



**DRAFT – VERSION 2**

**New York State Department of Health**

**Provider Contract Guidelines**  
**for**  
**MCOs, IPAs, and ACOs**

Revised XXX 2016

## Table of Contents

Introduction .....	2
Section I – Definitions .....	3
Accountable Care Organization (ACO).....	3
Claims Adjudication/Payment.....	3
Health Care Services .....	3
Independent Practice Association (IPA) .....	3
Managed Care Organization (MCO).....	3
Management Functions.....	3
Material Amendment.....	4
Material Change.....	4
New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts (Standard Clauses).....	4
New York State Value Based Payment Roadmap (Roadmap) .....	6
Shared Savings Arrangement .....	6
Technical and Administrative Services .....	6
Value Based Payment (VBP) .....	6
Section II – Contract Approval Requirements.....	7
Section III – Contract Review Process .....	9
A. Submission Requirements .....	9
B. Tier 1 – File and Use Review .....	10
C. Tier 2 – DOH Review and Tier 3 – Multi-Agency Review .....	10
D. Contract Templates (Tier 1 – File and Use ONLY).....	11
Section IV – Contract Implementation .....	12
Section V – General Contracting Requirements and Prohibitions.....	14
Section VI – Mandatory Contract Provisions .....	16
Section VII – Financial Review of MCO Contracts.....	21
A. Framework for Sharing Risk (Statutory and Regulatory) .....	21
B. Financial Review Criteria Used for Specific Review Tiers .....	22
C. Specific DOH Requirements .....	24
Appendix: Standard Clauses.....	26
Appendix: DOH-XXX Certification Statement .....	36

## Introduction

The purpose of these *Provider Contract Guidelines for MCOs, IPAs, and ACOs* (Guidelines) is to establish standards and a process for contract submission and review, set forth required contract provisions, and effectuate the provisions of Article 44 of the Public Health Law and 10 NYCRR Part 98.

These Guidelines are applicable to health maintenance organizations (HMO), special purpose health maintenance organizations, also known as prepaid health services plans (PHSP), comprehensive HIV special needs plans (HIV SNP), and managed long term care plans (MLTCP) certified by the State of New York under Article 44 of the Public Health Law, which may hereinafter be referred to as managed care organizations (MCO).

Contracts between a Workers' Compensation Preferred Provider Organization (WCPPO) and a provider or IPA must also be submitted for DOH approval under these Guidelines.

These Guidelines are applicable only to contracts that allow for the arrangement, or provision of Health Care Services and Technical and Administrative Services incidental thereto. The Guidelines incorporate all provider reimbursement arrangements, including value based and traditional arrangements.

Care management administrative service agreements and Health Home agreements do not come under the scope of these Guidelines.

These Guidelines are updated periodically and are available on the New York State Department of Health's website: [www.health.ny.gov/health\\_care/managed\\_care/hmoipa/hmo\\_ipa.htm](http://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm)

### **Questions or concerns regarding this document should be addressed to:**

For managed long term care plans: [MLTCcontract@health.ny.gov](mailto:MLTCcontract@health.ny.gov)

For all other MCOs: [contract@health.ny.gov](mailto:contract@health.ny.gov)

## Section I – Definitions

### **Accountable Care Organization (ACO)**

Shall mean an organization:

- comprised of clinically integrated independent health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population;
- with a mechanism for shared governance;
- that has the ability to negotiate, receive, and distribute payments, and to be accountable for the quality, cost, and delivery of Health Care Services to the ACO's patients; and
- that has been issued a certificate of authority as per 10 NYCRR Part 1003.

### **Claims Adjudication/Payment**

Shall mean making an independent determination to pay, deny, or pend claims for payment. This is different than the ministerial task of writing a check for payment based upon the decision to act on a claim made by a different entity. Therefore, if claims adjudication/payment is to be delegated, it must be addressed in a separate management contract, and not in the medical services contract. However, merely passing payment (including savings or recouping payment or losses) through an IPA or ACO to a downstream contracted provider does not constitute Claims Adjudication/Payment.

### **Health Care Services**

Shall mean, for purposes of these Guidelines covered services as defined in the subscriber contracts for Commercial products and in the Model Contracts for any Medicaid products. The following covered services are NOT considered Health Care Services for the purpose of these Guidelines:

- Medicaid Health Home services;
- MLTC Care Management services; and
- Fiscal intermediary services for the Consumer Directed Personal Assistance Services (CDPAS).

### **Independent Practice Association (IPA)**

Shall mean, for purposes of these Guidelines the same as defined in 10 NYCRR § 98-1.2(w).

### **Managed Care Organization (MCO)**

Shall mean:

- Traditional health maintenance organizations certified pursuant to New York State Public Health Law (PHL) § 4403; or
- Special purpose MCOs, also known as prepaid health services plans (PHSP), certified pursuant to PHL § 4403-a; or
- HIV Special Needs Plans (HIV SNP) certified pursuant to PHL § 4403-c; or
- Managed long term care (MLTC) plans certified pursuant to PHL § 4403-f.

### **Management Functions**

Shall mean those elements of an MCO governing body's management authority, which are listed in 10 NYCRR § 98-1.11(j), which may be delegated to another person or entity, but only pursuant to a management contract approved by DOH. The management functions listed in 10 NYCRR § 98-1.11(i) **must not** be delegated by an MCO to another person or entity.

**Material Amendment**

Shall mean an amendment to an approved contract or approved template that includes a Material Change.

**Material Change**

Shall include, but not be limited to:

- Any change to a required contract provision or appendix as specified in Section VI herein and the Standard Clauses;
- Any change to, or addition of a shared saving, risk sharing, or Value Based Payment arrangement other than the routine trending of fees or other reimbursement amounts (this includes changes in targeted budgets due to routine trending);
- The addition of an exclusivity, most favored nation, or non-compete clause;
- Any proposed subcontracting of the existing contractual obligations of an IPA and ACO;
- Any proposed subcontracting of the statutory or regulatory responsibilities of an MCO; or
- Any proposed revocation of an approved subcontract.

**Authority: 10 NYCRR § 98-1.2(aa)**

Only for the purpose of a contract based on an approved template, all changes are material EXCEPT:

- Technical changes to clarify a provision, to identify the parties, or to specify the contract for use with particular parties (e.g.: inserting the appropriate address and contract information into blank fields);
- Extension of the contract term in an executed agreement using an approved template;
- The addition of a National Committee for Quality Assurance (NCQA) required clause, provided that State law, regulation or the Standard Clauses will prevail in the event of a conflict;
- The addition of a Medicare Advantage-required or Fully Integrated Duals Advantage (FIDA)-required clause;
- The addition of clauses that apply to only lines of business that are not regulated by state law or regulation (such as self-funded products); and/or
- The addition of a required provision by the parent company, provided that state law, regulation, or the Standard Clauses will prevail in the event of a conflict.

**New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts (Standard Clauses)**

Shall mean the contract clauses mandated by the New York State Department of Health that are required to be attached to and expressly incorporated into the body of the contract. All parties to the contract are bound to honor the Standard Clauses except to the extent applicable law requires otherwise.

DRAFT

**New York State Value Based Payment Roadmap (Roadmap)**

Shall be defined as a document that is updated periodically by the New York State Department of Health and approved by the Centers for Medicare and Medicaid Services (CMS) to ensure that best practices and lessons learned throughout implementation of Value Based Payment into Medicaid Managed Care Organizations are leveraged and incorporated into the State's overall vision. The Roadmap contains detailed information regarding the VBP program, including the definitions and criteria for on-menu and off-menu VBP arrangements. The Roadmap is published on the New York State Department of Health's website:

[http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_reform.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm)

**Shared Savings Arrangement**

Shall mean a payment method that offers incentives for providers and IPAs and ACOs to control health care costs for a defined patient population by offering them a percentage of any net savings realized as a result of their efforts. Shared Savings are calculated in relation to a target budget. Shared Savings arrangements involve two payment streams: (i) an initial stream of payments, such as fee-for-service (FFS), and (ii) reconciliation payments made to providers for the agreed upon percentage of savings generated as compared to a target budget for the managed population.

**Technical and Administrative Services**

Shall mean any functions (other than Health Care Services) that an MCO is not prohibited from delegating by 10 NYCRR § 98-1.11(i), and that are not listed in 10 NYCRR § 98-1.11(j) as a management function which requires a management contract to be submitted to DOH for approval. Technical and Administrative Services expenses incurred by an IPA, ACO, or provider in the course of performing its business are not considered technical or administrative expenses of the MCO. The IPA or provider agreement must not address management functions which require a separate management contract to be submitted to DOH for approval.

**Value Based Payment (VBP)**

Shall mean a payment strategy that is used by purchasers to promote quality and value of Health Care Services. The goal of any VBP program is to shift from volume-based payment, as exemplified by fee-for-service payments, to payments that are more closely related to both quality and cost outcomes (e.g., Shared Savings arrangements, risk arrangements, bundles, fee-for-service for a limited set of preventative care activities tied to quality measures, and approved off-menu arrangements).

## Section II – Contract Approval Requirements

- A. An applicant shall submit to the Department of Health (DOH) for approval drafts of all contracts, templates, and Material Amendments related to the provision of Health Care Services. This includes contracts between:
- An MCO/WCPPO and a provider;
  - An MCO/WCPPO and an IPA or ACO (hereinafter referred to as IPA/ACO);
  - An IPA/ACO and providers;
  - An IPA and another IPA, in accordance with 10 NYCRR § 98-1.5(b)(6)(vii)(e)(1); and
  - A pharmacy or laboratory (that are not required to form IPAs) and providers.

Contracts, templates, and Material Amendments must comply with the requirements of these Guidelines, 10 NYCRR Subpart 98-1, and all other applicable statutes and regulations.

- B. Arrangements subject to these Guidelines should be for Health Care Services and Technical and Administrative Services only (as defined in Section I). Arrangements to delegate management functions (as defined in Section I) should be addressed in a separate agreement. Therefore, these Guidelines do NOT apply to the following contracts:
- Between an MCO and a management contractor; or
  - Between an MCO and IPA/ACO, when the IPA/ACO will perform management functions (see Section II.C below).

- C. Delegation of management functions to an IPA/ACO: If the MCO wishes to delegate management functions to the IPA/ACO, it must be done through a separate management agreement. These Guidelines set forth requirements applicable to IPA/ACO contracts for the provision of Health Care Services. The requirements for management contracts are addressed in the Management Contract Guidelines for MCOs and IPA/ACOs document located on the DOH website: [https://www.health.ny.gov/health\\_care/managed\\_care/plans/](https://www.health.ny.gov/health_care/managed_care/plans/)

Claims Adjudication/Payment is specified as a management function in 10 NYCRR § 98-1.11(j). Therefore, if Claims Adjudication/Payment is to be delegated to the IPA/ACO, it must be addressed in a separate management contract and not in the IPA/ACO Health Care Services contract.

- D. These revisions to the Guidelines are effective XXX 2016, and apply to new contracts, templates, and amendments, to existing approved contracts, submitted to DOH for review on or after XXX 2016. They shall not apply to previously approved contracts, templates, or amendments, in effect as of XXX 2016, or to contracts, templates or amendments, submitted to DOH for review and approval and received by close of business XXX 2016.

All existing contracts, templates, and amendments, approved or submitted by close of business XXX 2016, should be revised to conform to the provisions of these Guidelines no later than the following, whichever comes first:

1. The next amendment to the contract;

2. The next renewal of the contract;
3. The deadline specified by DOH as a condition of approving an MCO change of control, acquisition, merger, expansion, or the like; or
4. By XXX 2017.

Contract amendments that conform to these Guidelines do not have to be submitted for DOH review and approval if the only changes to the contract are: (a) updating to the most current version of the Standard Clauses; and (b) the addition of language or an amendment, as necessary, to provide that in the case of inconsistencies between the Standard Clauses and other provisions of the contract, the Standard Clauses shall prevail, except to the extent that applicable law requires otherwise.

**Notwithstanding the above, providers must be notified about any changes that directly affect them or their patients enrolled with the MCO by letter or by any other method agreed to by the parties and specified in the contract.**

Authority for DOH review of provider contracts: PHL § 4402(2)(a); 10 NYCRR §§98-1.5(b)(6), 98-1.7(b)(2), 98-1.8(b), 98-1.13(a), and 98-1.18(a)(b)(e).

DRAFT

## Section III – Contract Review Process

### A. Submission Requirements

DOH review will commence upon receipt of **ALL** of the following:

1. One (1) electronic copy of each contract, template, or Material Amendment submitted for approval, in a standard searchable PDF format that meets the following requirements:
  - (a) The Standard Clauses Appendix, without modification, must be attached (this is not required for a Material Amendment unless the Standard Clauses have not yet been updated as required by Section II.D) and the provisions of such Appendix must be expressly incorporated by reference in the body of the contract, template, or Material Amendment by using the required incorporation language as specified in Section VI.A.3.
  - (b) Each contract, template, or Material Amendment must be for Health Care Services and/or Technical and Administrative Services only (see Section II.B above).
  - (c) Each contract, template or Material Amendment must have an MCO-assigned unique identifier made up of any combination of letters and numbers; the unique identifier for a Material Amendment must use the unique identifier from the original contract or source template as a prefix. All contracts, templates, or Material Amendments including executed template agreements, must have the unique identifier printed on each page of the respective documents.
  - (d) Each contract or Material Amendment must be dated; all Material Amendments to an approved contract must reference the date of the originally approved contract; all new and amended language shall be underlined and all deleted language bracketed or otherwise highlighted (e.g., a redline version) for ease of review.
  - (e) Separate Shared Savings, risk sharing, or Value Based Payment arrangements, or templates for such arrangements, must be included with the contract submission as a fully incorporated appendix. The payment methodology must be described for such arrangements.

A contract between an MCO and an IPA/ACO or between an IPA and an IPA must be submitted with all related contracts between or among the MCO(s), IPA(s), ACO(s), and participating providers.

2. A completed DOH-XXX, Contract Statement and Certification, for each contract, template, or Material Amendment including an electronic copy of the DOH-XXX in PDF format, each bearing the same MCO-assigned unique identifier as the submitted contract, template, or Material Amendment. In all cases, the certification must be signed by an officer of the MCO or the MCO's legal counsel and must be notarized.
3. All required supporting documentation as described in these Guidelines and on the DOH-XXX.

The contract and required documentation should be submitted to:

- For managed long term care plans: [MLTCcontract@health.ny.gov](mailto:MLTCcontract@health.ny.gov)
- For all other MCOs: [contract@health.ny.gov](mailto:contract@health.ny.gov)

**Incomplete submissions will not be accepted for review.**

If at any time during the review process, modifications are made to the submitted contract that render inaccurate any statements made in the Contract Statement and Certification (DOH-XXX), the MCO must submit a new, corrected, and signed DOH-XXX. After DOH approval is received, the MCO must submit an electronic copy of the executed contract or amendment as directed in the approval letter. It is the responsibility of the MCO to provide approval letters if requested by DOH.

### **B. Tier 1 – File and Use Review**

Contracts and Material Amendments will be processed as File and Use if:

1. the contract or Material Amendment meets the criteria of Tier 1 – File and Use as described in Section VII.B of these Guidelines; and
2. the DOH-XXX certification is signed, dated and notarized; and
3. the contract expressly provides that the parties agree to incorporate all modifications required by DOH for approval or to terminate the contract if so directed by DOH.

Under Tier 1 – File and Use, the contract, template, or Material Amendment is deemed approved upon acknowledgement by DOH that the submission has been received and meets the requirements of Section III. The MCO may implement the contract immediately upon said acknowledgement. However, if directed by DOH, the parties to the contract will make the requested modifications or terminate the contract.

### **C. Tier 2 – DOH Review and Tier 3 – Multi-Agency Review**

Contracts and Material Amendments will be processed for programmatic and financial review if:

1. The resulting contract meets the criteria of either Tier 2 – DOH Review or Tier 3 – Multi-Agency Review as described in Section VII.B of these Guidelines; and
2. All required information and supporting documentation, as described in Section VII.B of these Guidelines, is included; and
3. The DOH-XXX certification is signed, dated, and notarized; and
4. The contract expressly provides that the parties agree to incorporate all modifications required by DOH for approval, or to terminate the contract if so directed by DOH.

Under Tier 2 - DOH Review, the contract, template, or Material Amendment may be implemented upon receipt of written approval from DOH (or DFS if applicable). Notwithstanding the foregoing, the contract or Material Amendment will be deemed

approved 90 days after receipt by DOH of a submission that meets the requirements of Section III. However, if directed by DOH, the parties to the contract will either make requested modifications or terminate the contract.

#### **D. Contract Templates (Tier 1 – File and Use ONLY)**

DOH will approve template provider contracts (or amendments to such templates) that: **(a)** conform to the requirement of these guidelines; and **(b)** involve only Tier 1 File and Use, as described in Section VII.B of these Guidelines. An approved template contract may be executed with multiple providers without separate DOH approval unless Material Changes are included in the individual contract with the provider.

Templates will be processed for programmatic and financial review if:

- Use of the template is likely, as determined by DOH, to result in a Tier 1 contract when used as described in the completed DOH XXX certification form;
- The DOH XXX certification is signed, dated, and notarized; and
- The template expressly provides that the parties agree to incorporate all modifications required by DOH for approval or to terminate the contract if so directed by DOH.

The MCO should not assume that use of an approved template will allow it to execute and implement contracts without submitting them to DOH. The MCO must always assess the review tier for all contracts and Material Amendments, even when the contract or Material Amendment is based on an approved template. If using an approved template with a particular provider or IPA/ACO yields a Tier 2 or Tier 3 contract, then the contract must be submitted to DOH for review prior to implementation, pursuant to Section III.C. a contract that yields a Tier 2 or Tier 3 review cannot be considered a template.

Similarly, if using an approved template with a particular provider or IPA/ACO yields a Tier 1 contract, but contains Material Changes to the template, then the contract must be submitted to DOH for File and Use, pursuant to Section III.B.

## Section IV – Contract Implementation

- A. Any contract, template, or Material Amendment that does not satisfy the requirements of Section III above may not be implemented without the prior written approval of DOH.**
- B.** The parties may implement a contract, template, or Material Amendment in accordance with the timeframes specified in Section III above. However, if directed by DOH, the MCO or IPA/ACO will either make modifications as requested by DOH or terminate the contract.
- C.** Contracts must identify, or provide a method for identifying, all affiliates and lines of business to whom an IPA/ACO or provider will have an obligation under the MCO contract. If a contract makes reference to an MCO's affiliates (including but not limited to parent and subsidiary corporations), acceptable methods of informing an IPA/ACO or provider of the identity of such affiliates include listing the names of the affiliates in the body of the contract, as an exhibit to the contract, in the MCO's provider manual or on the MCO's website. Whatever method is chosen, the IPA/ACO or provider must be provided written notice of subsequent changes to the list of affiliates and an opportunity to either opt out of the contract if the IPA/ACO or provider objects to participating with the additional affiliate(s) or opt out of participating with the additional affiliate(s). **NOTE:** Where a New York based IPA/ACO contracts with an MCO's affiliates, contracting is limited to the New York affiliates that are Article 44 MCOs or WCPPOs.
- D.** Contracts between an MCO and IPA/ACO may not be implemented in accordance with the requirements of this Section unless all related contracts between the IPA/ACO and providers meet the same requirements.
- E.** Under no circumstance may the MCO implement a contract, template, or Material Amendment if:
1. DOH, by written notice, has expressly withheld permission for the parties to proceed, pending further review, or DOH has issued a written disapproval of the contract, template, or Material Amendment; OR
  2. New York State Department of Financial Services (DFS) approval under Regulation 164 is required, and DFS has not issued a written approval, has issued a written disapproval of the contract, or has otherwise instructed that the contract cannot be implemented.
- F. Contract Oversight**
1. DOH may routinely select a sample of approved contracts, templates, or Material Amendments submitted from all MCOs for full verification of consistency with applicable laws, regulations, Guidelines, and the submitted Contract Statement and Certification (DOH-XXX).
  2. Notwithstanding the issuance by DOH of a final written approval of a contract, template, or Material Amendment, DOH may require the parties to make modifications or take other corrective action if DOH subsequently discovers, through verification review or by any other means, that contrary to representations made by the MCO, including the Contract Statement and Certification (DOH-XXX), the

- contract, template, or Material Amendment contains provisions which are inconsistent with such representations and/or are not in compliance with applicable laws, regulations, or guideline provisions.
3. Upon notice, DOH may request the production and/or submission of any MCO, IPA/ACO, or provider contract subject to 10 NYCRR Part 98-1, whether or not submission was required pursuant to these Guidelines for such contracts.
  4. An MCO's failure to make required modifications to the contract or to take other corrective action, as directed by DOH, may result in regulatory action.

DRAFT

## Section V – General Contracting Requirements and Prohibitions

The MCO must be a party and signatory to the contracts between the MCO and provider or the MCO and IPA/ACO. It is not acceptable for the MCO's parent or subsidiary corporation to be a party and signatory without the MCO also being a party to the agreement. It is not permissible for provider contracts to be between a provider and an MCO's management contractor.

For purposes of allowing enrollees that are temporarily out of the MCO's service area to obtain Health Care Services, an MCO may contract with:

- its parent, a sister, or subsidiary entity or other entity licensed or certified in another state in order to make available services and the benefit of discounted rates for its enrollees traveling out-of-state; or
- a sister or subsidiary MCO or other MCO operating within New York State to make available services and discounted rates to its enrollees incidentally when traveling within New York State but outside of the MCO's New York State service area.

The prohibition against the unauthorized corporate practice of medicine precludes any corporation or unlicensed entity from providing or arranging to provide professional services<sup>1</sup> unless licensed or otherwise authorized in statute or regulation. In light of this, an MCO may only contract with licensed, certified, or designated providers; professional corporations; professional services limited liability companies or partnerships; limited liability companies or corporations legally licensed, registered or certified to provide the contracted services; or IPA/ACOs. An MCO may not contract for Health Care Services with any other entity that arranges to provide professional services through a contracted provider network.

With respect to a pharmacy management company, formation of an IPA is not required when the pharmacy management company is also licensed as a pharmacy in New York State because §6808 of the New York Education Law has been interpreted to allow licensed pharmacies to contract with other licensed pharmacies. This forms the legal basis for the longstanding position that licensed pharmacies may 'arrange' by contract to make other licensed pharmacies available to MCOs and their enrollees without having to form an IPA.

An out-of-state pharmacy may contract in New York State with other pharmacies in or out of New York State to arrange for or provide pharmaceutical services to a New York State MCO and its enrollees if:

- (a) it is a licensed pharmacy under the laws of its home state;
- (b) it is authorized by the Secretary of State to do business in New York State; and
- (c) it is registered with New York State Education Department as a pharmacy in New York State.

The same holds true for licensed clinical laboratories. If the clinical laboratory is a licensed laboratory, it may properly arrange for the provisions of laboratory services by other licensed laboratories without organization as an IPA. However, with respect to out-of-state laboratories, Public Health law sections 572 and 574 require that laboratories accepting specimens from New York State must have a valid New York State permit to do so, and the laboratory's clinical director must apply for and receive a valid certificate of qualification from

---

<sup>1</sup> Professional services in this context refers to services provided by a licensed person or organization authorized under New York State Education Law or other applicable statutes to practice a profession.

New York State. Therefore, a licensed out-of-state laboratory may only contract with other licensed labs if it has received a New York State permit and a certificate of qualification (it may not so operate on the basis of its foreign licensure alone, as pharmacies may), and may only contract with other licensed labs that have also obtained a valid New York State permit and certificate of qualification.

Further, providers of covered services that are not subject to the corporate practice of medicine are not required to form an IPA, but may choose to for ease of contracting with MCOs.

DRAFT

## Section VI – Mandatory Contract Provisions

- A. This section identifies provisions that must be included in or addressed in contracts.
1. The contract must include a provision stating that this is the only agreement between the parties regarding the arrangement established therein. **(SC § B.1).**
  2. If a contract is to be implemented prior to DOH approval, as described in Section III of these Guidelines, it must include a provision that any changes to the contract required by DOH will be made by the parties and that the parties agree to terminate the contract at the direction of DOH effective 60 days subsequent to notice, subject to PHL § 4403(6) (e). **(SC § B.1).**
  3. The contract must include a provision whereby the parties agree to be bound by the mandatory Standard Clauses attached to and incorporated into the agreement. The parties must further agree that to the extent there are any inconsistencies between the other provisions of the agreement and the Standard Clauses, the Standard Clauses shall control, except to the extent applicable law requires otherwise and/or to the extent the parties to the contract have voluntarily agreed to other provisions that exceed the minimum requirements of the Standard Clauses. **No amendments or revisions to the Standard Clauses are permitted. The following language is mandatory and is required to be in the main body of the agreement:**

*The “New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts”, attached to the Agreement as Appendix \_\_\_\_\_, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments, and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.*
  4. The following contract provisions are strongly discouraged by DOH:
    - (a) “Exclusivity” clause, whereby a provider must agree not to contract with any other MCO or IPA/ACO;
    - (b) “Exclusion” clause, whereby a provider must agree not to accept enrollees of one or more specified MCOs; and/or
    - (c) “Most favored Nation” clause, whereby a plan may unilaterally reduce a negotiated rate to a provider where the provider negotiates a more favorable rate with a competing plan.
  5. The contract must include clear provisions for the reimbursement of providers, including, but not limited to fee for service, Shared Savings arrangements, Value Based Payment arrangements, or risk arrangements. The contract must prescribe:
    - (a) The method by which payments to a provider of Health Care Services shall be calculated, including any prospective or retrospective adjustments thereto and any Shared Savings or Value Based Payment arrangements;

- (b) The time periods within which such calculations will be completed, the dates upon which any such payments and adjustments shall be determined to be due, and the dates upon which any such payments and adjustments will be made;
- (c) The records, metrics, or other information which the MCO will rely upon to calculate payments and adjustments;
- (d) The dispute resolution procedures; and
- (e) If the provider is a health care professional, the procedure for implementing an “adverse reimbursement change,” which must conform to the requirements of PHL § 4406-c(5-c) and must include the MCO or IPA/ACO providing the health care professional written notice at least 90 days prior to the effective date of any such change. **(SC § C.3).**

See Section VII of these Guidelines for additional financial requirements.

NOTE: This section applies to all agreements among MCOs, IPA/ACOs, and participating providers including when a Value Based Payment arrangement is utilized between any of the entities on a contracted or subcontracted basis.

NOTE: If a contract is to be amended, the amended contract must specify the calendar date on which any proposed change to a payment rate will take effect, without regard to the date the contract amendment is fully executed.

NOTE: DOH approval of a contract or Material Amendment based upon provider solvency and related financial standards does not constitute an affirmation as to the reasonableness of the payments agreed to by the parties in the contract or Material Amendment. Approval of a contract or Material Amendment by DOH does not guarantee that the level of reimbursement in the contract or Material Amendment will be recognized in premium rates paid to the MCO by New York State for participation in and services provided under any government sponsored managed care or health insurance program.

Authority: PHL §§ 4403 (1)(c), (e), 4403-a(3), and 4406-c(5-a); 10 NYCRR §§ 98-1.5 (b)(6)(i), 98-1.6 (b), 98-1.11(d) and 98-1.18(e).

- 6. The contract must include provisions that are **not** inconsistent with the following:
  - (a) Assignment of an agreement between a MCO and an IPA/ACO, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the DOH Commissioner. **(SC § B.3).**

Contracts between a hospital (as defined in PHL § 2801) and licensed practitioners, professional corporations or professional services limited liability companies do not require DOH approval; however, such contracts should include provisions necessary to permit the hospital to meet its contractual obligations to the MCO or IPA/ACO.

(b) Termination or non-renewal of an agreement between a MCO and an IPA/ACO, institutional network provider, or medical group provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO and an institutional provider or medical group provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner. Notice to the Commissioner is also required if the termination or non-renewal of a medical group provider contract will leave fewer than two participating providers of that type within the county. Unless otherwise provided by statute or regulation, the effective date of termination should not be less than 45 days after receipt by the Commissioner of notice by either party, provided, however, that termination by an MCO may be effected on less than 45 days' notice when it can be demonstrated to DOH prior to termination that, e.g., a hospital has lost JCAHO accreditation or malpractice insurance coverage, or other circumstances have arisen which justify or require immediate termination. Notice to the Commissioner must include an impact analysis of the termination or non-renewal on enrollees' access to care. **(SC § E.1).**

NOTE: PHL § 4406-d prohibits termination of a health care professional contract by an MCO or IPA/ACO without notice and the opportunity for a hearing, subject to certain exceptions; non-renewal is permitted on 60 days' notice and shall not be considered a termination under § 4406-d. **(SC § E.2).**

Authority: PHL §§ 4406-d (2)(f) and (3); 10 NYCRR §§ 98-1.8 (b), 98-1.13 (c), 98-1.18 (a) and (b).

7. The contract must include a continuation of treatment clause whereby the provider agrees that in the event of MCO or IPA/ACO insolvency or termination of the contract for any reason, the provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract, Medicaid Managed Care contract or Managed Long Term Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. Such provisions shall by express statement survive termination of the agreement. **(SC § E.4).**

The contract may also include express provisions addressing the transitional care available to enrollees pursuant to PHL § 4403(6)(e) involved in an ongoing course of treatment at the time his/her provider's disaffiliation with the MCO at the enrollee's option, or as to an enrollee who has entered the second trimester of pregnancy, on the effective date of termination, through the delivery of post-partum care directly related to the delivery pursuant to PHL§ 4403 (6) (e). Addressing this enrollee option in provider contracts will help ensure provider awareness of these provisions.

Authority: PHL § 4403 (6)(e); 10 NYCRR §§ 98-1.6 (f), 98-1.13 (a) and (b).

8. MCO may not impose deductibles. Copayments and coinsurance are the only allowable enrollee cost-sharing mechanisms. Contracts should not reference deductibles.

The exception is that an MCO may impose deductibles pursuant to: (a) a point of service (POS); or (b) to the extent permitted by DOH and DFS, a High Deductible Health Plan (HDHP) combined with a health savings account (HSA). Use of the term “deductible” may be made in these contexts, or the contract may refer to “permitted deductibles,” defined as a deductible associated with a POS contract or an approved HDHP.

Authority: 10 NYCRR § 98-1.6(f) requires the availability and accessibility of Health Care Services to enrollees. DOH interprets that regulation as prohibiting the imposition of front-end deductibles since they impede access to care.

9. Coordination of Benefits (COB) monies generally become property of the MCO. Providers may participate in the collection of COB proceeds on behalf of the MCO, with COB proceeds accruing to the MCO. Pursuant to contract, COB proceeds may accrue to providers. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, providers must maintain and make available to the MCO records reflecting COB proceeds collected by the provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds. **(SC § C.2).**

MCOs are subject to audits under the government sponsored health insurance programs, including but not limited to the Medicaid and Child Health Plus programs, including audits which can be conducted without notice by the Office of the State Comptroller for COB collected for enrollees in these government programs. MCOs must therefore have records concerning collection of COB proceeds available.

10. The contract must include a provision whereby the parties agree to comply with all applicable Federal and State laws, rules, and regulations including but not limited to those specified in the Standard Clauses.

## **B. Risk Sharing Requirements**

1. For a contract involving Tier 2 or 3 arrangements as described in Section VII.B of these Guidelines, the contract must:
  - (a) Provide for the MCO’s ongoing monitoring of provider financial capacity and/or periodic provider financial reporting to the MCO to support the transfer of risk to the provider; and
  - (b) Include a provision to address circumstances where the provider’s financial condition indicates an inability to continue accepting such risk; and
  - (c) Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
  - (d) Include a provision that the provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.
2. For any contract (Tier 1, 2 or 3) involving an MCO sharing risk with an IPA/ACO, the contract must include provisions whereby:
  - (a) The parties expressly agree to amend or terminate the contract at the direction of DOH;

- (b) The IPA/ACO will submit both quarterly and annual financial statements to the MCO, as well as any additional documents requested by the MCO as necessary to assess and ensure the IPA/ACO's progress towards achieving Value Based Payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO; and
- (c) The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH; and
- (d) The parties agree that all provider contracts will contain a provision prohibiting providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the financial risk sharing agreement.

DRAFT

## Section VII – Financial Review of MCO Contracts

DOH programmatic and financial review and approval is required for all MCO agreements as described in these Guidelines. For prepaid capitation agreements effective after August 22, 2001, a separate financial review by the DFS under Regulation 164 may also be required.

This section describes the regulatory framework for all contracts, templates, or Material Amendments including VBP arrangements, and defines the different review tiers, the financial criteria that DOH will apply to each tier, and the criteria for determining what type of financial review a contract or Material Amendment requires.

### A. Framework for Sharing Risk (Statutory and Regulatory)

1. **PHL Article 44:** MCOs are licensed under Article 44 of the Public Health Law as entities that assume the obligation to provide or arrange for the provision of Health Care Services to subscribers or enrollees, in exchange for a predetermined payment amount per person per month. By assuming this obligation, MCOs must remain financially responsible for providing or arranging for Health Care Services pursuant to the applicable subscriber contract or government programs.

MCOs always retain this statutory obligation and may not transfer or otherwise dispose of their ultimate financial responsibility. MCOs must fulfill their obligation in any event, including the failure of a risk sharing arrangement with an IPA or health care provider.

2. **DOH regulations at 10 NYCRR Part 98:** Risk sharing is defined in § 98-1.2(kk) as “...*the contractual assumption of liability by a health care provider or IPA by means of a capitation arrangement or other mechanism whereby the provider or IPA assumes financial risk from the MCO for the delivery of specified Health Care Services to enrollees of the MCO.*” Risk sharing is sometimes referred to as accepting financial risk or medical risk.

Section 98-1.11 imposes financial requirements for entities licensed under Article 44 and allows an MCO to share risk with providers.

Section 98-1.5(b)(6)(vii)(e)(1) allows an IPA, incidental to its primary IPA/ACO powers and purposes, to share risk for the provision of Health Care Services with MCOs and to sub-capitate or otherwise compensate providers and IPAs with which it has contracted.

Section 98-1.18(e) prohibits an MCO from entering into a risk sharing arrangement with an IPA without first obtaining approval from DOH or DFS, as applicable, in accordance with these Guidelines and DFS Regulation 164.

10 NYCRR 1003.11(c) states the contract between an ACO and a Managed Care Organization shall be subject to all the requirements and reviews applicable under Article 44 of the Public Health Law and the Insurance Law and Regulation promulgated thereunder.

3. **DFS Regulation 164:** DFS Regulation 164, “Standards for Financial Risk Transfer Between Insurers and Health Care Provider” (11 NYCRR Part 101), requires MCOs to submit to DFS for approval any prepaid capitation arrangement whereby an insurer transfers all or part of its financial risk to a health care provider. In addition to prepaid capitation payments, if risk is transferred via any other provisions, DOH financial review and approval of these additional provisions is also required.
4. **CMS Regulation 42 CFR § 422.208 Physician Incentive Plan: requirements and limitations.** If applicable, DOH will conduct a separate review in accordance with the Physician Incentive Plan as described in the Standard Clauses § C.4.

## **B. Financial Review Criteria Used for Specific Review Tiers**

Based on the definitions for MCO contracting entities as specified in Section I of these Guidelines, three review tiers are described below:

### **1. TIER 1 – File and Use**

DOH will generally only conduct a programmatic review for contracts in this tier as defined below. The programmatic review for contracts under this tier will be abbreviated, but will ensure that certain requirements are met, including, but not limited to, ensuring the mandatory provisions are present and the financial attestations are complete. Generally, DOH and DFS will not conduct a financial review for contracts falling within this tier. DOH reserves the right to review any contract for financial and/or programmatic review.

Contracts with providers, groups of providers, or an IPA/ACO must meet the following criteria to be considered Tier 1:

(1) projected annual prepaid capitation payment is expected to be less than or equal to \$250,000; AND

(2) projected total annual payments at risk made to provider is expected to be less than or equal to \$1,000,000;

OR

(3) projected total annual payments at risk to provider is expected to be more than \$1,000,000, but none of the following are true:

(a) for Medicaid Contracts only:

(i) more than 25 percent of the projected total annual payments made to the provider by the MCO submitting the contract across all contracts between that provider and that MCO for Medicaid Managed Care or Medicaid Managed Long Term Care lines of business are at risk;

(ii) the provider’s projected payments under this contract consist of more than 15 percent of the provider’s projected overall Medicaid revenue from all payors; OR

(iii) an off menu arrangement, as referenced in the Roadmap, not previously approved by DOH.

(b) for Non-Medicaid Contracts only:

- (i) more than 25 percent of the projected total annual payments made to the provider under the submitted contract are at risk.

## 2. TIER 2 – DOH Review

DOH shall conduct both a financial and a programmatic review for contracting arrangements within this tier, as defined below. DFS will not conduct a financial review for contracts falling within this tier unless DOH requests a review from DFS.

This tier applies to contracts that transfer financial risk to providers or an IPA/ACO (e.g., capitation) whether for a single specific service or multiple services provided directly by the provider accepting risk for such services. These arrangements must meet the following criteria to be considered Tier 2:

- (1) projected annual prepaid capitation payment to provider at risk is expected to be less than or equal to \$250,000; AND
- (2) projected total annual payment at risk made to provider is expected to be more than \$1,000,000; AND
- (3)
  - (a) for Medicaid Contracts only at least one of the following is true:
    - (i) more than 25 percent of the projected total annual payments made to the provider by the MCO submitting the contract across all contracts between that provider and that MCO for Medicaid Managed Care or Medicaid Managed Long Term Care lines of business are at risk;
    - (ii) the provider's projected payments under this contract consist of more than 15 percent of the provider's projected overall Medicaid revenue from all payors; OR
    - (iii) an off menu arrangement, as reference in the Roadmap, not previously approved by DOH.
  - (b) for Non-Medicaid Contracts only:
    - (i) more than 25 percent of the projected total annual payments made to the providers under the submitted contract are at risk.

### Supporting Documentation for Tier 2:

Contract submission must include evidence of the providers or IPA/ACO's financial viability and may require a financial security deposit as described in Section VII. C of these Guidelines.

## 3. TIER 3 – Multi-Agency Review

DFS shall conduct a financial review for all contracts within this tier, as defined below. DOH may conduct its own financial review, in its sole discretion, but may also defer to a DFS approval following a DFS financial review and approval. DOH will conduct a programmatic review for all contracting arrangements within this tier.

This tier applies to contracts that transfer risk to providers, a group of providers, or IPA/ACOs under prepaid capitation arrangements in any form based on the criteria below. The Multi-Agency Review process will apply to all contracting arrangements where at least one of the following is true:

- (i) the provider's prepaid capitation payments are more than \$250,000; OR
- (ii) at the request of DOH.

## **C. Specific DOH Requirements**

### **1. Demonstration of Financial Responsibility**

The MCO must provide such information as necessary to allow DOH to determine whether a provider sharing risk is financially stable; capable of assuming such risk; and has satisfactory insurances, reserves, or other arrangements to support the expectation that it will meet its obligations.

The provider accepting risk must demonstrate sufficient capital and solvency via submission of certified audited financial statements or comparable means, such as an accountant's compilation in cases where the provider is a new entity. If the contract includes a provision that a provider's parent organization (such as a hospital system) guarantees the provision and payment of services, the certified audited financial statement of the guaranteeing parent can be used to establish the provider's solvency.

### **2. Financial Security Deposit**

If a financial security deposit is required, the provider must establish and provide evidence of a financial security deposit in the amount of 12.5 percent of the estimated annual medical costs for the Health Care Services covered under the risk arrangement. The financial security deposit must consist of cash and/or short-term marketable securities and must be held by the MCO. The entire amount of the security deposit must be available prior to contract approval.

Notwithstanding the above, at the discretion of DOH, the financial security deposit may be mitigated under limited circumstances (e.g., parental guarantee, risk corridors or caps on provider losses).

### **3. Out-Of-Network Account**

The estimated part of the payment needed to cover services referred or otherwise arranged by the contracting provider or intermediary to non-participating providers must be deposited by the MCO into a separate account designated as the "out of health care provider network account." This account must be maintained by the MCO for the sole purpose of paying for the services covered by the risk agreement that were rendered by providers outside of the IPA/provider's network. Amounts deposited in the out-of-IPA/provider network account must be reconciled at least annually with out-of-IPA/provider network incurred claims and expenses for the period covered by the reconciliation, and any excess in the account must be remitted to or otherwise settled with such IPA/provider within six months of the ending date of the reconciliation period. In the event the reconciliation reports a deficit, then the MCO must bill such deficit or otherwise settle such deficit with the IPA/provider within six months of the ending date of the reconciliation period.

#### **4. Requirements for IPA/ACO Risk Sharing**

- (a) The MCO must submit the complete text of the proposed IPA/ACO contract(s) and all attachments thereto.
- (b) The MCO and the IPA/ACO must demonstrate to the satisfaction of DOH that the proposed arrangement will not constitute improper incentives to providers, in accordance with physician incentive plan guidelines, and will not result in a decrease in access to or quality of care provided to enrollees.

#### **5. Miscellaneous Audits**

DOH and/or the Office of the Medicaid Inspector General (OMIG) will retain the right to conduct sample audits of contracts submitted under these Guidelines during plan survey and as frequently as deemed appropriate.

DRAFT

## **Appendix: Standard Clauses**

### **New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts**

(Revised XX/2016)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the parties agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with providers, and providers must agree to such clauses.

#### **A. Definitions for Purposes of this Appendix**

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individual entities and facilities licensed and/or certified to practice medicine and other health professions, and as appropriate, ancillary medical services and equipment. Under these arrangements such health care providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

#### **B. General Terms and Conditions**

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance

with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH or the New York City Human Resources Administration, as may be required by the Medicaid managed care contract between the MCO and DOH (or New York City).

3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network provider, or (3) a medical group provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional provider or (2) a medical group provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty days in advance of implementation, including but not limited to:
  - quality improvement/management;
  - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
  - member grievances; and
  - provider credentialing.
5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the Provider is a primary care practitioner, the Provider agrees to provide for twenty-four (24) hour coverage and back-up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA/AO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA/ACO's own acts or omissions, by indemnification or otherwise, to a provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the

Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid managed care contract between the MCO and DOH as set forth fully herein, including:
  - a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid managed care contract.
  - b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.
  - c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid managed care contract between the MCO and DOH.
  - d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid managed care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid managed care or the MCO does not offer a Medicaid managed care product in the mother's county of fiscal responsibility.
  - e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid managed care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
  - f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
  - g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of any Congress, or an employee of a Member of Congress in connection with the aware of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the

“Certification Regarding Lobbying,” Appendix \_\_\_\_ attached hereto and incorporated herein, if this Agreement exceeds \$100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds \$100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL “Disclosure Form to Report Lobbying,” in accordance with its instructions.

- h. The Provider agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee’s involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).
- i. The Provider agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).
- j. The Provider agrees to disclose to the MCO complete ownership, control, and relationship information.
- k. Provider agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than \$25,000 during the 12-month period ending on the date of the request made by DOH, OMIG or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.
- l. The Provider agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG’s website, within five (5) days of executing this agreement, stating that:
  - The Provider is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MC.
  - All claims submitted for payment by the Provider are for care, services or medical supplies that have been provided.
  - Payment requests are submitted in accordance with applicable law.

- m. The Provider agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:
- The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
  - All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
  - Payment requests are submitted in accordance with applicable law.
10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.
11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law § 33.13.
12. Compliance Program. The Provider agrees that if it claims, orders, or is paid \$500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.
13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on its website.

### **C. Payment and Risk Arrangements**

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek

compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology or payment policy indexing scheme.
4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR

§422.208, and 42 CFR §422.210 into any contracts between the contracting entity (provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.

5. The parties agree that a claim for home Health Care Services following an inpatient hospital stay cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided before a member's inpatient hospital discharge, consistent with Public Health Law §4903.
6. Section 3224-a of the Insurance Law provides timeframes for the submission and payment of provider claims to the MCO.
7. Section 3224-b(a) of the Insurance Law requires an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).
8. Section 3224-b(b) of the Insurance Law prohibits an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid managed care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.
9. Section 3224-c of the Insurance Law provides that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.
10. The contract cannot wave, limit, disclaim or in any way diminish the rights of a health care provider to receipt of claims payment for pre-authorization of health services required by and received from the MCO.
11. For a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
  - a. Provide for the MCO's ongoing monitoring of provider financial capacity and/or periodic provider financial reporting to the MCO to support the transfer of risk to the provider; and
  - b. Include a provision to address circumstance where the provider's financial condition indicates an inability to continue accepting such risk; and

- c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
  - d. Include a provision that the provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.
12. For any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
- a. The parties expressly agree to amend or terminate the contract at the direction of DOH;
  - b. The IPA/ACO will submit both quarterly and annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess and ensure the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO; and
  - c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MOC, if requested by DOH; and
  - d. The parties agree that all provider contracts will contain provision prohibiting providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement.

#### **D. Records and Access**

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human

Services, the County Department of Social Services, the Comptroller of the State of New York, the Officer of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.

3. The parties agree that medical records shall be retained for a period of six years after the date of service, and in the case of a minor, for three years after majority or six years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

#### **E. Termination and Transition**

1. Termination or non-renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 days' notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.
2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days' notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the

IPA/ACO's Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.

4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "provider" shall include the IPA/ACO and the IPA/ACO's contracted providers if this Agreement is between the MCO and an IPA/ACO.** This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating providers of its network to assist in the orderly transfer of enrollees to another Provider.

#### **F. Arbitration**

To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.

#### **G. IPA/ACO-Specific Provisions**

Any reference to IPA/ACO quality assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual providers.

**Appendix: DOH-XXX Certification Statement**

See attached.

DRAFT



Provider Contract Statement and Certification

Office of Health Insurance Programs

Instructions:

- 1. Type or print the information in the space provided.
2. Please read the New York State Department of Health Provider Contract Guidelines for MCOs, IPAs, and ACOs before completing this form.
3. Complete a separate statement for each provider contract or Material Amendment for which the MCO is seeking approval.
4. 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.
5. Do NOT use this form for management contracts.

Section A: Submission Includes
1. Check one:
[ ] Contract
[ ] Contract Template1
[ ] Shared Savings (if separate from main contract)
[ ] Material Amendment
Original Contract #
Original Approval Date:
Original Effective Date:
2. Anticipated effective date: mm/dd/yyyy
3. MCO unique Contract or Amendment ID#
4. Standard Clauses attached.
5. a. Does this contract contain an "exclusivity", "exclusion", or "most favored nation" clause...
b. Additional requirements for agreements with behavioral health providers:
6. Is alternate dispute resolution included in lieu of external appeal for contracts with an Article 28 facility?

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

**Section B: Contracting Parties**

1. MCO Name: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Email address: \_\_\_\_\_

2. a. Agreement between:  MCO and IPA/ACO\*  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 purpose of this form. Contracts between MCO and IPA must be submitted together with all related IPA/provider or IPA/ACO agreements. A separate Contract Statement and Certification is required for each agreement.*

b. If MCO/ACO or MCO/ACO Agreement, providers will be paid by:

ACO  IPA  MCO  MSO

c. If either the IPA or ACO or MSO is paying claims, has the management agreement been submitted?

Yes  No

*Note: Even if the MSO is paying claims on behalf of a provider or IPA, no risk can be transferred to the MSO.*

3. Primary IPA Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

4. Provider/ACO Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_

5. Check all lines of business covered by contract:

<input type="checkbox"/> Child Health Plus	<input type="checkbox"/> FIDA IDD	<input type="checkbox"/> Medicaid Advantage	<input type="checkbox"/> MLTC Partial
<input type="checkbox"/> Commercial HMO	<input type="checkbox"/> HARP	<input type="checkbox"/> Medicare Advantage	<input type="checkbox"/> QHP
<input type="checkbox"/> Essential Plan	<input type="checkbox"/> HIV SNP	<input type="checkbox"/> MLTC MAP	<input type="checkbox"/> Other
<input type="checkbox"/> FIDA	<input type="checkbox"/> Medicaid	<input type="checkbox"/> MLTC PACE	

6. Type of Provider:

<input type="checkbox"/> ACO	<input type="checkbox"/> Individual Practitioner	<input type="checkbox"/> OASAS Licensed or Designated
<input type="checkbox"/> FQHC	<input type="checkbox"/> IPA	<input type="checkbox"/> OMH Licensed or Designated
<input type="checkbox"/> Hospital	<input type="checkbox"/> Medical Group	<input type="checkbox"/> Other

Other: \_\_\_\_\_

**Section C: Contract Provisions**

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

**2. a. Check all that apply:**

Services	Initial Payment Stream			Other Payment Stream			
	FFS	Prepaid Capitation	Non-Prepaid Capitation	Shared Risk Upside/Downside (includes target budget)	Shared Savings Upside Only (includes target budget)	Pay for Performance (Quality with no target budget)	Other (Please describe below)
Ambulatory Surgery/Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Durable Medical Equipment (DME)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home and Community Based Services (HCBS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Care Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialist Physician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other <b>than listed</b> (Describe Below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**b.** For Medicaid Managed Care or Managed Long Term Care: Please check all of the on-menu VBP arrangement types that apply to this contract

(on-menu arrangement types must be consistent with those defined within the VBP Roadmap and the Clinical Advisory Group Playbooks):

- Total Care for General Population (TCGP)
- Integrated Primary Care
- Bundle (check all that apply)
  - Chronic Bundle
  - Maternity Bundle
  - Other Bundle (describe below)

Please describe: \_\_\_\_\_

- Total Care for Subpopulation

Please list the Subpopulation(s) included in the contract: \_\_\_\_\_

- Off-menu

Please describe: \_\_\_\_\_

**c.** For Medicaid Managed Care or Managed Long Term Care, please indicate the Value Based Payment (VBP) level that payments made under this contract or template are categorized as (see Roadmap homepage - [http://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_reform.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm)):

- VBP Level 0
- VBP Level 1
- VBP Level 2
- VBP Level 3
- FFS (non-VBP)

Please answer the following:

Do the arrangements have a quality measure?  YES  NO

Is the quality measure the same as determined in the Clinical Advisory Group Playbook?

YES  NO (attach description of measures)

**Section D: Financial Arrangements**

1. Indicate initial payment methodology to provider

(check all that apply):

- FFS
- Capitation\*

\*If Capitation payments are included, are they:

- Prepaid Capitation
- Non-Prepaid Capitation<sup>2</sup>

2. a. Additional payment methodology to provider:

- No
- Yes

If Yes (check all that apply and cite contract page):

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

- |   |   |
|---|---|
| <input type="checkbox"/> Shared Savings (with target budget)      | <input type="checkbox"/> Shared Risk (with target budget)         |
| <input type="checkbox"/> Bonus (no target budget)                 | <input type="checkbox"/> Withhold (no target budget)              |
| <input type="checkbox"/> Up to 25% of IPA/Provider payment        | <input type="checkbox"/> Up to 25% of IPA/Provider payment        |
| <input type="checkbox"/> Greater than 25% of IPA/Provider payment | <input type="checkbox"/> Greater than 25% of IPA/Provider payment |

- Other

If other, please describe: \_\_\_\_\_

b. If bonus or withhold is checked above, please confirm, by checking the box below, that parties agree to comply with the requirements of Physician Incentive Plan Regulations and that no specific payments will be made directly or indirectly as an inducement to reduce or limit medically necessary services.

3. Are the rates of payment included within this contract that are made to ambulatory OMH and/OASAS providers equivalent to the rates such providers would have received under the Ambulatory Patient Grouping (APG) methodology established by the state for all applicable services?

- Yes       No

If No, has the MCO received prior approval from DOH for the payment methodology that OMH and/or OASAS licensed or designated providers will be reimbursed under?

- Yes       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.

## Section E: Tier Determination

Please select only ONE of the three tiers below:

### Tier 1 – File and Use

- (1) projected annual prepaid capitation payment is expected to be less than or equal to \$250,000; AND
- (2) projected total annual payments at risk to provider is expected to be less than or equal to \$1,000,000; OR
- (3) projected total annual payments at risk to provider is expected to be more than \$1,000,000, but none of the following are true:
  - (a) for Medicaid Contracts only:
    - (i) more than 25 percent of the projected total annual payments made to the provider by the MCO submitting the contract across all contracts between that provider and that MCO for Medicaid Managed Care or Medicaid Managed Long Term Care lines of business are at risk;
    - (ii) the provider's projected payments under this contract consist of more than 15 percent of the provider's projected overall Medicaid revenue from all payors; NOR
    - (iii) an off menu arrangement, as referenced in the Roadmap, not previously approved by DOH.
  - (b) for Non-Medicaid Contracts only:
    - (i) more than 25 percent of the projected total annual payments made to the provider under the submitted contract are at risk.

*If Tier 1 is checked, proceed to Section G: Certification.*

### Tier 2 – DOH Review

- (1) projected annual prepaid capitation payment to provider at risk is expected to be less than or equal to \$250,000; AND
- (2) projected total annual payment at risk made to provider is expected to be more than \$1,000,000; AND
- (3) at least one of the following is true:
  - (a) for Medicaid Contract only at least one of the following is true:
    - (i) more than 25 percent of the projected total annual payments made to the provider by the MCO submitting the contract across all contracts between that provider and that MCO for Medicaid Managed Care or Medicaid Managed Long Term Care lines of business are at risk;
    - (ii) the provider's projected payments under this contract consist of more than 15 percent of the provider's projected overall Medicaid revenue from all payors; OR
    - (iii) an off menu arrangement, as reference in the Roadmap, not previously approved by DOH.
  - (b) for Non-Medicaid Contracts only:
    - (i) more than 25 percent of the projected total annual payments made to the providers under the submitted contract are at risk.

*If Tier 2 is checked, proceed to Section F, questions 1-3.*

### Tier 3 – Multi-Agency Review

The Multi-Agency Review process will apply to all contracting arrangements where the provider's prepaid capitation payments are more than \$250,000 on an annual basis.

*If Tier 3 is checked, proceed to Section F, question 4.*

**Section F: Additional Requirements (as applicable)**

**1. 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?

No

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.***

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 described the monitoring activities and time frames and provide a brief summary.

Contract page: \_\_\_\_\_ Clause: \_\_\_\_\_

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

**2. 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: \_\_\_\_\_

**3. DOH Financial Security Deposit Requirements (refer to risk tiers in the Contract Guidelines):**

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

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

Yes (complete a-c below)

a. What is the projected total amount of compensation at risk under this agreement for the 12 months from effective date: \$ \_\_\_\_\_

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

b. The financial security deposit must be 12.5% of the 12-month compensation payments in question 3.a, less any funds already retained by the MCO for the out of contracting participating network services in question 2.

Proof of the deposit, i.e., bank statement must be submitted with this package.

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

[.125 X (12-month Projection – Out of IPA/Provider Network Payments) = 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: \_\_\_\_\_

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

**d. Please check the box and attach applicable documents:**

- 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)

**4. Department of Financial Services (DFS) Requirements for Capitation Agreements:**

**a. Please provide the date this contract was submitted for review from DFS:** \_\_\_\_\_

**b. Has an approval letter been received from DFS and attached to this contract submission?**

- DFS approval letter has been received and is attached
- DFS approval not yet received.

**c. Please check the range representing the amount of annual capitation payments made under this arrangement\*:**

- Greater than \$250,000 but less than or equal to \$1,000,000
- Greater than \$1,000,000

**d. Identify contract provision describing payment timing.**

Contract page: \_\_\_\_\_

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

\*Please note that contracts less than or equal to \$250,000 in prepaid capitation would NOT fall under Tier 3 Multi-Agency Review.

DRAFT

**Section G: 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, template, or Material Amendment herewith submitted and that such contract, template, or Material Amendment or template being submitted because of non-material extensive 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 contained in the Material Amendment to the applicable previously submitted and approved contract identified in this Contract Statement and submitted herewith are highlighted in the attached red-line copies; that such previously submitted and approved 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 further hereby certify that the New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts are attached and properly incorporated into the main body of the contract, template, or Material Amendment, being submitted using the mandatory incorporation language required in Section VI.A.3 of the New York State Department of Health Provider Contract Guidelines for MCOs and IPAs.

I also understand the following: DOH approval of this contract or Material Amendment is based upon provider solvency and related financial standards as described in the New York State Department of Health Provider Contract Guidelines for MCOs and IPAs 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 Material Amendment by DOH does not guarantee that the level of reimbursement in the contract or Material 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.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval, 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.

\_\_\_\_\_  
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

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

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

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

\_\_\_\_\_  
Notary



October 4, 2016

## Provider Contract Guidelines – DOH Responses to Industry Comments

### Section I - Definitions

*Industry Comment:* A comment was made that the Guidelines provide a definition for an Accountable Care Organization, however the term is not used within the Guidelines. Confusion as to whom an ACO can contract with also needed clarification.

*DOH Response:* DOH added ACO to parts of the Guidelines for clarification as to whom an ACO can contract with.

*Industry Comment:* A comment was made that the definition of Health Care Services needs clarification. Specifically, it suggests that only services delivered by 'health care professionals' are included within the definition. There are a variety of services that are not delivered by health care professionals, including personal care services, Consumer Directed Personal Assistance Services (CDPAS), transportation, home-delivered meals, and support.

*DOH Response:* DOH updated the definition of Health Care Services to clarify what is considered a health care service.

*Industry Comment:* A comment was made to clarify the definition of Independent Practice Association (IPA) to include transportation vendors, specifically, that they should be treated similarly or IPA should be clarified that they need to be an IPA to contract with downstream providers.

*DOH Response:* DOH did not update the definition of IPA to include transportation. However, Section V of the Guidelines was updated to clarify when it is legally necessary to form an IPA in order to contract with an MCO.

*Industry Comment:* A comment was made that the definitions of Material Amendment and Non-Material Extensive Amendment are ambiguous and overly broad.

*DOH Response:* DOH removed the concept of Non-Material Extensive Amendment. Subsequently, the definition of Non-Material Extensive Amendment from the Guidelines was also removed. DOH updated the definition of Material Amendment and included a new definition of Material Change to be more consistent with Part 98, to provide greater clarity.

*Industry Comment:* A comment was made to update the definition of Shared Savings Agreement to include not just fee-for-service payments, but also capitation payments for the providers' own services (i.e.: capitation for primary care physicians).

*DOH Response:* DOH did not update the definition for Shared Savings Agreement to incorporate capitation payments. Shared Savings agreements can be either fee-for-service or capitation payments. Shared savings is related mainly to fee-for-service payment arrangements with upside and/or downside risk.

*Industry Comment:* A comment was made that the definition of Value Based Payments may require clarification. The term 'value-based payment' in the draft Guidelines is used principally to describe the contracts (and elements of contracts) that must be submitted to DOH under the applicable mandatory contract provisions. In the draft, value-based payment is defined to

include arrangements that involve both quality and cost outcomes. Under both the State's Roadmap and the DOH XXX form, VBP arrangements may include quality alone (Level 0). This discrepancy may create confusion. Accordingly, DOH should ensure that the definition is aligned with the intended meaning of the term 'value-based payment'. However, if the Guidelines definition is broadened to include arrangements that include only quality (and not cost), DOH should clarify that such arrangements are not subject to the various requirements applicable to those VBP arrangements that involve cost or risk.

*DOH Response:* DOH reviewed the comment and took the comments into consideration. After further discussion, DOH determined that it is not germane to the contract review process as it relates to these Provider Contract Guidelines. For example, if there is downside risk that initiates the Tier 2 – DOH Review Tier, it does not matter whether the arrangement meets the VBP Level 2 requirements or is only a VBP Level 0. The downside financial risk would be evaluated the same way.

*Industry Comment:* A comment was made to update the definition of Value Based Payment to include examples from the Roadmap as to the type of payments considered 'value-based' (i.e.: shared savings, risk sharing, bundles, fee-for-service for a limited set of preventive care activities and other off-menu arrangements not included in the Roadmap). In addition, the definition should be revised to clarify that it is a 'payment' strategy utilized to promote quality and value.

*DOH Response:* DOH has updated the definition of Value Based Payment to reflect this comment.

*Industry Comment:* A comment was made to include the definition of Claims Adjudication/Payment and to have it align with the definition in the Management Contract Guidelines and Department of Financial Services advisory opinions.

*DOH Response:* DOH agrees with this comment and has included the definition of Claims Adjudication/Payment to the Guidelines; this definition aligns with the Management Contract Guidelines as well.

*Industry Comment:* A comment was made that the Guidelines use the terms 'risk', 'risk sharing', 'risk arrangement', 'transfer financial risk', and 'financial risk sharing agreement/arrangement'. The Guidelines (page 19) set forth the definition of 'risk sharing' under Part 98 and the 'standards for risk transfer' under Regulation 164. A uniform definition of 'risk' should be included in the definition section and be used consistently throughout the Guidelines.

*DOH Response:* DOH took the comment into consideration. However, DOH believes the current definition of risk is sufficiently explained in the regulations and, therefore, does not need to be further defined in these Guidelines.

*Industry Comment:* A comment was made that the Guidelines use the term 'contract', 'template', and 'amendment' interchangeable without being defined, and it is not clear if there is a distinction.

*DOH Response:* DOH reviewed the use of the terms contract, template, and amendment throughout the Guidelines. DOH made changes as appropriate to make the use of the terms more consistent when applicable.

## **Section II**

*Industry Comment:* A comment was made that Paragraph II.A states that all contracts require approval, however the Guidelines explain that only certain contracts are subject for approval.

*DOH Response:* DOH has a responsibility under the law to review/approve all contract. File and use contracts can be implemented once an ok to implement letter has been received from DOH; it will now be the plan's responsibility to retain the letter. Although File and Use contracts can be implemented immediately upon receipt of acknowledgement, DOH considers such acknowledgement an approval. Therefore, the term approval was kept in the Guidelines.

*Industry Comment:* A comment was made for Paragraph II.B that it should be revised to remove the 'or' and replaced with 'and' for Technical and Administrative Service contracts since they are not subject to the Provider Guidelines unless included in a provider agreement.

*DOH Response:* DOH has updated the Guidelines to make this language clearer.

*Industry Comment:* A comment was made for Paragraph II.C to include a definition of Claims adjudication/payment, as it needs clarification.

*DOH Response:* DOH has added a definition of Claims Adjudication/Payment for the Guidelines for clarification.

*Industry Comment:* A comment was made that the Standard Clauses should be incorporated into provider agreements through reference to a link on the DOH's website, as this would save time and money when updated versions of the Standard Clauses are made.

*DOH Response:* DOH considered the comment. DOH feels this would create a legal issue with the validity of the contract if a hard copy of the Standard Clauses is not attached and incorporated into the contract.

### **Section III**

*Industry Comment:* A comment was made that Paragraph III.A.1.c should be clarified with respect to use of unique identifiers. In the event that a template is amended so that existing contracted providers are subject to the amended template and new providers are contract with a contract that incorporates the old template and the new amended provision, do two contract statements need to be submitted to DOH with two unique IDs?

*DOH Response:* DOH updated this section in respect to the unique identifying number. The Guidelines now state "the unique identifier for a Material Amendment must use the unique identifier for the original contract or source template as a prefix. DOH needs to be able to tie each amendment/update back to the originally approved contract with the ID number.

*Industry Comment:* A comment was made that in Paragraph III.A.1.e, the statement "the contract submission as a fully incorporated appendix" needs clarification. Additionally, a comment was made regarding the statement "the payment methodology must be described"; it is believed that it may be difficult at the time of submission to include this information for a downstream contract. It should also be clarified that payment cannot be shared amongst providers without going through an IPA and these provider guidelines.

*DOH Response:* DOH believes that the statement "the contract submission as a fully incorporated appendix" is clear and states exactly what DOH means. Additionally, pursuant to PHL § 4406-c(5-a) payment methodology must be defined and explained when the contract is submitted for approval.

*Industry Comment:* A comment was made in regards to Paragraph III.A.3 that it is burdensome and inefficient to require a plan to have its CEO or CFO execute a new contract statement in the event of a minor error on the form. Discretion should be afforded to the plan and DOH project manager in such circumstances to allow for substitution of the pages.

*DOH Response:* DOH uses its discretion in these situations already.

*Industry Comment:* A comment was made that the Draft Revised Guidelines should be clarified with respect to the types of material amendments that will be processed as file and use. In particular, Paragraph III.B now affords file and use processing for any change to/addition of a risk-sharing arrangement that falls within Tier 1. Assuming the Department's intent is to continue to require prior approval for amendments that are material for reasons other than the change to/addition of a risk sharing arrangement (e.g. change to a required contract clause, addition of an exclusivity, MFN, non-compete clause), this should be made clear. The new file and use process for material amendments that fall under Tier 1 is also inconsistent with Standard Clause Paragraph B.2, which continues to state that "any material amendment „ is subject to the prior approval of DOH, and ... shall be submitted for approval at least thirty (30) days, or ninety (90) days if the amendment adds or materially changes a risk sharing arrangement that is subject to DOHI review, in advance of anticipated execution." As such, the foregoing Standard Clause provision should be revised to conform to the new file and use process applicable to material amendments qualifying for Tier I.

*DOH Response:* DOH has reviewed the comment and added language to clarify and have updated the Guidelines accordingly.

*Industry Comment:* A comment was made for clarification that templates may only be submitted for a Tier 1 arrangement and that any arrangement that qualify under Tier 2 or 3 will need to be submitted to DOH and/or DOH and DFS. In addition, please clarify that a fee-for-service or per diem contract without any Value-Based Payment should be categorized as a Tier 1 arrangement.

*DOH Response:* Only arrangements that fall under Tier 1 review category are eligible for templates. Traditional fee-for-service or per diem payments with no downside risk would fall under the Tier 1 review. If the fee-for-service or per diem arrangement contains a withhold or other downside financial risk that meets the Tier 2 – DOH review threshold, then a template may not be used.

*Industry Comment:* A comment was made in regards to Non-Extensive Material Amendments and the requirements that DOH requires for approval and resubmission.

*DOH Response:* DOH has removed the term Non-Extensive Material Amendment from this section and the Guidelines as a whole.

**Section IV**

*No comments made from the industry on this section.*

## **Section V**

*Industry Comment:* A comment was made that this section implies that an MCO may contract only with a parent entity, an affiliated entity to make available services in another service area, or certain pharmaceutical suppliers and labs at discounted rates. We're certain that the Department does not intend for this section to be interpreted in such a limited fashion. We believe that it is intended to merely to ensure compliance with fraud and abuse laws by limiting the circumstances in which an MCO may contract with an affiliated entity or with certain providers/suppliers at a discount. If that is the Department's intent.

*DOH Response:* DOH has updated this section to be clearer as to whom an MCO may contract with.

*Industry Comment:* A comment was made that this section states that MCO cannot contract with unlicensed professional and is not clear whether this applies to other benefits that do not require certification, such as transportation.

*DOH Response:* DOH has updated the section to clarify licensed vs unlicensed and benefits that do not require certification and how an MCO may contract with those entities.

## **Section VI**

*Industry Comment:* A comment was made that there should be a legal requirement that providers comply with the mandatory contract provisions. We suggest language be added to the Guidelines and that compliance is a condition for participation in Delivery System Reform Incentive Payments and Value-Based Payments.

*DOH Response:* DOH has considered this comment, however this would require NYS Legislation in order to implement.

*Industry Comment:* A comment was made that mandatory provisions, including the language clarifying Insurance Law Section 3224-b, which the Department has interpreted to require health plans to recoup Medicaid overpayments for 6 years and not 24 months as is the case for commercial plans. It also would be helpful to clarify that the requirement for a provider to disclose ownership and control information includes providing each plan with the date of birth and other identifying information of the owners on the Disclosure of Ownership form. Plans consistently receive pushback from providers when trying to complete with this requirement.

*DOH Response:* DOH has added these provision back in, they are now listed in the Standard Clauses.

*Industry Comment:* A comment was made that reimbursement provisions to downstream providers regarding Shared Savings, Risk and other Value-Based Payment Arrangements. At the time of contracting, an IPA likely will not know when and how IPA Providers will be paid Shared Savings or other Value-Based Payments. Thus, payments for savings, as opposed to payment for services, should not be required to be included in any downstream contracting arrangement.

*DOH Response:* DOH has reviewed the comment and pursuant to PHL § 4406-c(5-a) payment methodology must be defined and explained when the contract is submitted for approval.

*Industry Comment:* A comment was made regarding subparagraphs B.1(d) and B.2(b) and (c) add new "mandatory contract provisions" that obligate the provider/IPA (1) to provide additional documentation to the MCO regarding the provider's/IPA's financial condition, if requested by DOH, and (2) to provide documents as requested by the MCO to assess the IPA's progress toward achieving VBP Roadmap goals. To facilitate the contract negotiation process, we request that these new mandatory contract provisions be included in the Standard Clauses as new paragraphs.

*DOH Response:* DOH has added these items into the Standard Clauses as number 11 and 12.

*Industry Comment:* A comment was made regarding section VI.B - Risk Sharing Requirements. Please clarify whether or not the requirements contained in paragraph 2 of Section B for contracts between plans and IPAs "sharing risk" apply to all Tier 2 and Tier 3 arrangements.

*DOH Response:* DOH has reviewed the comment and has added clarifying language.

*Industry Comment:* A comment was made regarding section VI, Paragraph B.1(a) should be revised to read as follows: "Provide for the plan's ongoing monitoring of the provider's financial capacity and/or periodic financial reporting by the provider to the plan to support the risk sharing."

*DOH Response:* DOH has considered this change and does not believe such change is necessary.

## **Section VII**

*Industry Comment:* A comment was made regarding clarity in regards to the factors that trigger review under each of the three tiers.

*DOH Response:* DOH has updated the requirements of each of the three tiers to provide greater clarification.

*Industry Comment:* A comment was made regarding Regulation 164. Under Regulation 164, DFS review and approval is only required when the projected pre-paid capitation payment over a 12-month period is \$1,000,000 or more. Thus, the Guidelines are imposing a higher standard than currently exists for Tier 3 arrangements. In addition, the \$250,000 in annual capitation payments is a low threshold and it is impractical to require a financial security deposit when total payments are only \$250,000.

*DOH Response:* As discussed at the VBP Subcommittee meetings, the requirements for Regulation 164 have not changed with the implementation of VBP. The criteria remains the same, DFS 11NYCRR §101.10.

**Appendix – Standard Clauses**

*No comments made from the industry on this section.*

## **Appendix – DOH XXX – Certification Form**

*Industry Comment:* A comment was made that the summary section/line in Section A.4 should be removed.

*DOH Response:* DOH has removed the summary section/line.

*Industry Comment:* A comment was made that Section A.7 should be moved to Section F, as the question in A.7 is only applicable in the event of a Tier 2 or 3 arrangement.

*DOH Response:* DOH has moved A.7 to Section F, as it is finance related and should appear in the finance section.

*Industry Comment:* A comment was made that the sentence 'Note: If the MSO is paying claims, no risk can be transferred to the MSO' needed clarification.

*DOH Response:* DOH has clarified the statement.

*Industry Comment:* A comment was made that HCBS needs clarification in Section C.2.b.

*DOH Response:* DOH has spelled out Home and Community Based Services as well as keeping the acronym on the form.

*Industry Comment:* A comment was made that the certification form defines the VBP arrangement types and the payment levels instead of just referencing the Roadmap Section C.2.c.

*DOH Response:* DOH will not further define VBP arrangement types and the payment levels on the certification form. The link to the Roadmap is provided for reference for further clarification. The Roadmap is a living document that will continually be updated, therefore if the clarification is on the certification form, the form would need to be updated each time the roadmap is updated.

*Industry Comment:* A comment was made regarding Section C.2.c needed definitions included for the VBP Level that the contract falls under.

*DOH Response:* DOH has provided a link to the Roadmap with definitions of the VBP Levels.

*Industry Comment:* A comment was made that Section F.1.b, the DOH Financial Viability Requirements, should mirror the two 5% tests for net worth and liquid assets as is similarly required for Regulation 164 compliance.

*DOH Response:* DOH has reviewed the comment and decided that the DOH Financial Viability Requirements will remain as is. This is the same as the old Guideline requirements and DOH can request different amounts than DFS.

*Industry Comment:* A comment was made in regards to Section F.3.b, that the financial security deposit should be changed to 7.5% or 12.5% instead of just 12.5%.

*DOH Response:* DOH has reviewed the comment. The Guidelines permit this on a case by case basis. Therefore, no changes to the certification form are necessary.

*Industry Comment:* A comment was made for Section F.4; the last sentence should have the additional statement added to the end of it. "and that agreements greater than \$250,000, but less than or equal to \$1,000,000 annually do not require DOH/DFS agency review and approval, but must comply with the requirements of Regulation 164."

*DOH Response:* DOH has reviewed the requested change and determined no changes are necessary. The sentence is clear as written currently.

*Industry Comment:* A comment was made that a section should be added for Tier 2 and Tier 3 contracts to identify the pages in the contract where the Risk Sharing Requirements in the Guidelines (Section VI.B) are met. Alternatively, these required provisions for Risk and Shared Savings arrangements should be added to the Standard Clauses, which would avoid disputes between plans and providers that refuse to provide financial statements to the plan.

*DOH Response:* DOH has reviewed the comment. Section F.1.c of the Certification Form requires plans to indicate the page of the contract that contain provisions meeting the provider financial viability monitoring requirements. DOH is not adding this to the Standard Clauses.

*Industry Comment:* A comment was made that fee-for-service contracts that do not provide for any type of Value-based payment need to be included within Tier 1.

*DOH Response:* DOH has reviewed the comment. Fee-for-service contracts with no risk sharing or prepaid capitation will fall under Tier 1 as defined in the Guidelines. The criteria for Tier 1 contracts accommodates this as it currently stands.

*Industry Comment:* A comment was made regarding the third paragraph of Section G, that the Certification to the Standard Clauses relating to the Department's mandatory incorporation language should be removed. Plans cannot certify to this if they are only updating existing contracts with an amendment for the new Standard Clauses. Alternatively, please clarify that such an amendment would not require the plan to certify or revise existing agreements provided that some incorporation language is already used to attach and incorporate the Standard Clauses into the main body of the contract.

*DOH Response:* DOH has reviewed the comment. Incorporation of the Standard Clauses into the main contract is a requirement of the Provider Contract Guidelines. Therefore, there will not be a modification to the Statement and Certification form.