

Please read the "NYSDOH MCO and IPA Provider Contract Guidelines" before completing this form. Complete a separate statement for each provider contract or material amendment for which the MCO is seeking approval. If additional space is needed, attach a continuation page and identify the question(s) by number. If all applicable questions are not answered, if answers are determined to be incomplete or inaccurate, or required supporting documentation is not attached, the agreement will not be accepted for review. Do not use this form for management contracts.

**Submission includes:** **Date:** \_\_\_\_\_

<p><b>i. Check one:</b></p> <p><input type="checkbox"/> Contract</p> <p><input type="checkbox"/> Contract Template<sup>1</sup></p> <p><input type="checkbox"/> Material Amendment</p> <p><input type="checkbox"/> Extensive Non-Material Amendment Revisions</p> <p>Orig contract #: _____</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%;"></td> <td style="width: 10%; text-align: center;">MM</td> <td style="width: 10%; text-align: center;">DD</td> <td style="width: 55%; text-align: center;">YYYY</td> </tr> <tr> <td>Orig approval date:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Orig effective date:</td> <td></td> <td></td> <td></td> </tr> </table>		MM	DD	YYYY	Orig approval date:				Orig effective date:				<p><b>ii. Anticipated effective date:</b> _____</p> <p style="text-align: right;">MM/DD/YYYY</p> <p><b>iii. MCO Unique Contract or Amendment ID #</b> <i>(required, must also be indicated on each page of the contract):</i></p> <p>_____</p> <p>_____</p>
	MM	DD	YYYY										
Orig approval date:													
Orig effective date:													

**iv. Standard Clauses Appendix attached?**  Yes  No

The main body of the contract must expressly incorporate the Appendix and state that in the event of inconsistencies the Appendix controls. Identify the relevant provision.

Contract Page: \_\_\_\_\_ Clause: \_\_\_\_\_

**v. Does this contract delegate any management services? (N/A on IPA/Provider Agreements)**

Yes, identify the relevant contract provision and provide a brief summary:

Contract Page: \_\_\_\_\_ Clause: \_\_\_\_\_

Summary: \_\_\_\_\_

No

**vi. Does this contract contain an "exclusivity", "exclusion" or "most favored nation" clause as described by items #21, 22 and 23 in Section V.A. in the MCO and IPA Provider Contract Guidelines?**

Yes, identify the relevant contract provisions

Contract Page: \_\_\_\_\_ Clause: \_\_\_\_\_

No

**vii. Check if enclosed: (N/A on IPA/Provider Agreements)**

MCO Contractor's (and guaranteeing parent's if applicable) most recent certified audited financial statement

Proof of Financial Security Deposit (i.e., annotated bank statement)

**Section A: Contracting Parties**

**1. MCO Name:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**2. Agreement between:**  MCO and IPA\*  MCO and Provider  IPA and Provider  IPA and IPA\*

*\*Intermediate entities are limited to an IPA, Laboratory or Pharmacy and all should be treated as an IPA for the purposes of this form. Contracts between a MCO and IPA must be submitted together with all related IPA/provider or IPA/IPA agreements. A separate Contract Statement and Certification is required for each agreement.*

<p><b>3. Primary IPA Name:</b> _____</p> <p><b>Address:</b> _____</p> <p>City _____ State _____ Zip _____</p> <p>Phone: _____</p>	<p><b>4. Provider Name:</b> _____</p> <p><b>Address:</b> _____</p> <p>City _____ State _____ Zip _____</p> <p>Phone: _____</p>
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**5. Check all lines of business covered by contract:**

<input type="checkbox"/> Child Health Plus	<input type="checkbox"/> Commercial	<input type="checkbox"/> Family Health Plus	<input type="checkbox"/> HIV SNP	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Medicaid Advantage	<input type="checkbox"/> Medicare	<input type="checkbox"/> PACE	<input type="checkbox"/> Partial MLTC	<input type="checkbox"/> MAP

**6. Type of Provider:**

Hospital  Medical Group  Individual Practitioner  IPA  FQHC  Other

**DOH USE ONLY**    **ON DOS: Y / N**    **IFN ON SRVR: Y / N**    **DOH CONTRACT ID#:** \_\_\_\_\_

<sup>1</sup> Templates may only be approved to form and cannot contain risk arrangements requiring DOH review as per the Contract Guidelines.

## Section B: Contract Provisions

7. Briefly describe the purpose of this contract/amendment: \_\_\_\_\_

8 a. Contracted Services: **Check only one:**

Contract is for single service

Contract is for multiple services

8 b. Check all categories of health care services covered under the contract, each service provided directly by the provider, covered under the contract but through subcontracts with participating providers, and check each service if payment will be made FFS or with a withhold/bonus no greater than 25%, with no other risk sharing arrangement.

Category of Services Covered	Provided Directly	Covered Through Participating Provider Network	Service Paid FFS or Withhold/Bonus up to 25%
<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Specialist Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory Surgery/Other Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> DME	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Home Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental Health/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nursing Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orthopedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Personal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Private Duty Nursing Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <i>Other than above</i> _____			
<input type="checkbox"/> Out of Provider Network Referral Services			

8 c. Is alternate dispute resolution included in lieu of external appeal for contracts with an Article 28 facility?

Yes, identify the relevant contract page(s):

Contract Page: \_\_\_\_\_

Clause: \_\_\_\_\_

No

**Section C: Financial Arrangements Between MCO and IPA or MCO and Provider**

(N/A on IPA/Provider Agreements)

9. Indicate payment methodology and any risk sharing arrangements for health care services in this contract (check all that apply):

Fee for service Contract Page(s)  Clause:

Withhold or bonus  
 Up to 25% of IPA/Provider payments  Greater than 25% of IPA/Provider payments

Capitation Contract Page(s)  Clause   
 Prepaid  Not Prepaid<sup>2</sup>

Risk Pools  
Contract Page(s)  Clause

Other (describe) \_\_\_\_\_  
Contract Page(s)  Clause

10. If "Withhold/bonus greater than 25%", "Capitation", "Risk Pools" or "Other" is checked in question #9:

a. What is the expected number of members covered under this contract at the end of the first contract year? \_\_\_\_\_

b. What is the expected number of member months paid under this contract for the first contract year? \_\_\_\_\_

11. If MCO/IPA Agreement, PROVIDER will be paid by:

IPA  MCO  MSO  Other (describe): \_\_\_\_\_

12. Applicability of State Insurance Department (SID) Regulation for Capitation Agreements:

a. Does this contract's compensation FALL UNDER the SID Regulation 164 definition of prepaid capitation?  
 Yes → Does this contract REQUIRE APPROVAL under Part 101 of Title 11 of NYCRR (Regulation 164)?  
 If Yes, provide date contract submitted to SID for approval: \_\_\_\_\_  
 SID approval letter has been received and is attached.  SID approval not yet received.

No, exempt because expected 12-month payments are:  Less than \$250,000  Less than \$1,000,000

No, compensation does not fall under SID Regulation 164

b. Identify contract provision describing payment timing.  
Contract Page:  Clause:

If all financial arrangements fall under SID Regulation 164, are fee-for-service, or are fee-for-service with a withhold/bonus of no more than 25%, or if the contract is for a single directly provided service (except hospital inpatient), skip questions 13 - 15, proceed to the Certification.

13. DOH Financial Viability Requirements:

a. Net worth of the MCO's contractor (Hospital, IPA, Provider): \$ \_\_\_\_\_ As of: \_\_\_\_\_  
*The most recent certified audited financial statements (or comparable means, such as accountant's compilation) for the MCO's contractor must be included with this package.*

b. Is a parent company providing a guarantee for services and payment?  
 Yes, identify the guarantee contract provision, provide a brief summary and indicate net worth of parent:  
Contract Page:  Clause:   
Summary: \_\_\_\_\_  
Net worth of guaranteeing parent: \$ \_\_\_\_\_ As of: \_\_\_\_\_  
*The most recent certified audited financial statements for any guaranteeing parent must be included with this package.*

No

<sup>2</sup> Capitation that is not prepaid per Part 101 of Title 11 of the NYCRR (Regulation 164) is not subject to Regulation 164.

13 c. **MCO Monitoring Requirement:** The MCO must monitor, on an ongoing basis, their contractor's financial capacity to support the transfer of risk. Identify the contract provision that describes the monitoring activities and timeframes and provide a brief summary.

Contract Page:  Clause:

Summary: \_\_\_\_\_

**14. Out of IPA/Provider Network Services:**

Identify the amount of funds the MCO will retain to provide out of IPA/provider network services (services covered under the contract but performed by providers not included in the MCO contractor's participating network) and identify the contract provision that states the MCO will retain the funds, pay the out of IPA/provider network claims, and perform a reconciliation within 6 months. Provide a summary of the reconciliation process.

MCO Retained Funds: \$ \_\_\_\_\_

Contract Page:  Clause:

Summarize how this was determined: \_\_\_\_\_

**15. DOH Financial Security Deposit Requirements (refer to risk levels 3-5 of the Contract Guidelines):**

Is a financial security deposit required based on the Contract Guidelines?

Yes

a. **Project the total amount of compensation under this agreement for the 12 months from effective date of contract:** \$ \_\_\_\_\_

Summarize how this was determined: \_\_\_\_\_

b. **The financial security deposit must be 12.5% of the 12-month compensation payments in Q.13 (a) less any payments to out-of-network providers included in Q.12. Proof of the deposit, i.e., bank statement, must be submitted with this package.**

Amount of security deposit: \$ \_\_\_\_\_

[  $.125 \times (12 \text{ mo. Projection} - \text{Out of network payments}) = \text{Financial security deposit}$  ]

.125 X ( \_\_\_\_\_ ) - ( \_\_\_\_\_ ) = \$ \_\_\_\_\_

c. **The MCO must monitor the security deposit to ensure it is sufficient to cover 12.5% of the actual annual contract payments.** Identify the contract provision addressing this requirement and provide a brief summary.

Contract Page:  Clause:

Summary: \_\_\_\_\_

No, indicate why a financial security deposit is not required: \_\_\_\_\_

## Certification

The undersigned hereby certifies that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true and complete in all material respects. The undersigned further certifies that I am knowledgeable **[(For Corporate Officer) and have been fully informed by legal counsel]** as to the statutes, regulations and guidelines applicable to the provider contract or amendment herewith submitted and that such contract or amendment **or template being submitted because of extensive non-material revisions** is in full compliance with those applicable statutes, regulations and guidelines to the best of my informed knowledge and belief.

I further hereby certify that any changes or amendments to the applicable previously submitted and approved contract identified in this Contract Statement and submitted herewith are highlighted in the attached black-lined copies; that such previously submitted and approved provider contract language is clearly and correctly identified in this filing, and that all changes to previously approved language are to the best of my informed knowledge and belief, **[having been fully informed by legal counsel,]** in full compliance with applicable statutes, regulations and guidelines.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval process, and that should it be determined that this certification is materially false or incomplete or incorrect or includes incorrect, false or misleading, information, appropriate enforcement action will be taken.

I also understand the following: DOH approval of this contract or amendment is based upon provider solvency and related financial standards as described in the MCO & IPA Provider Contract Guidelines and does not constitute an affirmation as to the reasonableness of the payments agreed to by the parties in this contract or amendment. Further, approval of this contract or amendment by DOH does not guarantee that the level of reimbursement in the contract or amendment will be recognized in premium rates paid to the MCO by NYS for participation in and services provided under any government sponsored managed care or health insurance program.

\_\_\_\_\_  
Signature of MCO Officer or Legal (General) Counsel

\_\_\_\_\_  
Date

**Please print or type all of the following:**

\_\_\_\_\_  
Name of MCO Officer

\_\_\_\_\_  
Officer's or Counsel's Address

\_\_\_\_\_  
Title

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Direct Telephone Number

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
MCO Unique Contract/Amendment ID # (required)

\_\_\_\_\_  
Notary