SECTION V: HMO REQUIRED SUBMISSION MATERIAL

Instructions for the HMO Required Submission Material

All questions must be answered. Responses to the questions asked in the HMO Required Submission Material should be provided in the exact format shown in the HMO Required Submission Material. All documents must be named exactly as they appear in the Specifications and be in a searchable format. The website contains a file in Microsoft WORD format that may be used by the HMO for its response and the forms that must be completed. Where there is a discrepancy, the PDF document contained on the website is the controlling document. Any attachment(s) submitted in response to a question should be clearly labeled with the part and question number to which it refers and inserted in the binder in the appropriate order. Each page of an HMO's response including completed forms and any attachments should be clearly labeled with the HMO's name. HMOs are cautioned to submit only those materials that directly respond to the question asked.

Required Documents:

1. **Certificate to Operate:** Include a copy of the Certification to operate within an approved Service Area and the ability to provide comprehensive hospital, medical and prescription drug benefits for covered Enrollees as applicable under Insurance Law Article 43 and /or Public Health Law Article 44.

2. **NYSHIP Medicare Advantage Plan Offering:** Indicate if the HMO plans to offer a NYSHIP Medicare Advantage Plan, in addition to the Commercial Plan.

3. **List of Counties:** Include a list of Counties and associated rating region configuration for the HMO's proposed 2016 NYSHIP Service Area. NOTE: Counties **must** be contiguous and listed for both Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP. The Medicare Advantage Plan Service Area must be identical to the Commercial Plan and all counties must be CMS approved. **The Department, in consultation with the JLMC, considers Chemung and Schuyler counties in New York State to be underserved.**

4. **Schedule M:** Provide a copy of your organization's most recent annual filing of Schedule M (Complaints).

5. **NYSHIP Dependent Eligibility Rider**: Submit a copy of the *draft* NYSHIP Dependent Eligibility Rider your organization will file with the New York State Department of Financial Services (DFS). The HMO must agree to accept all determinations of eligibility made by the Department, and must provide a rider that includes all NYSHIP dependent eligibility provisions. A draft NYSHIP Eligibility Rider is included as Exhibit II.C "2016 NYSHIP Dependent Eligibility Rider" and provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.

6. Submit coverage and benefit documents. Note: All PDF documents are to be formatted to allow for document search functionality (e.g., search by word or phrase.)

   a. Certificate of Coverage (for Commercial Plan) and coverage riders. The proposed standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. NOTE: As stated in Section IV.B.1.b. of the 2016 HMO Specifications, HMOs may meet the minimum benefit requirements through the use of a standard contract, or through a combination of a standard contract and riders.

   b. Evidence of Coverage (for Medicare Advantage Plans) and coverage riders, if offering a Medicare Advantage Plan. The proposed Medicare standard contract and riders should be available with prescription drug coverage and without prescription drug coverage.

   c. Completed Benefit Charts (Exhibits III.B.1 and III.B.2) for both Commercial and Medicare Advantage Plans, as applicable, **citing where each of the named benefits proposed for 2016 can be found in contract or rider language. All contracts and/or riders relating to your 2016 benefit offering must be listed. If there is no additional cost, indicate N/C in Projected Monthly Premium column. List the cost of the standard contract and riders for each rating region once, reference the citation in all other appropriate areas.**

   d. Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. Additional information and instructions for accessing and completing the mandatory HMO e-page online will be sent under separate cover. NOTE: It is expected the HMO e-page will be available on or about May 27, 2015. HMOs will have one week to complete the HMO e-page.

   e. Schedule of Benefits – required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. NOTE: If this is part of your Certificate of Coverage and/or Evidence of Coverage, please indicate page numbers where this information can be found.

f. Side by Side Comparison of Benefit Changes 2015 to 2016 (document must be titled as such) identifying changes from 2015 (current year) to 2016 (upcoming year) –for Commercial Plan and Medicare Advantage Plan Enrollees, if applicable. In the event there are no changes in the benefits offered, the HMO is required to mail an affirmative statement to Enrollees confirming that there are no changes from the previous year; a copy of the statement of "no change" should be included in this submission, if applicable. This requirement is only for HMOs that participated in NYSHIP in 2015. (See Exhibit II.F for sample format.)

g. Listing of Certificate/Group Contract, Riders and/or Amendments (see Exhibit II.L for sample format). Note: Include both Commercial HMO and Medicare Advantage Plan documents.

h. Summary of Benefits and Coverage (SBC): Submit the Federally required SBC for the proposed benefit package offered through NYSHIP. If the final 2016 SBC is not available for inclusion with this submission, please submit a draft version and advise when it is expected to be finalized. A finalized SBC must be submitted as soon as it is available, but no later than October 1, 2015.

i. Additional Communication Materials to Enrollees for 2016 – Cover Letters, Optional Marketing Materials. Refer to Section IV.D of the 2016 Specifications for specific details. Please note: To ensure all Enrollees have plan information prior to the NYSHIP Option Transfer Period, HMOs must submit confirmation to the Department that all Required Communications Materials have been mailed to Enrollees by October 21, 2015.

Prescription Drug Benefit (Commercial Plan)

Provide responses to the following questions regarding your Commercial Plan prescription drug benefit:

1. Complete the following chart as applicable to the prescription drug program proposed for NYSHIP using the definitions below:

Formulary *(indicate using X in appropriate category)*				
Open or Incented[1]		Closed[2]		
Copayments for 30 day supply and 31-90 day supply				
If not available at specific pharmacy type put a "N/A" in appropriate box	Retail Acute	Retail Maintenance	Mail Order	Specialty Pharmacy
30 Day Supply				
Generic				
Preferred Brand				
Non-Preferred				
Specialty				
31-90 Day Supply				
Generic				
Preferred Brand				
Non-Preferred				
Specialty				

Cost Containment/Care Management Strategies *(indicate using X in appropriate category)*						
Mandatory Generic Requirement[1]	Prior Authorization[2]	Step Therapy[3]	Dose Optimization[4]	Half Tab Program[5]	OTC Program[6]	Generic Trial Program[7]

Definitions

Formulary:

(1) Open or Incented Formulary: The HMO provides coverage for all medications regardless of whether or not they are listed on the formulary. However, some drugs such as those for cosmetic use or over-the-counter drugs may be excluded from coverage. Members may incur additional out of pocket expenses for using non-formulary drugs.

(2) Closed Formulary: Non-formulary drugs are not reimbursed by the HMO. Administrative procedures are used to allow reimbursement for and access to non-formulary medications where medically appropriate.

Cost Containment Features:

(1) Mandatory Generic Requirement – When a generic drug is available, the HMO covers only the cost of the generic. If the member requests the brand name when a generic is available, an additional payment is required. This additional payment represents the cost difference between the generic and brand name.
(2) Prior Authorization – HMO requires members to receive authorization or approval before benefits will be provided for the prescribed drug.
(3) Step Therapy (and Fail First Requirements) – HMO requires members to try one or more "prerequisite therapy" drug(s) first before benefits will be provided for another drug.
(4) Dose Optimization – HMO requires members to switch to a higher once-daily dose of a drug when they are taking multiple daily doses of a lower strength.
(5) Half Tab Program – A voluntary half tablet/pill splitting program. By submitting a prescription for twice the dosage and half the quantity, with the physician's directions to take half a tablet at the regularly scheduled time, a member is eligible to receive the medication at half the cost of the regular copayment.
(6) OTC Program – Members allowed to choose specified over-the-counter drugs identical to the prescription version at no cost or at the lowest copay amount.
(7) Generic Trial Program – HMO covers the first 30-day fill of select generic drugs at no cost to the member.

2. How often are changes typically made to your prescription drug formulary? Describe how formulary changes are communicated to HMO providers and members.

3. Are members allowed to purchase a 90-day supply of maintenance medication at a participating retail pharmacy or only through mail order? If maintenance medications can be purchased at a retail pharmacy, state any supply limitations. In addition, describe the copayment structure applied to retail and/or mail order purchases for maintenance medications.

4. If HMO utilizes as a cost containment strategy, Mandatory Generic Requirement, describe the generic appeals procedure, if one is available, and how generic appeals information is communicated to members.

5. Does your prescription drug benefit have separate requirements or limitations for "specialty medications"? If so, please define "specialty medications" and describe the process members must use to obtain specialty medications, including whether specialty medications have to be purchased through a designated Specialty Pharmacy, supply limitations or other restrictions. If specialty medications are required to be purchased through a designated Specialty Pharmacy, have you implemented specialty prescription drug fulfillment hardship exception criteria?

Administrative Information

1. Complete the following chart listing any Key Subcontractors or Affiliates the HMO will employ to deliver a category of services to NYSHIP enrollees. A Key Subcontractor or Affiliate is a vendor with whom the HMO subcontracts to provide Program Services and incorporates as a part of the HMOs Program Team. If service is performed in-house by Contractor, indicate "self-administered" in appropriate column.

Key Subcontractors

Type of Service	Name of Organization	Contract Term and Renewal Dates	Description of Subcontracted Services
Mental Health and Substance Abuse Program Administration			
Prescription Drug Benefit Administration:			
Retail			
Mail Order			
Specialty Pharmacy			
Laboratory Services			
Utilization Review			
Medical Necessity Reviews			
Communication Materials			
Claims Processing			
Call Center			
Benefit Card			
Other (list each and describe)			

2. Describe any significant changes anticipated in your subcontracting relationships through the end of the contract term, 2016-2020.

3. Provide a listing of wellness programs/activities held or scheduled for 2015 and a summary of planned activities for 2016.

Wellness Programs/Activities

Description of Program/Activity	Planned Date

4. For your HMO business, complete the following chart listing your current ten largest employer groups in descending order by number of contracts:

Current Ten Largest Employer Groups

Employer Name	Number of Contracts

5. In accordance with Section IV.G.7 of these Specifications, please provide the following:
   - The URL address to the online prescription drug formulary you propose for the NYSHIP plan;
   - access information necessary for JLMC members to enter the HMO website to view applications available to members other than protected health information, such as provider search, wellness programs, etc.; and
   - For the Provider search, confirm the message that would be returned if a member entered a zip code outside of the HMOs approved NYSHIP service area. For example, if a member entered a Florida zip code, would the search results include providers in your Florida (non-NYSHIP) service are network instead of "NO Search Results Found"?

Provider Standards and Access Information

Amended May 21, 2015

1. Describe the method you use to determine that all members have reasonable access to Network Providers. For example, access to primary care physicians (PCP) should be within a 5-mile radius in an urban setting and 15 miles in a rural area. Provide the minimum standards you use to measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2015.

2. How do you monitor if Network Providers are accepting new patients into their practices? Do your proposed access standards take into account Provider availability; if yes, how?

3. Describe your approach for credentialing Network Providers; specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review? Include a description of how you monitor disciplinary actions by licensing agencies.

4. Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.).

5. Do you ever incorporate pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers? If yes, describe. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

6. Provide an electronic copy of the most recent Health Plan Network (HPN) report submitted to the Department of Health indicating the HMOs provider network in place at the time of submission. This electronic report must be provided for both the Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP.

7. Describe the utilization review procedures used when determining if care is medically necessary.

8. State if your plan requires referrals to network specialists. If referrals are required, describe the procedure enrollees must follow for referrals to network specialists. This information should be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

9. Describe the procedure Enrollees must follow for referrals to non-network providers. This information must be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

10. For HMOs proposing to offer both a Commercial Plan and a Medicare Advantage Plan (MAP) through NYSHIP, state if the provider networks for both plans are identical. If there are differences in the networks, describe any differences among the networks relative to provider type. For example, 95% of the primary care physicians in the Commercial Plan also participate in the Medicare Advantage Plan and 40% of the Specialty providers (HMO must define “Specialty providers”) in the Commercial Plan also participate in the Medicare Advantage Plan.

11. For HMOs proposing to offer a Medicare Advantage Plan through NYSHIP, provide the last three (3) years of CMS Star Ratings for the MA Plan that will be offered through NYSHIP. Has CMS frozen enrollment any time during the last three (3) years?