SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the Specifications is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of these Specifications.

5.1 Plan Requirements

The Offeror must provide a copy of their current DOH Certificate of Authority to operate an HMO.

In addition, the Offeror must:

1. Submit a copy of the draft NYSHIP Dependent Eligibility Rider that the organization will file with the DFS. A draft *2020 NYSHIP Dependent Eligibility Rider* (Attachment 19) provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.

   Please find our draft copy of our NYSHIP Dependent Eligibility Rider as **Tab 1**.

2. Indicate whether or not the HMO will be proposing a Medicare Advantage offering.

   BlueCross BlueShield of Western New York (BlueCross BlueShield) and BlueShield of Northeastern New York (BlueShield) are proposing a Medicare Advantage Offering.

3. Provide a list of Counties and associated rating region configuration for the HMO's proposed 2021 NYSHIP Service Area. 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. However, additional participation in underserved counties is permissible during the term of the Contract. As of January 1, 2020, the Department, in consultation with the JLMC, considers Chemung, Schuyler, Rockland, Bronx, New York, Richmond, Queens, Kings, Nassau, and Suffolk counties in New York State to be underserved. The Department, in consultation with the JLMC currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) NYSHIP HMO is offered. The definition of an

"underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.

Please find BlueCross BlueShield of Western New York's and BlueShield of Northeastern New York's list of counties as **Tab 3**.

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

   Please see **Tab 4** for a copy of our most recent annual filing of Schedule M.

5. Describe the method that the Offeror uses 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 that the Offeror uses to measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2020.

   - BlueCross BlueShield and BlueShield are committed to providing a comprehensive participating provider network for its membership
   - To meet the needs of its membership, BlueCross BlueShield and BlueShield are committed to maintaining an adequate network of providers including facility and ancillary; primary care, behavioral health, and specialty care practitioners
   - BlueCross BlueShield and BlueShield use the network adequacy requirements prescribed by the New York State Department of Health (DOH) and the Centers for Medicaid and Medicare Services (CMS) to measure provider network adequacy
   - The requirements vary between the regulatory entities
   - BlueCross BlueShield and BlueShield review network adequacy at a minumum of four (4) times per year.
     - These reviews align with reporting requirements for DOH and CMS which include network reviews for:
       - Medicare Advantage HMO and PPO
       - Commercial HMO
       - Medicaid & Child Health Plus
       - Essential Plan
       - Health Plan Marketplace products.

On a continual basis, BlueCross BlueShield and BlueShield monitor how effectively the network meets the needs and preferences of our members. This is done by analyzing network adequacy reports (as compiled through the use of Quest Analytics software) and querying the Member Services, Government Programs, Health Care Quality Improvement, and Utilization Management Departments.

The availability standards that are used for this analysis are outlined in the Credentialing Network Optimization and Composition Policy and Procedure. These include, but are not limited to the following:

Access to Care Standard in travel time/distance:

Specialty	Physician (normal conditions, primary roads)
Cardiology, Dermatology, Gastroenterologists, General Surgery , OB/GYN, Ophthalmologists, Orthopedic Surgeons, Urology	1 practitioner within 30 miles and/or 30 minutes
PCPs: Pediatrics, Internal Medicine, Family Practice, Adolescent Medicine, Geriatrics	3 practitioners within 30 miles and/or 30 minutes
Behavioral Health: Psychiatrists, Psychologists, Certified Social Workers	1 practitioner within 30 miles and/or 30 minutes

Facility	Facility (normal conditions, primary roads)
Behavioral Health Facilities: Psychiatric & Chemical Dependency ;	98% of members have access to 1 Facility within 30 miles
All Facilities: Psychiatric & Chemical Dependency ; Hospital, SNF, HHC, ASU, DME, Lab and UCC	98% of members have access to 1 Facility within 30 miles

6. Describe how the Offeror monitors if Network Providers are accepting new patients into their practices. Indicate whether the Offeror's proposed access standards take into account Provider availability. If yes, describe how.

BlueCross BlueShield and BlueShield have maintained a process to validate the accuracy of our reported provider network. The process includes direct outreach to providers listed by BlueCross BlueShield and BlueShield as participating in our provider network. The goal of this process is to validate participation by providers and to ensure providers are aware of their participation in the network and to validate the accuracy of data submitted on the Health Plan Network.

7. Describe the Offeror's approach for credentialing Network Providers; specify if the Offeror utilizes an external credentialing verification organization. When was this process last completed? What is the Offeror's process for confirming continuing compliance with credentialing standards? How often does the Offeror conduct a complete review? Include a description of how the Offeror monitors disciplinary actions by licensing agencies.

The Practitioner Credentialing and Recredentialing Programs address the selection and retention of practitioners for participation with BlueCross BlueShield and BlueShield. The purpose of using credentialing and recredentialing criteria is to establish consistent, clear objectives for the credentialing and recredentialing of participating practitioners.

SCOPE: All physicians (M.Ds, D.Os), Podiatrists (D.P.M.s), and Oral Surgeons (D.D.Ss, D.M.D.s) practicing in an ambulatory (non-hospital based) setting.

POLICY: The criteria for credentialing address the selection of practitioners seeking participation with HealthNow New York Inc., dba BlueCross BlueShield of Western New York and BlueShield of Northeastern New York. The goal of using credentialing criteria is to establish consistent, clear objectives for the credentialing process.

The decision to accept a practitioner is based on the information available, including but not limited to the information gathered through a completed practitioner application, evaluation process, and the verification of all information collected by the Credentials Department.

BlueCross BlueShield and BlueShield reserve the right to deny participation to any practitioner that is an employee or an independent practitioner of a direct competitor. General Practice is not a recognized specialty by BlueCross BlueShield and BlueShield.

BlueCross BlueShield and BlueShield do not discriminate against health care professionals who serve high-risk populations, who specialize in the treatment of costly conditions, and/or perform certain procedures. (i.e. abortions, HIV.) The credentialing process is conducted in a non-discriminatory manner, without regard, but not limited to: race, color, religion, sex, national origin, age, marital status, sexual orientation, and veteran status.

Annual audits of in-process, denied, and approved credentialing files are conducted to ensure that practitioners were not discriminated against. A spreadsheet is maintained for audit purposes. In addition, BlueCross BlueShield

and BlueShield conduct annual audits of practitioner complaints to determine if there are complaints alleging discrimination; maintains a heterogeneous credentials committee, and requires those responsible for credentialing decisions to sign an affirmative statement to make decisions in a nondiscriminatory manner. This includes affirmation on the Credentialing Committee sign-in sheet.

Effective 9/11/18, BlueCross BlueShield and BlueShield updated its Board Certification Policy.

SCOPE: All physician practitioners (MO, DO, DDS, DMD, DPM) participating with the HealthNow NewYork Inc. Products.

POLICY: All physicians are required to be currently board certified in their area of specialty. If the physician is board certified, no further action is needed.

HealthNow, New York Inc. only recognizes board certification for MD/DO medical professionals from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); The American Board of Oral Surgeons for Oral and Maxillofacial Surgery for DDS and DMD practitioners; Board of Podiatric Medicine or American Board of Foot and Ankle Surgery for DPM.

General Practice is not a recognized specialty by HealthNow New York Inc.

If a physician is not board certified he/she must meet the following standards:

1. Have admitting privileges at one (1) or more in-network hospitals or written agreement with in- network provider/group that will admit on behalf of provider.

2. Completed an accredited residency program in their area of specialty.

Admitting privilege exceptions may be granted to physician practitioners under the following conditions. If any exceptions are granted this must be documented in writing and included in the providers file:

1. If there is a demonstrated access issue (e.g., rural area, individual consideration may be given by the plan Medical Director or designee.

2. Practitioner possesses extraordinary credentials and potentially unique abilities worthy of consideration. Circumstances of this nature will be reviewed for consideration by the Medical Director or designee.

3. Physicians whom are currently sitting for their Boards. A written letter from the practitioner will be submitted along with documentation from the Board stating the date which the provider will be sitting.

Provisional Credentialing – Chapter 237 of the Laws of 2009 was amended to include new credentialing requirements effective October 1, 2009. The statute amends the language of 4406-d (1) by adding a new paragraph (b), concerning the application process for credentialing newly licensed Health Care Professionals (HCP) or HCPs locating from another state, who are joining a group practice of in-network providers. A HCP joining a group practice can be considered a "provisionally" credentialed provider on the 61st day after submitting a completed application to an MCO, if the MCO does not approve or decline the application. During this provisional period the HCP is considered an in-network provider for the provision of covered services to members, but may not act as a primary care provider (PCP).

Effective April 1, 2017 chapter 425, public health law of New York was updated to amend PHL 4406-d and Insurance Law 4803 to require health plans to more efficiently credential health care professionals. The health care plan shall complete review of the health care professional's application to participate in the in-network portion of the health care plan's network and shall, within sixty days of receiving a health care professional's completed application notify the health care professional as to (i) whether she or he is credentialed; or (ii) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instance where additional time is necessary because of a lack of necessary documentation, a health plan shall make every effort to obtain such information as soon as possible and shall make a final determination within 21 days of receiving the necessary documentation.

PROCEDURE: (Reference Practitioner Credentialing Grid for specific primary source verification and criteria information).
MINIMUM STANDARD REQUIREMENTS FOR ALL PHYSICIANS

1. All sections of the CAQH application answered/completed and attested to within 180 days of credentialing decision date.

2. Medical School Graduate (US, Canada, Educational Commission for Foreign Medical Schools).

3. Valid unrestricted license, to practice medicine in the State of New York and/or Vermont, Massachusetts or Pennsylvania, with current registration of that state. Physicians working for the Veteran's Administration Hospital will, on an exception basis, be reviewed for participation if they hold a valid unrestricted license from a state other than New York.

4. New York State: Copy of current professional liability (malpractice) insurance binder/certificate indicating minimal liability limits of $1,000,000 per occurrence and $3,000,000 aggregate. (1.9/3.9 million if required by NYS to carry excess insurance). ***Physicians that practice more than fifty percent (50%) of the time within The Commonwealth of Pennsylvania qualify and secure protection for the Catastrophic Loss Fund which adds an additional layer of protection of $1,000,000 per occurrence and $3,000,000 aggregate over the basic limits of $200,000 per occurrence and $600,000 aggregate. The Catastrophic Loss fund or CAT Fund is administered by the Pennsylvania Medical Society Liability Insurance Company (PMSLIC).

5. Current DEA certificate (as applicable). Not applicable to Pathologists.

6. Attests to no physical or mental health problems that interfere with providing medical care, with or without accommodation.

7. Provides 24 hour coverage, seven days per week. (See Telephone/24 Hour to Access to Care Policy and Procedure.)

8. List of Continuing Medical Education (CME) credits for the previous three years or Certificate of Recognition for CME credits.

9. Attestation to clinical privileges at the hospital designated as the primary admitting facility.
   Affiliation types: temporary, courtesy, active, non-clinical (teaching). Another arrangement would be that the provider would admit to the hospital service. The hospital service would be managed by a hospitalist group at the facility.

   Admitting privileges are included with the hospital affiliation type: temporary, courtesy and active.

   For providers with no hospital affiliation, information must be given regarding their use of either covering providers or an arrangement with a hospitalist group. Primary source verification will be a copy of the arrangement between the physician and the covering provider. The provider may also (as stated above) use the hospital service for their patients.

For example: If a provider states that they use hospitalists, no hospital affiliation will be indicated on the application. The covering provider or hospitalist group must be participating.

10. Must demonstrate an appropriate history of employment, clinical practice and hospital privileges for the previous 5 years. Documents evaluated for continuous 5 year work history post-graduation. New graduates may have less than 5 year work history. Provider must provide verbal or written explanation for any employment history gap of 6 – 12 months. Written explanation is required for employment history gaps of more than 12 months.

11. A requirement of the BlueCross BlueShield and BlueShield standards for physicians is as follows: Exchange of information in an effective, timely and confidential manner. This includes, but is not limited to, patient approved communications between medical practitioners and behavioral health practitioners and providers. The information must be communicated within 30 days of treatment date.

12. All sections of the Disclosure of Ownership and Control form answered/completed and attested to within 180 days of credentialing decision date.

13. Proof of Office-Based Surgical Procedure accreditation if the physician performs any surgical or other invasive procedure outside of a hospital, diagnostic & treatment center or Article 28 facility in which a moderate sedation or deep sedation or general anesthesia is utilized to provide comfort to a patient in order to perform the procedure. Office-based Surgical Procedure accreditation:
    - Accreditation Association for Ambulatory Health Care (www.aaahc.org)
    - American Association for Accreditation of Ambulatory Surgery Facilities (www.aaaasf.org)
    - The Joint Commission (www.jointcommission.org/accreditationprograms/office-basedsurgery)
    - DNV – Det Norske Veritas (www.dnvglhealthcare.com/hospitals)

14. Board Certified as outlined in Board Certification Policy 2015. Physician certification:
    - American Board of Medical Specialties
    - American Osteopathic Yearbook (on-line)
    - The American Medical Association Masterfile if not Board Certified at facility where residency completed, or
    - Educational Commission for Foreign Medical Schools

Primary source verification will be completed through the following sources and document the following:

- Licensure
- Confirmation of clinical privileges at designated primary admitting facility (this includes, but not limited to date of appointment, standing/status of clinical privileges and restrictions).
- National Practitioner Data Bank (NPDB)

For exclusions, sanctions or opting out of Medicare:

- Office of Medicaid Inspector General (OMIG)
- Office of Inspector General (OIG)
- System for Award Management (SAM)
- Social Security Administration list – effective June 2017, utilizing ATTUS' WatchDOG elite to access the SSA list. Previously, used NTIS' Death Master File (which was in effect June 2015).
- Opt Out status (NGS for NYS physicians and Novitas for PA physicians). If the practitioner's name appears on the "Opt-out" list, the practitioner cannot participate in any BlueCross BlueShield and BlueShield Medicare Advantage products.
- License sanctions (health.ny.gov)
- Effective 1/1/19, CMS Preclusion List

PRIMARY CARE PHYSICIAN

All Primary Care Physicians must have satisfactory completion of the on-site/medical record keeping review to be completed by the Provider Relations staff.

Family Practice, Internal Medicine, Geriatric Primary Care and Pediatric physicians will be credentialed as primary care physicians, if they are Board Eligible and have successfully completed an approved post- graduate training program in these fields.

1. Obtains an average of 50 Continuing Medical Education credits (CME) per year, over a three year period, in Primary Care Medicine or corresponding specialty recognition Award for Continuing Medical Education.

2. If the physician has not met the requirements for Continuing Medical Education credits or corresponding specialty recognition Award for Continuing Medical Education, he/she will be required to obtain an average of 50 CME credits per year at the following re-credentialing cycle.

SPECIALIST PHYSICIAN

The physician must have completed postgraduate training in the specialty and be Board Eligible in the specialty in which they are practicing. The following is also required:

1. Unrestricted privileges in the specialty requested at every hospital in which the physician practices. Not required for Radiology, Dermatology, Pathology, and Anesthesia (at Ambulatory Surgery Centers).

2. Obtains an average of 50 Continuing Medical Education credits (CME), over a three year period in the specialty per year or corresponding specialty recognition Award for Continuing Medical Education.

If the physician has not met the requirements for Continuing Medical Education credits or corresponding specialty recognition Award for Continuing Medical Education he will be required to obtain an average of 50 CME credits at the following recredentialing cycle.

3. Postgraduate training is verified through AMA or AOA for DOs for residencies. If information is not available through the AMA source, then the school where residency was completed must be contacted directly and must verify completion of program.

All Behavioral Health Specialists must have a satisfactory completion of the on-site/medical record keeping review.

All Specialist physicians must have clinical privileges at designated primary admitting facility commensurate with license, in good standing with facility as applicable.

All Allergists must be Board Eligible by the American Board of Allergy & Immunology.

Specialist physicians are responsible for notifying their patients, in writing, when they are no longer participating with BlueCross BlueShield and BlueShield within three (3) working days of the termination.

DUAL APPOINTMENT PHYSICIANS

A physician who seeks to be credentialed both as a primary care physician and a specialist physician (i.e. OB/GYN, Geriatric Medicine) must demonstrate:

1. That training requirements of both primary care physician and specialty physician have been successfully completed and that they are board-eligible in both a general and sub-specialty.

2. Obtains 25 Continuing Medical Education credits in primary care medicine in addition to 75 Continuing Medical Education credits in the specialty per two (2) year cycle.

3. If the physician has not met the requirements for Continuing Medical Education credits or corresponding specialty recognition Award for Continuing Medical Education, he/she will be required to obtain an average 50 CME credits at the following re-credentialing cycle.

4. All specialists seeking participation as a primary care physician must have clinical privileges at designated primary admitting facility.

5. A physician who seeks to be credentialed with a sub-specialty in Addictions Medicine must be Board Eligible in their primary specialty (FP, IM, etc) and receive a certificate of training from the American Board of Addictions Medicine.

PODIATRISTS

All Podiatrists must have hospital privileges commensurate with license, and be in good standing with a facility in the managed care and PPO network(s), as applicable.

All Podiatrists are required to be board-eligible or qualified by the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. All Podiatrists are required to obtain twelve (12) continuing education credits per calendar year.

If the podiatrist has not met the requirements for Continuing Medical Education credits, he will be required to obtain 12 CME credits at the following recredentialing cycle.

If the criteria are not met, the Medical Director will review the credentials on a case by case basis. BlueCross BlueShield and BlueShield in its sole judgement has the authority to accept participation for the managed care and PPO product(s) under

the appropriate circumstances.

OFFICE-BASED SURGICAL & INVASIVE PROCEDURE ACCREDITATION

Public Health Law Section 230-d describes the required accreditation process for MDs, DOs, or PAs who perform any surgical or other invasive procedure outside of a hospital, diagnostic & treatment center or Article 28 facility in which a moderate sedation or deep sedation or general anesthesia is utilized to provide comfort to a patient in order to perform the procedure. The approved accrediting agencies designated by the NYSDOH Commissioner are:

- Accreditation Association for Ambulatory Health Care (www.aaahc.org)
- American Association for Accreditation of Ambulatory Surgery Facilities (www.aaaasf.org)
- The Joint Commission (www.jointcommission.org/accreditationprograms/office-basedsurgery)
- Det Norske Veritas- DNV (http://dnvglhealthcare.com/hospitals)

Primary source will be verified and the accreditation certificate, ID#, date and State will become part of the practitioner's file.

NOTIFICATION

The practitioner is notified within sixty (60) calendar days, via e-mail, of their participation status. Should a practitioner inquire about their credentialing status, the Credentialing Specialist will review the practitioner's record in Cactus and verbally convey the information to the practitioner. The Credentialing Specialist will offer the practitioner written confirmation at the discretion of the practitioner. If the practitioner requests this written verification, the Credentialing Specialist will send it within two (2) working days.

Recredentialing Overview

A. Collection of Information

The objective of the Recredentialing Program is to ensure the retention of practitioners who have the same qualifications that are required for initial participation under the Practitioner Credentialing Program. The information provided will be evaluated in accordance with the Practitioner Credentialing Criteria.

The decision to retain or not retain a participating practitioner is based on the totality of information available, including information gathered through the recredentialing process and verified as complete by the Credentials Committee. Review of information to evaluate continued participation of practitioners is ongoing and periodic.

All recredentialing information is reviewed by the Medical Director or designee and the Credentials Committee. The Credentials Committee makes the final decision regarding continued participation.

B. Recredentialing Process

Participating providers will be recredentialed at a minimum of every three years.

The CAQH application must be updated for the recredentialing process to be completed. Sixty days prior to the recredentialing due date, the Credentialing Specialist ensure the form has been completed.

A critical component of recredentialing includes the evaluation of information obtained through the following sources:

- Quality reviews
- On-site reviews, as applicable
- Medical records reviews, as applicable
- Utilization data
- Member satisfaction surveys
- Member complaints
- Adherence to the policies and procedures of BlueCross BlueShield and BlueShield
- Verification of renewal of credentials with expiration dates.

1. **Credentials that expire include:**
   - State license/registration to include sanction status
   - DEA certificate
   - Malpractice coverage
   - Board certification, where applicable
   - Medicare/Medicaid sanction status
   - Medicare Opt-Out status

Proof of renewal of these documents is required upon recredentialing from primary sources for participating practitioners.

2. **Recredentialing on CAQH**
   - Practitioners will be required to complete the Recredentialing process, at a minimum, on a triennial basis (at least every 36 months). Providers must regularly update their CAQH application for the recredentialing process to be completed timely.
   - An updated list of hospitals in which the practitioner has privileges must be obtained. Changes to hospital affiliation are investigated by the Provider Relations and Contracting team. If a practitioner's hospital privileges have

clinical restrictions, this information will be evaluated by the Credentials Committee.

- If at the time of credentialing the physician was, according to the American Board of Medical Specialists, a board candidate in the specialty in which he/she practices, then he/she is strongly encouraged to have achieved board certification within the five-year period following completion of his/her residency. Physicians approved prior to the effective date of this policy are not subject to this qualification.
- Office practice information must be updated as part of the practitioner re-evaluation process, then reviewed to confirm continued adequacy of practice coverage arrangements and access.
- Information requested pertains to hospital privileges, professional disciplinary actions, license suspension or revocation (whether or not stayed), malpractice history, the physical/mental health of the practitioner, and chemical dependency/substance abuse history. As in the Credentialing Program, any practitioner who answers affirmatively to any of the disclosure questions, and who does not provide adequate information regarding the matter, must be contacted to obtain details and documentation.
- Recredentialing of any practitioner who answers affirmatively to any disclosure question is subject to review by the Credentials Committee.

The CAQH application must be signed and dated by the practitioner to be considered complete.

C. Ongoing Re-evaluation

Each practitioner's performance as a participating practitioner will be monitored on an individual basis. Each physician must comply with the requirements under contractual obligations with BlueCross BlueShield and BlueShield. Data will be maintained in the Internal Performance Evaluation Directory and incorporated as it becomes available. This information will be reviewed by the Credentials Committee for the purpose of practitioner recredentialing.

1. Clinical Measures - sources of information may include Utilization Management reports, medical record reviews, and focused quality of care reviews.
2. Service Measures - sources of information may include information from grievances filed, member complaints, feedback regarding primary doctor changes, and member satisfaction surveys.

D. Administration of Ongoing Review

A practitioner's profile will accumulate continuously as data becomes available. The data will be incorporated in each participating practitioner's credentialing file. In addition, it may be captured in a report card that summarizes number and type of occurrence (e.g., grievances and complaints, results of medical record reviews

and quality of care reviews).

E. Timetable

Applicable physicians and health care professionals will be reviewed, at a minimum, on a 36 month recredentialing cycle. BlueCross BlueShield and BlueShield may require participating practitioners to be recredentialed more frequently at the recommendation of the Medical Director, Credentials Committee, the Quality Improvement Committee, or any other internal source.

License Sanction Review and Decision Making Process

We complete surveillance of the network for practitioners whose license to practice their profession has been sanctioned by the New York State Office of Professional Medical Conduct or the New York State Board of Regents or any state in which the practitioner has or has had a license to practice their profession. Surveillance will include review for sanctions from any local, state, or federal government agency or department.

On a monthly basis, credentialing personnel will review regulatory bulletins published by Office of Professional Medical Conduct, New York State Board of Regents, any local, state, or federal government agency or department, or other resource for disciplinary actions taken against practitioners. IOG, OMIG and SAM are viewed monthly for exclusions for Medicaid and Medicare.

Procedure:

When a sanctioned practitioner is identified, verification of the sanction from the regulatory agency will be requested and documented. Any additional information received from the reporting agency will become a permanent part of the practitioner record. All records are kept for a minimum of seven years after termination.

If the sanctioned practitioner does not provide a response within 30 days of receiving the initial request for information, the practitioner will be subject to termination per the Termination Policy and Procedure.

If the sanction is revocation of license, suspension without stay of the suspension, or summary suspension, confirmation of the sanction by the reporting agency will be obtained. If any of the above sanctions are confirmed, the practitioner will be terminated from the provider panel(s) per the Termination Policy and Procedure.

If the sanction indicates that the practitioner may not participate in the Medicare or Medicare program(s), the practitioner will be removed from the appropriate panel(s), and the information will be presented to the Credentials Committee to determine continued participation in the Commercial Managed Care Network.

If termination is recommended, the practitioner will be terminated per the Termination Policy and Procedure.

All other sanctions will be reviewed on a case-by-case basis by the Credentials Committee for recommendation to the Chief Medical Officer or designee regarding termination or continued participation with or without restriction.

8. Explain the Offeror's approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements that the Offeror has with each type of Provider (e.g., per diems, case rates, hourly rates, all-inclusive per diems covering Facility and Practitioner fees, etc.).

   Examples of Provider reimbursement include fee schedule that is based on a percentage of Medicare, DRG, bundled payments, case rates, per diems, and percent of charge.

   The Medicare fee schedule is used as a basis for most of BlueCross BlueShield and BlueShield's physician and facility contracts in Western New York and Northeastern New York. The inpatient facility contractual arrangements are paid at a percentage of the prevailing Medicare rates and reimbursement is based on Medicare DRG and SIW. Outpatient facility contractual agreements are based on various methodologies, such as case rates (e.g., ER visits), fee schedules and percentage of charges. Outpatient ancillary contractual arrangements are based on the Medicare professional fee schedules.

   Our provider compensation strategy is to shift from traditional fee for service reimbursement methodologies to value-based contracting models. For example, in 2014 we implemented various shared-savings pilots, as well as a bundled payment model for outpatient total joint replacements. In 2015, we began compensating providers for demonstrating that their diabetic patients' blood glucose is controlled through the use of CPT Category II codes. This rewards the provider real time for ensuring their diabetic patients are well managed, which ultimately results in reduced health care costs.

   Additionally, understanding how important it is that our Medicare Advantage population receives their annual wellness visit, we have enhanced the fee schedule for the initial and subsequent visits to incent and appropriately compensate physicians for this extended assessment. The Annual Wellness Visit is a comprehensive office visit that includes the completion of a health risk assessment, resulting in a personalized prevention plan to guide the patient's overall health management.

We continue to expand alternative reimbursement models, which include but are not limited to the following models:

- Primary Care Provider - Continued expansion and transformation of fee-for-service reimbursement into outcome and value based alternative payment models that support Primary Care Providers and adhere to the triple aim. In 2017 BlueCross BlueShield, in our Western New York region, implemented its premier Best Practice payment program which is inclusive of a risk, efficiency, quality and performance based per-member per-month care partial capitation payment. A similar alternative value-based payment program is intended to be expanded to a selection of large clinically integrated practices in Northeastern New York region in 2019.
- Inclusion of additional CPT Category II payments to reward for positive health outcomes at the time of service,
- Expansion of bundled payments for various disease states and/or medical conditions

9. Indicate whether the Offeror ever incorporates pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers. If yes, describe.

   Yes, we have a physician pay-for-performance program that focuses on improving quality outcomes and fostering delivery of preventive care. Please see our response to Question 4 for further information regarding our innovative programs that reward providers for performance, health outcomes, and control of medical expense.

10. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

    We have a few shared savings programs that in a pilot phase. We are currently looking to implement value based compensation models that may include capitation (without withhold), expansion of bundled payment, and outcomes based and risk based reimbursement. The implementation timeline is over the next one (1) to three (3) years.

11. Provide an electronic copy of the most recent Health Plan Network (HPN) report submitted to the DOH indicating the HMO 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.

    As this is too large to include in our hard copy submissions, this is attached as **Tab 5, Exhibit 1** in our electronic submission.

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

Medical necessity is based on the following definition from the BlueCross BlueShield Association:

The term “Medically Necessary” means technologies, services, procedures, treatments, supplies, devices that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease (note: Not all contracts contain this medical necessity criterion).

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors. A service or treatment which is appropriate and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered.

In order to determine if a procedure is “medically necessary” the service is reviewed based on our Corporate Medical Protocols. Corporate Medical Protocols are reviewed and re-evaluated at least annually, and more frequently as new information emerges that affects them. When no protocol exists, a criteria hierarchy is followed for determination of the most appropriate medical criteria to use. For example, it may be most appropriate to refer to InterQual guidelines (licensed), Medicare guidelines, or input from a physician consultant who is board-certified and has recognized expertise in a particular subject matter, including a physician from one of our delegated vendors.

Our Corporate Medical Protocols are posted on both our member and provider websites.

13. If the Offeror previously participated in NYSHIP, provide the total appeals filed by, or on behalf of NYSHIP Members for the previous plan year. Please provide the number of upheld, denied, and modified internal and external appeals. For internal appeals, HMOs must provide a breakdown of appeals by administrative and clinical categories.

    The 2019 NYSHIP appeals file are below:

Appeal Type	Denial Overturned, Appeal Approved	Denial Upheld, Appeal Denied	Grand Total
NY State External Standard Appeal	1	5	6
Standard Post-Service Appeal	2	7	9
Standard Pre-Service Appeal	10	22	32
Grand Total	13	34	47

14. State if the Offeror 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.

    Commercial plans and Medicare Advantage plans do not require referrals to network specialists. Both plans, however, do require referrals for out-of-network specialists. The member's primary doctor or an in-network specialist is responsible for referral submission on behalf of the member. We encourage members to ensure referral authorization for out-of-network services prior to accessing those services.

15. 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.

    Commercial plans and Medicare Advantage plans do not require referrals to network specialists. Both plans, however, do require referrals for out-of-network specialists. The member's primary doctor or an in-network specialist is responsible for referral submission on behalf of the member. We encourage members to ensure referral authorization for out-of-network services prior to accessing those services.

16. 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.

    BlueCross BlueShield of Western New York and BlueShield of Northeastern New York are proposing both a commercial HMO Plan and a Medicare Advantage plan.

    The Commercial and Medicare Advantage networks in both Western New York and Northeastern New York service area counties are as follows:

    All hospitals in Commercial are also in Medicare: 100%

    NENY Commercial PCP: 796
    NENY Medicare Advantage PCP: 706
    Percentage of MA in Commercial network: 88%

    NENY Commercial Specialists: 5,122
    NENY Medicare Advantage Specialists: 4316
    Percentage of MA Specialists in Commercial network: 85%

    WNY Commercial PCP: 988
    WNY Medicare Advantage PCP: 810
    Percentage of MA in Commercial network: 82%

    WNY Commercial Specialists: 7827
    WNY Medicare Advantage Specialists: 5881
    Percentage of MA Specialists in Commercial network: 75%

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

    Provided below is our CMS Star Rating for our MA plan offering through the last three years:

    Year CMS Star Rating
    2020: 4 Stars
    2019: 3.5 Stars
    2018: 4 Stars

18. Describe the Offeror's Medicare Enrollment reporting process. This description must include how changes to Medicare eligibility and enrollment/ disenrollment is identified and the proposed frequency and method these enrollment changes will be provided to the Department. Additionally, an Offeror is encouraged to suggest/identify a methodology of preference that will facilitate the most accurate and frequent sharing of information.

    We create an eligibility and termination report monthly with the enrollments and terminations of current Medicare Advantage members.

    The report includes effective date, disenrollment date, name, address, MBI, TRR code if a termination.

    This report will be weekly for 2021 per the request in this submission.

19. Describe the Offeror's process for Enrolling Members into their Medicare Advantage that conforms to the requirements set forth in Chapter 2 of the MMCM.

    Commercial members who age into Medicare automatically are enrolled in the MA per the "NYBEAS" file. We also utilize a CMS report weekly to make sure we are capturing retirees' who should be enrolled in MA and we manually enroll them in the MA plan per CMS guidelines.

20. Provide current status of the NCQA or URAC rating. Please provide the 5-point NCQA rating scale or the applicable URAC rating. The JLMC encourages an HMO to seek accreditation by nationally recognized organizations such as NCQA or URAC. If not currently accredited by NCQA or URAC, provide a detailed explanation why accreditation was not obtained.

2019-2020 Rating Results Summary
Ratings include both accredited and nonaccredited health plans.

HealthNow Results

PRODUCT	2019-2020 Rating
Private/Commercial	**4.5**
Medicare HMO	**4.0**
Medicare PPO	**4.0**
Medicaid	**3.5**

21. HMOs (charitable organizations) that are not for profit entities must provide a statement that the organization is exempt pursuant to one of the categories indicated on the Office of Attorney General's Request for Registration Exemption (Schedule E). The statement must identify the specific category under which the charitable organization is exempt.

HealthNow New York Inc. is registered as a Charitable organization with the NYS Attorney General's office. Our annual CHAR500 form (annual charity form filing) which is filed with the NYSAG is attached as **Tab 5, Exhibit 2**. Please note this is our 2018 filing as there was no activity for 2018 or 2019. The 2019 filing is in process and due until November.

22. Outline what, if any, coverage is available to both Commercial and Medicare Members travelling outside of the United States. Please provide an overview for both Commercial and Medicare coverage as well as emergent, non-emergent and prescription drug services.

Commercial

We offer **Away From Home Care** for our commercial members. This unique offering provides employees and their dependents access to in-network care when living away from home. Available in 32 states, Away From Home Care is perfect for students away at school, families living in different parts of the country, and long-term travelers.

Members must meet one of these criteria to qualify for the Away From Home Care Program:

Long-Term Traveler – A member or covered dependent traveling outside the plan's service area for up to 90 days.
Families Living Apart – Applies when a member is required by court order to assume responsibility for a dependent's medical coverage, and the custodial parent or dependent child lives outside the member's plan service.
Student – A member's dependent that lives outside the plan's service area to attend school, but whose principal residence is still the member's permanent residence. Student guest memberships are effective in September for one year; however, students may extend guest membership benefits for subsequent school years by completing a new application.

Commercial and Medicare

Worldwide Coverage
Members are covered for emergency anywhere in the world. While traveling outside of their health plan service area, all they have to do is show their member ID card (also known as the BlueCard) to any participating BlueCross BlueShield plan doctor or hospital whenever they need medical care.

23. Provide an overview of the current telemedicine/telehealth program available to NYSHIP Members in the HMO. Explain if there is an out-of-pocket cost to Members for these services and what the cost would be. Indicate if the program is administered in house or if the HMO uses a subcontractor. Describe when Members have access to telemedicine/telehealth services.

BlueCross BlueShield and BlueShield offer both Telemedicine and Telehealth services to our members. Please see below for definitions of each of these services. These benefits apply to the member out-of-pocket maximum and will apply the primary care physician cost share.

Telehealth
If any of our participating providers offer covered services using telehealth, BlueCross BlueShield and BlueShield will not deny the covered services because they were delivered using telehealth. Covered services delivered using telehealth may be subject to utilization review, quality assurance requirements, and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. “Telehealth” means the use of electronic information and communication technologies by a participating provider to deliver covered

services to a member while the member's location is different than he provider's location.

Telemedicine

In addition to providing covered services via telehealth, we cover online internet consultations for providers who participate in our telemedicine program for medical conditions that are not an Emergency Condition. Not all participating providers participate in our telemedicine program. Our telemedicine program allows members to communicate with doctors via two-way video, secure chat, or telephone from the comfort of their home or office. Medical conditions that would be appropriate for this service include: cold or flu symptoms, periodic pains, and prescription refill or general health questions. Technical requirements for this service: A high-speed Internet connection, an up-to-date web browser (Explorer, Firefox, or Safari), and Adobe Flash are needed to access our telemedicine program which is hosted by our vendor/provider Doctor on Demand. http://www.doctorondemand.com/.

Members can access providers 24 hours a day, seven days a week.

24. Provide confirmation that the HMO will cover the diagnosis and treatment of Gender Dysphoria. Please also provide any Member cost-sharing or prior authorizations that may apply.

    Confirmed. We are required to cover medically necessary services associated with Gender Dysphoria. Services may include office visits, laboratory, mental health services, drug therapy and gender reassignment surgery.

25. Complete the charts and answer the narrative questions as they appear on the *Prescription Drug Benefit Form* (Attachment 14).

    Confirmed.

26. 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. If the Certificate of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Certificate and separate out the prescription drug coverage provisions.

    Confirmed.

27. 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. If the Evidence of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Evidence of Coverage and separate out the prescription drug coverage provisions.

    Confirmed.

28. A completed *Commercial Benefits Chart* (Attachment 35) and *Medicare Benefits Chart* (Attachment 36) for both Commercial and Medicare Advantage Plans, as applicable, citing where each of the named benefits proposed for 2021 can be found in Contract or rider language. All Contracts and/or riders relating to the 2021 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.

    Confirmed.

5.2 Member Communication Material Requirements

The Offeror must:

1. Submit drafts of the Cover Letter for the Member communications materials mailing to HMO Members, federally mandated Summary of Benefits and Coverage (SBC) and Schedule of Benefits, in both hard copies and PDF with their Proposals. In addition, those HMOs that participated in NYSHIP in 2020 are required to submit drafts of the Side by Side Comparison of Benefits in both hard copies and PDF with their Proposals. HMOs that did not participate in NYSHIP in 2020 will not be required to furnish the Side by Side Comparison with their Proposals.

    These have been included as **Tabs 12, 13, 15, and 16** as outlined in the following responses.

2. The Offeror must provide a list of wellness programs/activities held or scheduled for 2020 and a summary of planned activities for 2021 using the Wellness Programs/Activities chart (Attachment 15).

   These have been included as **Tab 10**.

3. The Offeror must provide a list of its current five largest employer groups in descending order by number of contracts using the *Current Five Largest Employer Groups* chart (Attachment 16).

   These have been included as **Tab 11**.

4. Federally required Summary of Benefits and Coverage (SBC) for the proposed benefit package offered through NYSHIP. If the final 2021 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, 2020.

   These have been included as **Tab 12**.

5. Additional Member Communication Materials to Members for 2021 – Cover Letters, Marketing Materials. Refer to Section 3.6 of these Specifications for specific details. To ensure all Members 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 Members by October 21, 2020.

   These have been included as **Tab 13**.

6. Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. HMOs will have ten business days to complete their HMO e-page(s), after which time, access will be denied. All HMOs submitting Proposals will be required to access a Department online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool. [**Note:** HMOs will ONLY be granted access to the Department's online data interface with their ePage if they have completed and submitted an affirmative *Notice of Intent* (Attachment 28) to participate in the

2021 NYSHIP plan year. The *Notice of Intent* will only be considered valid if it is sent to both the Department and the *JLMC Contact Members* (Attachment 13).]

HMOs that participate in NYSHIP during 2020 will be able to edit selected fields of their 2021 Choices page content in the electronic templates to accurately describe plan benefits for the 2021 Plan Year. HMOs that did not participate in NYSHIP during 2020 will access blank electronic templates to electronically submit their Choices page information.

The Department's Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off for accuracy via e-mail from the Communications Unit. Benefits described on an HMO's Choices pages will be binding upon such HMO, even in the event of erroneous oversight during such review.

These have been included as **Tab 14**.

7. Schedule of Benefits required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. [**Note**: If this is part of the Offeror's Certificate of Coverage and/or Evidence of Coverage, indicate page numbers where this information can be found].

   These have been included as **Tab 15**.

8. Side by Side Comparison of Benefit Changes 2020 to 2021 (document must be titled as such) identifying changes from 2020 (current year) to 2021 (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 Members 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 2020. See *SAMPLE Side-by-Side Comparison* (Attachment 25).

   These have been included as **Tab 16**.

9. Listing of Certificate/Group Contract, Riders and/or Amendments (see *SAMPLE Contract and Rider* Summary (Attachment 30)). Include both Commercial HMO and Medicare Advantage Plan documents.

   These have been included as **Tab 17**.