Ensure that each individual who chooses to do so can self-direct his or her services including the option for budget and employer authority;

- Maintain a well trained workforce that minimally meets all OPWDD requirements and is culturally competent to meet the needs of the individuals seeking or receiving supports and services.

- Ensure adherence to applicable CMS HCBS Regulations and HCBS Waiver Assurances for enrollees who are also enrolled in the 1915 (c) waiver. The assurances are:
  - ✓ Level of Care - Persons enrolled in the waiver have needs consistent with an institutional level of care
  - ✓ Service Plan - Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan
  - ✓ Qualified Providers - network providers are qualified to deliver services/supports
  - ✓ Health and Welfare - Participants' health and welfare are safeguarded and monitored
  - ✓ Financial Accountability - Claims for waiver services are paid according to approved payment methodologies in accordance with contracts.

- Describes methods for identification and review of problems (i.e., "discovery"), the development of timely and appropriate recommendations, and the follow-up on implementation of recommendations for the resolution of problems.

- Describes methods to be used for individual case record review/audits including sampling techniques.

- Procedures used to identify and review incidents involving members and the potential quality of care implications from review of these incidents. This review should focus on ensuring that the individual is immediately safeguarded as well as any systemic improvements needed as a result of the review and trending of all incidents involving the DISCO's members.

- Assurances that the DISCO and affiliated providers will cooperate with the OPWDD in Mortality Reviews necessary for a DISCO enrollee.

- Description of credentialing/re-credentialing procedures and other processes to ensure that network providers and staff are qualified to deliver services and supports in accordance with all federal and state law/regulations and any OPWDD guidance.

  This includes a description of how the DISCO will ensure that all HCBS Waiver providers meet the qualifications and standards to deliver HCBS waiver services (delegated waiver operational/administrative function to DISCO contractor) and a description of how the DISCO will assess whether direct support professionals and direct support professional supervisors and other applicable staff of network providers meet the

OPWDD Core Competencies developed by the Talent Development Consortium in accordance with OPWDD specified requirements and timeframes.

- A description of how member concerns will be identified, considering sources including but not limited to grievances and complaints and satisfaction surveys and how individual concerns will be integrated into the overall QA/ plan and QI activities; and

- A process to review the effectiveness of the Care Coordination and person centered planning function including the ability to assess enrollee's care needs, sustain the enrollee's informal supports, identify the enrollee's treatment goals and individual outcomes, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization including social and environmental supports, evaluate that services and supports are provided in the most integrated settings; and amend care delivery processes and the support plan as necessary to effectuate outcome achievement and progress toward established individualized goals

Required Methodology for Review of Personal Outcome Measures:

Council on Quality and Leadership (CQL) Certified Interviewers:

- The DISCO is required to use CQL certified interviewers to conduct CQL interviews using the CQL interview methodology based upon the 21 CQL outcome measures on a representative sample of DISCO members annually.

- The DISCO may contract with other entities approved by OPWDD to obtain CQL certified interviewers or may obtain certification for its own staff or network provider staff. In the latter case, the DISCO must ensure that certification is retained and that there is an adequate number of certified interviewers to conduct the required certified interviews at least annually.

- The DISCO will adhere to OPWDD CQL Practice Guidelines for DISCOs to be published on OPWDD's website including the sampling parameters.

Reporting and Use of Annual CQL Interview Outcome Data:

- Using the CQL methodology, DISCOs would assess the degree to which individual outcomes are present and the degree to which supports/services provided are supporting individual outcomes. This data would be compiled and aggregated by the DISCO for the representative sample of individuals interviewed.

- DISCOs will utilize the results of the CQL interviews for each individual interviewed in the planning and care coordination process.

- DISCOs will analyze and utilize the aggregated results of the CQL interviews for continuous quality improvement purposes in the DISCO's quality assurance and improvement program and across the DISCO's network.

- DISCOs will provide the results of the CQL interviews to OPWDD annually in the form and format specified by OPWDD and such results may be published by OPWDD or used in any manner deemed appropriate by OPWDD.

OPWDD Review of DISCO's CQL Interviews and Data Collection and Use for Quality Improvement:

- OPWDD and/or the EQRO will review that the DISCO is utilizing CQL certified interviewers and conducting CQL interviews annually using the CQL methodology; that the DISCO is aggregating the data obtained from the interviews, and making use of the data for improvements to individual plans of care; and for continuous quality improvement.

National Core Indicator Benchmarks:

OPWDD (or its contractors) will annually collect a representative sample of NCI interviews from each DISCO's enrollees. Particular interest lies in results for the following NCI domains/topical areas: individuals' exercise of choice and self-direction (managing both daily activities and longer term life goals), degree of community inclusion, and basic satisfaction of care coordination plus supports and services in the areas of home, employment, health, and relationships. OPWDD will share the summary data on these measures, along with NCI benchmarks collected from the regional fee for service population: DISCOs will then utilize NCI in their Quality Plans by tracking year to year trends and ongoing comparison with fee for service performance in their region. In the second year of managed care implementation, OPWDD will risk adjust each DISCO's NCI benchmarks according to relevant charcarteristics of their enrollee pools, e.g., large concentrations of medically frail people may limit aggregate growth in NCI community inclusion scores. As the risk adjustment framework is implemented OPWDD will use this data to help assess DISCO to DISCO performance.

The DISCO will incorporate appropriate OPWDD specified performance measures in its Quality Assurance and Improvement Program and written Quality Plan. OPWDD will maintain information on its website that specifies the measures that DISCOs will be required to include as well as measures that OPWDD may use in its Statewide Quality improvement activities.

ATTACHMENT 8. Surplus Note

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 9. 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

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:

Attachment 10

New York State Office for People With Developmental Disabilities

Request for Grant Applications

Managed Care Start-Up Costs for DISCOs

OPWDD will provide funding to support start-up costs for Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs) used to support the transition to managed care, which will ultimately improve care coordination for individuals with developmental disabilities, including both physical health and long-term care services. This funding will be made available through the federal Balancing Incentive Program (BIP).

KEY DATES

RGA Release	August 21, 2014
Questions Due	August 30, 2014
Updates and Responses to Applicant Questions Posted	September 19, 2014
Applications Due	November 1, 2014

OPWDD Contact Name and Address:

Katherine Marlay
NYS OPWDD
44 Holland Avenue
Albany, NY 12229

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I. Summary

A. Description of Program

The Office for People With Developmental Disabilities (OPWDD) initiated a process in April 2013 by issuing a request for Letters of Intent to organizations that wish to offer specialized developmental disability services within a managed care delivery system. Provisions added to the Public Health Law and Mental Hygiene Law in the recently enacted New York State (NYS) budget offer several options for providing specialized intellectual and developmental disabilities services within managed care. One of these options is a new type of managed care entity called a Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) that is described in Public Health Law §4403-g. The new law also allows for existing managed care entities to offer developmental disability services with the approval of the commissioners of OPWDD and the New York State Department of Health (DOH).

Organizational Framework for Entities Coordinating Developmental Disability Services

The People First Waiver, when approved by the federal Centers for Medicare & Medicaid Services (CMS), will provide federal authority to create DISCOs. Eligible organizations must be controlled by one or more non-profit organizations with a history of providing or coordinating services to persons with developmental disabilities. DISCOs will be responsible for providing individualized care coordination and long-term supports and services for individuals with developmental disabilities who voluntarily enroll in managed care.

B. Balancing Incentive Program:

Funding for DISCO start-up costs will be provided through the federal Balancing Incentive Program (BIP). New York State's participation in the BIP will allow the State to build upon current efforts to rebalance the delivery of long term services and supports (LTSS) and to promote enhanced consumer choice. New York State will utilize the resources available through BIP to work toward streamlined eligibility processes, improved access, and expanded LTSS for those in need.

Participation in the BIP program will reinforce New York State's ongoing efforts to improve access to home and community-based long term care services for those with physical, behavioral health needs and/or intellectual disabilities throughout New York State.

II. Period of the Grant

It is expected that contracts resulting from this RGA will begin on November 1, 2014 and end on September 30, 2015 (with no contract renewal).

Continued funding throughout this period is contingent upon availability of funding and state and federal budget appropriations. OPWDD also reserves the right to revise the award amount as necessary due to changes in the availability of funding.

III. Who May Apply

Any entity that meets the legislative requirements of the DISCO as described in § 4403-g of the Public Health Law and § 13.40 of the Mental Hygiene Law:

Public Health Law § 4403-g: Paragraph (a) of subdivision (1) defines "Developmental disability individual support and care coordination organization" or "DISCO" as "an entity that has received a certificate of authority pursuant to this section to provide, or arrange for, health and long term care services, as determined by the commissioner and the commissioner of the office for people with developmental disabilities, on a capitated basis in accordance with this section, for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law, which the organization is authorized to enroll." Paragraph (b) of subdivision (1) defines "Eligible applicant" as "an entity controlled by one or more non-profit organizations which have a history of providing or coordinating health and long term care services to persons with developmental disabilities."

Mental Hygiene Law § 13.40: Subdivision (a) provides that the People First Waiver program "shall include the use of developmental disability individual support and care coordination organizations, herein referred to as DISCOs, pursuant to section 4403-g of the public health law."

IV. Minimum Eligibility Requirements

A DISCO applicant must be controlled by one or more non-profit organizations with a history of providing or coordinating health and long term care services to persons with developmental disabilities. The expectation is that the leadership of the DISCO (board members and officers) will have extensive experience coordinating care for individuals with Intellectual/Developmental Disabilities (I/DD), as well as overseeing and operating entities that deliver Medicaid Service Coordination, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and/or HCBS waiver services that are in good standing with OPWDD.

The DISCO and all its network providers, with which it enters into provider contracts, will be required to be in compliance with all applicable State and federal licensing, certification, and other requirements. These networks must have demonstrated capacity to perform the needed services. For network providers under the jurisdiction of OPWDD, competence will be demonstrated with acceptable OPWDD survey and fiscal reviews.

The DISCO must maintain an administrative and organizational structure that supports high quality supports and services and comprehensive care coordination. The management structure should ensure effective linkages between administrative areas: Quality Management, Network Development and Contracts Management, Information Technology (Utilization Review), Enrollment / Disenrollment, Care Coordination, Accounts Receivable / Accounts Payable, and Budget, Finance and Accounting. A complete description of a DISCO's areas of responsibility will be identified in its contract with New York State that will be published separately, and will be released for informational purposes prior to grant awards.

V. Grant Awardees' Selection

NYS is modeling the DISCO start-up grant activities after successful grant programs that have been implemented in the past through Health Care Efficiency and Affordability Law (HEAL) grants and through start-up grants specialized in managed care programs for people with HIV/AIDS. Grant applicants will be selected on the basis of the successful completion of the initial phase of the Certificate of Authority (COA) process to operate a DISCO, as well as satisfactory narrative descriptions for use of funds as outlined in Section VI. The initial phase of the COA review process will be conducted jointly by the Department of Health and OPWDD and will ensure that the applicant successfully meets the Article 44 New York State Public Health Law (NYSPHL) requirements in the following areas listed below: (*please note that page numbers in the Plan Qualification Document (PQD) for* Developmental Disabilities Individual Support and Care Coordination Organization (DISCO) *have been included for reference and further detail*).

Public Health Law Article 44 Requirements:

- Organizational Structure (PQD Section I.A, pg. 6)
  - Detailed description of DISCO and related organizational structure.
  - Organizational Chart.
  - Certificate of Incorporation.
  - Bylaws.

- Management of the DISCO (PQD Section I.B, pg. 6)
  - List of names and addresses for incorporators, stockholders (if any), and members (if any).
  - Identify management staff, including positions budgeted but not yet filled.
  - List of names addresses and official positions for Chief Executive Officer (CEO), Medical Director, governing body and all management staff.
  - Describe responsibilities of all key management staff, workload estimates and salaries.
  - Identification of any delegated authority, and, if authority is delegated to contractors, identifies the contractors.
    - If functions such as claims payment, quality assurance, or utilization review are delegated to contractors, the contract itself must be reviewed by the state for regulatory compliance.

- Character and Competence (PQD Section I.C., pg. 7)
  - Comprehensive review of the licensure, qualifications, and background of the Medical Director, CEO, incorporators, stockholders, members, and each member of governing body of DISCO. (COH-793B and COH-793C forms).
  - Location of Administrative Office.

- Governing Board (PQD Section II., pg. 7)
  - Description of the role and responsibility of governing board.
  - The bylaws of the governing board must also be submitted for review if the board's duties are not specified in the corporate bylaws.

- Description of the board's engagement with individuals served by the DISCO and opportunities for these individuals to provide meaning input.

- Service Area (PQD Section III., pg. 7)
  - Description of service area. Identify counties to be served and explain rationale for choosing service area.
  - Enrollment projections and basis for projections.

- Enrollment Projections and Target Population (PQD Section IV., pg. 7)
  - Description of Target Population and basis for Enrollment Projections
  - Qualified individuals of all ages living in the area served by the DISCO will be eligible to enroll in the DISCO, with the authorization of OPWDD. An individual will qualify for enrollment, if he or she has a developmental disability, meets ICF/IID level of care and is Medicaid-enrolled. This includes those enrolled in both Medicaid and Medicare. Specifically, this includes individuals now receiving:
    - OPWDD 1915(c) Comprehensive Waiver Services
    - ICF/IID services
    - OPWDD Targeted Case Management (MSC)
    - Other long term support services (e.g., personal care) under the auspice of state agencies other than OPWDD
    - Office of Mental Health (OMH) institutional services and Office of Alcohol Substance Abuse Services (OASAS) inpatient services

- Finance (PQD Section XVIII., pg. 19)
  - Description of the DISCO's mechanism to maximize reimbursement from Medicare and other benefits.
  - Description of the DISCO's systems for securing and integrating any potential sources of funding for services provided by or through DISCO, including funding available under:
    - Supplemental Security Income program
    - Medicare
    - Medicaid
    - SCHIP program

  - The applicant must also include the following:
    - Revenue & Expense Statement
    - Pro-forma Balance Sheet
    - Source of initial capitalization
    - Proposed loan document if a subordinated loan
    - Describe arrangements to share financial risk, if appropriate

  - Description of systems to process payment for services

The second phase of the COA review process is a detailed review of DISCO policy and operating procedures; provider contracts; provider network adequacy; notices; and ultimately the preparation for an onsite review. The State expects that applicants that successfully complete the initial phase of the COA process will ultimately be issued a COA upon completion of the entire review process.

VI. Costs Eligible for Grant Funding

The intent of the grant award is that all successful applicants will receive a matching grant award based on a review of the applicant's need and approval of a start-up budget that identifies expenditure items that are available. Grant awards are contingent upon availability of BIP funds.
Grant funds may support four cost categories for pre-operational/start-up costs: (Please include a narrative description for each category and complete the Excel Spreadsheet Attachments 2A – 2F). PLEASE NOTE: Capital costs are NOT eligible for funding.

- **Management Information System (MIS) Development** (Potential eligible costs include salary for MIS support, Reporting/Data Maintenance, Applications, Network Support, Helpdesk; and Non-Salary items such as file server/PC software, Personal Computers).
- **Management Staff** (Potential eligible costs include pre-operational costs for enrollment, claims, member services, finance and management staff).
- **Provider Network Development** (Salary and non-Salary costs associated with credentialing, on-site review, and clerical functions).
- **Establishment of Clinical Linkages** (Potential eligible costs include salary and non-salary costs during the pre-operational period for pre-certification/authorization functions, case management, referrals, Medical Director, Provider Liaison).
- **Other Start-Up Costs** (Salary and non-Salary cost associated with general start-up costs).

The types of MIS funding categories eligible for the grant awards are described above. DISCOs will be expected to have available or have a plan for obtaining a full electronic record system that integrates all services on a single platform, with the following features:

- Electronic records are integrated into the person's electronic service plan (eISP).
- Program planning must include Personal Outcome Measures based on OPWDD guidance with corresponding outcomes set by the member and his/her circle of support that are identified in the electronic service plan.
- Ability for alerts to be shared between network providers and the care coordinator.
- How the individual and/or family will have access to care plan information via a web based 'portal' or through other means.

In keeping with information system policy for NYS, DISCO applicants must demonstrate how the organization will come into compliance with the current version of the Statewide Policy

Guidance, which includes common information policies, standards and technical approaches governing health information exchange. It is expected that all successful DISCO applicants will come into compliance with these guidelines within 18 months of becoming operational. The guidance can be found at:

http://health.ny.gov/technology/statewide_policy_guidance.htm

- Funding that would allow not-for-profit entities (DISCOs) for support with the adoption and implementation of specialized Electronic Health Care Record (EHR) that provides for:
  - Integration of Care among network providers, including community-based providers of specialized, developmental disability services,
  - Care Coordination capabilities, and
  - Implementation and effective utilization of an electronic health record by community-based network providers.

VII. Available Grant Amounts

The applicant must demonstrate that the organization will expend ¼ of the cost for eligible expenses, and grant awards may meet the remaining ¾ of the eligible expenses. An applicant will be capped at $1.5 million in grant funding and the State will not issue awards in excess of this amount. At this time, OPWDD expects that payment of the grant awards will likely occur in two phases. The first payment will be issued upon the successful completion of the initial phase of the COA review. The remaining grant award will be withheld subject to issuance of the COA.

VIII. Administrative Requirements and Process

A. Issuing Agency

This RGA is issued by the New York State Office for People with Developmental Disabilities. This Agency is responsible for the requirements specified herein and for the evaluation of all applications.

B. Question and Answer Period

a. All substantive questions must be submitted by electronic mail to the following e-mail address, peoplefirstwaiver@OPWDD.ny.gov, with "DISCO start-up RGA" in the subject line.
b. To the degree possible, each inquiry should cite the RGA section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RGA.
c. Prospective applicants should note that all clarifications and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of an application.

d. Questions of a technical nature can be addressed in writing at the e-mail address in a. above. **Questions are of a technical nature if they are limited to how to prepare your application (e.g., formatting) rather than relating to the substance of the application.**

e. This RGA has been posted on the Agency's public website at: http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/Becoming_a_DISCO and the NYS Grants Gateway website at: http://www.grantsreform.ny.gov/

f. Questions and answers, as well as any updates and/or modifications, will also be posted on these websites. All such updates will be posted by the date identified on the cover sheet of this RGA.

C. Applicant Conference

An applicant Teleconference/Webinar will be held for this project on Tuesday September 23, 2014. There will be call-in directions provided for this teleconference in advance of the date. Call details will be posted on the OPWDD's website and sent to all entities that submitted a letter of interest.

D. How to Submit a Proposal/Application

Proposals/Applications must be received at the following address by the date and time posted on the cover sheet of this RGA. Late proposals/applications will NOT be accepted.

Katherine Marlay
OPWDD
44 Holland Avenue
Albany, New York 12229

Applicants must submit **2 original**, signed applications, **4 copies** and an electronic PDF copy of the application with all attachments on a CD or USB flash drive. Application packages should be clearly labeled with the RGA name and number as listed on the cover of this RGA document. **Applications will not be accepted via fax or e-mail.**

* It is the applicant's responsibility to see that applications are delivered to the address above, prior to the date and time specified. Late applications due to a documentable delay by the carrier may be considered at the Agency's discretion.

E. Public Information Requirements

All Proposals/Applications upon submission will become the property of OPWDD. OPWDD will have the right to disclose all or any part of a Proposal/Application to public inspection based on its determination that disclosure of all or any part of the Proposal/Application will serve the public interest. Applicants are further advised that, except for trade secrets, other proprietary information and certain personnel information (which OPWDD has reserved the right to disclose), all parts of Proposals/Applications must ultimately be disclosed to those members of the general public making inquiry under the New York State Freedom of Information Law (Public

Officers Law, Article 6) although Proposal/Application contents cannot ordinarily be disclosed by OPWDD prior to grant award. Information relating to Applicant price submissions, including commercial, book or list pricing, applicable discounts or final bid price and like information, shall not be entitled to confidentiality protection whether or not submitted or designated as proprietary. Should an Applicant wish to request exception from public access to information contained in its Proposal/Application, (i) the Applicant shall inform OPWDD prior to or with submission of its Application, in writing, that such records are being furnished, are proprietary and are not to be disclosed; and (ii) such records shall be sufficiently identified; (iii) Applicant shall state the reasons with specificity why the information should be exempted from disclosure; and (iv) designation of such records as exempt from disclosure is determined to be reasonable and accepted by OPWDD.

F. OPWDD Rights Reserved

The OPWDD reserves the right to:

1) Reject any or all applications received in response to this RGA.

2) Withdraw the RGA at any time, at the Agency's sole discretion.

3) Make an award under the RGA in whole or in part.

4) Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RGA.

5) Seek clarifications and revisions of applications.

6) Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RGA.

7) Prior to application opening, amend the RGA specifications to correct errors or oversights, or to supply additional information, as it becomes available.

8) Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RGA amendments.

9) Change any of the scheduled dates.

10) Waive any requirements that are not material.

11) Award more than one contract resulting from this RGA.

12) Conduct contract negotiations with the next responsible applicant, should the Agency be unsuccessful in negotiating with the selected applicant.

13) Utilize any and all ideas submitted with the applications received.

14) Unless otherwise specified in the RGA, every offer is firm and not revocable for a period of 60 days from the bid opening.

15) Waive or modify minor irregularities in applications received after prior notification to the applicant.

16) Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RGA.

17) Negotiate with successful applicants within the scope of the RGA in the best interests of the State.

18) Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.

19) Award grants based on geographic or regional considerations to serve the best interests of the state.

G. Term of Contract

It is expected that contracts resulting from this RGA will begin on November 1, 2014 and end on September 30, 2015 (eleven months, with no contract renewal).

Continued funding throughout this eleven month period is contingent upon availability of funding and state and federal budget appropriations. The OPWDD also reserves the right to revise the award amount as necessary due to changes in the availability of funding.

H. Reporting and Payment Requirements

The grant contractor will be required to submit monthly invoices and required reports of expenditures to the State's designated payment office:

Managed Care Start up Cost Grants
NYS Office for People with Developmental Disabilities
44 Holland Avenue
Albany, NY 12229

Grant contractors must provide complete and accurate billing invoices to the Agency's designated payment office in order to receive payment. Billing invoices submitted to the Agency must contain all information and supporting documentation required by the Contract, the Agency, and the Office of the State Comptroller (OSC).

Payment for invoices submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized by the

Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with OSC's procedures and practices to authorize electronic payments. Authorization forms are available at OSC's website at: http://www.osc.state.ny.us/epay/index.htm, by email at: epayments@osc.state.ny.us or by telephone at 855-233-8363. CONTRACTOR acknowledges that it will not receive payment on any claims for reimbursement submitted under this contract if it does not comply with OSC's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such claims for reimbursement by the State (NYS OPWDD) shall be made in accordance with Article XI-A of the New York State Finance Law. Payment terms will be*:* Contractor will be reimbursed for actual expenses incurred as allowed in the Contract Budget and Work Plan.

I. Minority & Woman-Owned Business Enterprise Requirements

In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if the Master Contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of $25,000.00, whereby a contracting State Agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting State Agency; or (ii) a written agreement in excess of $100,000.00 whereby a contracting State Agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of $100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the Contractor certifies and affirms that (i) it is subject to Article 15-A of the Executive Law which includes, but is not limited to, those provisions concerning the maximizing of opportunities for the participation of minority and women owned business enterprises and (ii) the following provisions shall apply and it is Contractor's equal employment opportunity policy that:

1. The Contractor shall not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status;

2. The Contractor shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts;

3. The Contractor shall undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

4. At the request of the State, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative shall not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative shall affirmatively cooperate in the implementation of the Contractor's obligations herein; and

5. The Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants shall be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

The Contractor shall include the provisions of subclauses 1 – 5 of this Section (VII)(I), in

every subcontract over $25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (Work) except where the Work is for the beneficial use of the Contractor. Section 312 of the Executive Law does not apply to: (i) work, goods or services unrelated to the Master Contract; or (ii) employment outside New York State. The State shall consider compliance by the Contractor or a subcontractor with the requirements of any Federal law concerning equal employment opportunity which effectuates the purpose of this section. The State shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such Federal law and if such duplication or conflict exists, the State shall waive the applicability of Section 312 of the Executive Law to the extent of such duplication or conflict. The Contractor shall comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

J. Limits on Administrative Expenses and Executive Compensation

Effective July 1, 2013, limitations on administrative expenses and executive compensation contained within Governor Cuomo's Executive Order #38 and related regulations published by the Agency (Part 1002 to 10 NYCRR – Limits on Administrative Expenses and Executive Compensation) went into effect. Applicants agree that all state funds dispersed under this procurement will, if applicable to them, be bound by the terms, conditions, obligations and regulations promulgated by the Agency. To provide assistance with compliance regarding Executive Order #38 and the related regulations, please refer to the Executive Order #38 website at: http://executiveorder38.ny.gov.

K. Vendor Identification Number

Effective January 1, 2012, in order to do business with New York State, you must have a vendor identification number. As part of the Statewide Financial System (SFS), the Office of the State Comptroller's Bureau of State Expenditures has created a centralized vendor repository called the New York State Vendor File. In the event of an award and in order to initiate a contract with the New York State Office for People with Developmental Disabilities, vendors must be registered in the New York State Vendor File and have a If already enrolled in the Vendor File, please include the Vendor Identification number on the application cover sheet. If not enrolled, to request assignment of a Vendor Identification number, please submit a New York State Office of the State Comptroller Substitute Form W-9, which can be found on-line at: http://www.osc.state.ny.us/vendor_management/issues_guidance.htm.

Additional information concerning the New York State Vendor File can be obtained on-line at: http://www.osc.state.ny.us/vendor_management/index.htm, by contacting the SFS Help Desk at 855233-8363 or by emailing at helpdesk@sfs.ny.gov.

L. Vendor Responsibility Questionnaire

The New York State Office for People with Developmental Disabilities recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at http://www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep system online at https://portal.osc.state.ny.us.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website at: http://www.osc.state.ny.us/vendrep/forms_vendor.htm or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

M. Vendor Pre-Qualification for Not-for-Profits

Beginning July 31, 2013, all not-for-profit vendors subject to prequalification will be required to prequalify prior to grant application and execution of contracts.

Prequalification is a new statewide process designed to facilitate prompt contracting for not-for-profit vendors. Interested vendors will be asked to submit commonly requested documents, and answer frequently asked questions once. The application requests organizational information about the vendor's *capacity, legal compliance,* and *integrity.*

Not-for-profit vendors subject to prequalification will submit their responses online in the new Grants Gateway, and all information will be stored in a virtual, secured vault. Once a vendor is registered with the system, State agencies will have ready access to the vault, eliminating redundant submissions of such information by the vendor. Not-for-profits will only have to prequalify every three years, with responsibility to keep their information current throughout the three year period. To obtain access to the Grants Gateway, vendors should submit a registration form downloadable on the Grants Reform website at: http://grantsreform.ny.gov/Grantees.

N. General Specifications

1) By signing the "Application Form" each applicant attests to its express authority to sign on behalf of the applicant.
2) Contractors will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.

3) Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RGA, including the terms and conditions of the contract. Any exceptions allowed by the Agency during the Question and Answer Phase must be clearly noted in a cover letter attached to the application.
4) An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
5) Provisions Upon Default

a. The services to be performed by the Applicant shall be at all times subject to the direction and control of the Agency as to all matters arising in connection with or relating to the contract resulting from this RGA.

b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RGA, the Agency acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.

c. If, in the judgment of the Agency, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State, the Agency acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RGA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

O. Appendices

IX. Completing the Application

As described above, applicants must submit a narrative justification for all elements described in Section V (Grant Awardees' Selection) and VI (Costs Eligible for Grant Funding), as well as complete the Excel spreadsheet included in Attachments 2A – 2E.

A. Key Dates

Request for Grant Applications are due by November 1, 2014. Awards will be granted by December 1, 2014

X. Attachments

Attachment 1: Applicant Attestation
Attachment 2A: Pre-Operational Start-Up Costs - Master Summary
Attachment 2B:Pre-Operations Period: Master Information System (MIS) Detail
Attachment 2C:Pre-Operations Period: Management Staff Detail
Attachment 2D: Pre-Operations Period: Provider Network Development Detail
Attachment 2E: Pre-Operations Period: Establishing Clinical Linkages Details
Attachment 2F: Other Costs

Attachment 1
Applicant Attestation
(Must be attached to application packet)

I certify that the information provided is correct. I certify that my agency meets the minimum eligibility requirements outlined in the RGA. I understand and agree that, at any time, the State may review all employer records and documentation necessary to ensure compliance with the requirements of the demonstration and that any monies found to have been expended which are not in compliance with the terms and conditions of the grant may be recouped by the State. The applicant further agrees to comply with the requirements of the RFP including all appendices.

I certify that my organization will provide, and our staff able to use, computer software compatible with the products used by the Agency to organize, analyze and store data and project related information and to transfer reports and other information to the Agency via e-mail. [Note: At least one copy of the submitted applications must contain original signatures.]

I certify that my organization employs or contracts with a sufficient number of individuals with developmental disabilities to be able to conduct peer outreach counseling in fulfillment of the goals and objectives of this project.

Signature of official from lead organization:

_____

Print/type Name:

_____

Title and Organization:

_____

Correspondence Address:

_____

E-mail Address: _____

Telephone: _____

Fax Number: _____

Date Signed: _____

ATTACHMENT 2A
Applicant Name:

Request for Grant Funds

Pre-Operational Start-Up Costs - Master Summary Total

Uses of Grant Funds	Amount of Grant Funding Requested (75%)	In-Kind Contribution (25%)	Totals
Pre-Operations - Master Summary Total			
Master Information System (MIS) (Tab 3B)	$ -	$ -	$ -
Management Staff (Tab 3C)	$ -	$ -	$ -
Network Development (Tab 3D)	$ -	$ -	$ -
Establishment of Clinical Linkages (Tab 3E)	$ -	$ -	$ -
Other Costs (Tab 3F)	$ -	$ -	$ -
Totals	$ -	$ -	$ -

Notes:
* Applicant must provide a detailed narrative justification for each item for which grant funding is requested.

ATTACHMENT 2B
Applicant Name:

Pre-Operations Period: Master Information System (MIS) Detail

SALARY - MIS

Category	# FTE's	Annual Salary & Benefits	Total Salary & Benefits for Pre-Operational Period	$ Amount Grant (75%)	$ Amount In-Kind (25%)
MIS Support	0.00	$ -	$ -	$ -	$ -
Reporting Data/Maintenance	0.00	$ -	$ -	$ -	$ -
Applications	0.00	$ -	$ -	$ -	$ -
Network Support	0.00	$ -	$ -	$ -	$ -
Help Desk	0.00	$ -	$ -	$ -	$ -
Other	0.00	$ -	$ -	$ -	$ -
Total Salary-MIS	0.00	$ -	$ -	$ -	$ -

NOTES:
Indicate expected starting date of plan.
Indicate % of fringe benefits included in above salaries.
If appropriate, additional lines may be added.
1 FTE = 1 full time equivalent employee.
Sum of Grant & In-Kind columns should equal Total Salary

NON-SALARY - MIS

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Personal Computers	$ -	$ -	$ -
PC Software	$ -	$ -	$ -
Mini-computer and HMO software	$ -	$ -	$ -
File Server and Network	$ -	$ -	$ -
Cabling	$ -	$ -	$ -
Printers	$ -	$ -	$ -
Other	$ -	$ -	$ -
Total Non-Salary-MIS	$ -	$ -	$ -

Sum of Grant & In-Kind columns should equal Total Cost

TOTAL MIS COSTS (Salary & Non-Salary)

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost	
MIS Support	$ -	$ -	$ -	
Reporting Data/Maintenance	$ -	$ -	$ -	
Applications	$ -	$ -	$ -	
Network Support	$ -	$ -	$ -	
Help Desk	$ -	$ -	$ -	
Other (Salary)	$ -	$ -	$ -	
Personal Computers	$ -	$ -	$ -	
PC Software	$ -	$ -	$ -	
Mini-computer and HMO software	$ -	$ -	$ -	
File Server and Network	$ -	$ -	$ -	
Cabling	$ -	$ -	$ -	
Printers	$ -	$ -	$ -	
Other (Non-Salary)	$ -	$ -	$ -	
Total MIS (Salary & Non-Salary)	$ -	$ -	$ -	

Sum of Grant & In-Kind columns should equal Total Cost

Total MIS costs on this schedule should equal the Total Column for MIS in Schedule 3-A

FOR ANY CATEGORY WHICH DOES NOT APPLY, PLEASE ENTER THE NUMBER 0.

ATTACHMENT 2C
Applicant Name:

Pre-Operations Period: Management Staff Detail

SALARY

Category	# FTE's	Annual Salary & Benefits	Total Salary & Benefits for Pre-Operational Period	$ Amount Grant (75%)	$ Amount In-Kind (25%)
Management Staff					
Executive Director	0.00	$ -	$ -	$ -	$ -
Executive Admin.	0.00	$ -	$ -	$ -	$ -
Enrollment	0.00	$ -	$ -	$ -	$ -
Claims	0.00	$ -	$ -	$ -	$ -
Member Services	0.00	$ -	$ -	$ -	$ -
Finance	0.00	$ -	$ -	$ -	$ -
Marketing Field Reps	0.00	$ -	$ -	$ -	$ -
Other	0.00	$ -	$ -	$ -	$ -
Total Management Staff	0.00	$ -	$ -	$ -	$ -

NOTES:
Indicate expected starting date of plan.
Indicate % of fringe benefits included in above salaries.

If appropriate, additional lines may be added.
1 FTE = 1 full time equivalent employee.
Sum of Grant & In-Kind columns should equal Total Salary.
Total Management Staff costs should equal the Total Column for Management Staff in Schedule 3-A

FOR ANY CATEGORY WHICH DOES NOT APPLY, ENTER THE NUMBER 0.

ATTACHMENT 2D
Applicant Name:

Pre-Operations Period: Provider Network Development Detail

SALARY: Network Development

Category	# FTE's	Annual Salary & Benefits	Total Salary & Benefits for Pre-Operational Period	$ Amount Grant (75%)	$ Amount In-Kind (25%)
Network Development					
Credentialing (Salary)	0.00	$ -	$ -	$ -	$ -
On Site Review	0.00	$ -	$ -	$ -	$ -
Clerical	0.00	$ -	$ -	$ -	$ -
Other (Salary)	0.00	$ -	$ -	$ -	$ -
Total Network Development (Salary)	**0.00**	$ -	$ -	$ -	$ -

NOTES:
Indicate expected starting date of plan.
Indicate % of fringe benefits included in above salaries.
If appropriate, additional lines may be added.
1 FTE = 1 full time equivalent employee.
Sum of Grant & In-Kind columns should equal Total Salary

NON-SALARY: Network Development

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Credentialing (Non-Salary)	$ -	$ -	$ -
Other (Non-Salary)	$ -	$ -	$ -
Total Network Development (Non-Salary)	$ -	$ -	$ -

Add additional items to non-salary category if appropriate.
Sum of Grant & In-Kind columns should equal Total Cost

TOTAL NETWORK DEVELOPMENT COSTS (Salary & Non-Salary)

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Credentialing (Salary)	$ -	$ -	$ -
On Site Review	$ -	$ -	$ -
Clerical	$ -	$ -	$ -
Other (Salary)	$ -	$ -	$ -
Credentialing (Non-Salary)	$ -	$ -	$ -
Other (Non-Salary)	$ -	$ -	$ -
Total Network Development (Salary & Non-Salary)	$ -	$ -	$ -

Sum of Grant & In-Kind columns should equal Total Cost
Total Network Development costs on this schedule should equal the Total Column
for Network Development in Schedule 3-A

FOR ANY CATEGORY WHICH DOES NOT APPLY, PLEASE ENTER THE NUMBER 0.

ATTACHMENT 2E
Applicant Name:

Pre-Operations Period: Establishing Clinical Linkages Detail

SALARY: Establishing Clinical Linkages

Category	# FTE's	Annual Salary & Benefits	Total Salary & Benefits for Pre-Operational Period	$ Amount Grant (75%)	$ Amount In-Kind (25%)
Clinical Linkages					
Pre-Cert/Auths	0.00	$ -	$ -	$ -	$ -
Large Case Management	0.00	$ -	$ -	$ -	$ -
Referrals	0.00	$ -	$ -	$ -	$ -
Medical Director	0.00	$ -	$ -	$ -	$ -
Concurrent Review	0.00	$ -	$ -	$ -	$ -
Provider Liasons	0.00	$ -	$ -	$ -	$ -
Other	0.00	$ -	$ -	$ -	$ -
Total Clinical Linkages (Salary)	**0.00**	$ -	$ -	$ -	$ -

NOTES:
Indicate expected starting date of plan.
Indicate percentage of fringe benefits included in above salaries.
If appropriate, additional lines may be added.
1 FTE = 1 full time equivalent employee.
Sum of Grant & In-Kind columns should equal Total Salary

NON-SALARY: Establishing Clinical Linkages

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Pre-Cert/Auths	$ __ -	$ -	$ -
Large Case Management	$ -	$ -	$ -
Referrals	$ -	$ -	$ -
Concurrent Review	$ -	$ -	$ -
Provider Liasons	$ -	$ -	$ -
Other	$ -	$ -	$ -
Total Clinical Linkages (Non-Salary)	$ -	$ -	$ -

Add additional items to non-salary category if appropriate.
Sum of Grant & In-Kind columns should equal Total Cost

TOTAL ESTABLISHING CLINICAL LINKAGES COSTS (Salary & Non-Salary)

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Pre-Cert/Auths (Salary)	$ -	$ -	$ -
Large Case Management (Salary)	$ -	$ -	$ -
Referrals (Salary)	$ -	$ -	$ -
Medical Director (Salary)	$ -	$ -	$ -
Concurrent Review (Salary)	$ -	$ -	$ -
Provider Liasons (Salary)	$ -	$ -	$ -
Other (Salary)	$ -	$ -	$ -
Pre-Cert/Auths (Non-Salary)	$ -	$ -	$ -
Large Case Management (Non-Salary)	$ -	$ -	$ -
Referrals (Non-Salary)	$ -	$ -	$ -
Medical Director (Non-Salary)	$ -	$ -	$ -
Concurrent Review (Non-Salary)	$ -	$ -	$ -
Provider Liasons (Non-Salary)	$ -	$ -	$ -
Other (Non-Salary)	$ -	$ -	$ -
Total Clinical Linkages (Salary & Non-Salary)	$ -	$ -	$ -

Sum of Grant & In-Kind columns should equal Total Cost
Total Clinical Links should equal the Total Column for Clinical Linkages in Schedule
FOR ANY CATEGORY WHICH DOES NOT APPLY, PLEASE ENTER THE NUMBER 0.

ATTACHMENT 2F
Applicant Name:

Other Costs - Salary & Non-Salary

SALARY: Other

Category	# FTE's	Annual Salary & Benefits	Total Salary & Benefits for Pre-Operational Period	$ Amount Grant (75%)	$ Amount In-Kind (25%)
Other					
Consulting *	0.00	$ -	$ -	$ -	$ -
Auditing	0.00	$ -	$ -	$ -	$ -
Actuarial	0.00	$ -	$ -	$ -	$ -
Legal	0.00	$ -	$ -	$ -	$ -
Training	0.00	$ -	$ -	$ -	$ -
Travel	0.00	$ -	$ -	$ -	$ -
Printing	0.00	$ -	$ -	$ -	$ -
Promotion and Advertising	0.00	$ -	$ -	$ -	$ -
Recruiting	0.00	$ -	$ -	$ -	$ -
Communications	0.00	$ -	$ -	$ -	$ -
Survey & Analysis	0.00	$ -	$ -	$ -	$ -
Equipment Maintenance	0.00	$ -	$ -	$ -	$ -
Other (Specify)	0.00	$ -	$ -	$ -	$ -
Total Other (Salary)	$ -	$ -	$ -	$ -	$ -

NOTES:
*** Please identify the consultant(s) and what tasks they will be performing. Indicate amount paid to each consultant if more than one.**
Indicate expected starting date of plan.
Indicate % of fringe benefits included in above salaries
If appropriate, additional lines may be added.
1 FTE = 1 full time equivalent employee.
For other category, please provide supporting documentation indicating what expenses are included.
Sum of Grant & In-Kind columns should equal Total Salary

NON-SALARY: Other

Category	$ Amount Grant (75%)	$ Amount In-Kind (25%)	Total Cost
Rent	$ -	$ -	$ -
Utilities	$ -	$ -	$ -
Office Supplies	$ -	$ -	$ -
Postage	$ -	$ -	$ -
Newsletters	$ -	$ -	$ -
Dues & Subscriptions	$ -	$ -	$ -
ID Cards	$ -	$ -	$ -
Banking Fees	$ -	$ -	$ -
Office Furniture	$ -	$ -	$ -
Facsimile	$ -	$ -	$ -
Telephone Systems/Voice Mail	$ -	$ -	$ -
Other (Specify)	$ -	$ -	$ -
Total Other (Non-Salary)	$ -	$ -	$ -

Sum of Grant & In-Kind columns should equal Total Cost