LeadingAge New York

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Director
Susan R. Bentley
NYS Department of Health
Division of Health Plan Contracting and Oversight
Bureau of Certification and Surveillance
Empire State Plaza, Corning Tower
Albany, New York 12237

Re: Comments on Draft Revised Provider Contract Guidelines (the "Draft Guidelines")

Dear Mr. Bick and Ms. Bentley:

I appreciate the opportunity to submit these initial comments on the Draft Guidelines on behalf of LeadingAge New York. LeadingAge New York's nearly 500 members represent the entire continuum of not-for-profit and public providers of senior housing and long-term/post-acute care (LTPAC), including managed long term care plans, home and community-based services, adult day health care, nursing homes, continuing care retirement communities, assisted living facilities, and hospice programs.

These comments seek principally to ensure that the updated Guidelines provide a streamlined submission and review process that will support a significant increase in VBP arrangements under managed care, reflects changes in the law and regulations in relation to ACOs, and is clear to all affected parties. While many users of the updated Draft Guidelines will be familiar with a long history of practice and interpretation in relation to prior versions of the Guidelines, this new version should strive to be understandable by all users, whether or not they have experience with the prior versions and DOH practices.

Definitions

The definition of health care services for purposes of describing the contracts that are subject to these Draft Guidelines requires clarification. It suggests that only services delivered by "health care professionals" are included within the definition. As you know, managed long term care (MLTC) plans[1] offer coverage of 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, home modifications, etc. MLTC plans and providers may be interested in entering into value-based arrangements that involve both clinical care and other non-clinical services and supports. It is my understanding that the Draft

[1] For purposes of this letter, "managed long term care plans" include partially-capitated plans, Fully-Integrated Duals Advantage (FIDA) plans, Medicaid Advantage Plus plans, and Programs of All-Inclusive Care for the Elderly (PACE).

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Guidelines are intended for value-based arrangements that encompass both clinical and non-clinical services. I would recommend modifying the definition as follows:

> **Health Care Services**
> Shall mean, for purposes of these guidelines, services delivered to maintain or improve health and/ through the diagnosis, treatment, and prevention of disease, illness, injury, or other physical, mental ~~and~~ or substance use disorder needs. Health care services shall also include long-term services and supports delivered for the purpose of supporting the ability of the member to live or work in the setting of his or her choice, which may include the member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.[2] ~~Health Care Services are delivered by health care professionals (providers and practitioners) and include the provision of primary care, secondary care, tertiary care, and behavioral health care.~~ All ~~other~~ Medicaid State Plan and Waiver services are considered health care services.
> For purposes of these Guidelines, health care services shall not include Medicaid Health Home services and MLTC Care Management services.
> ~~• All other Medicaid State Plan and Waiver services are considered health care services.~~

The definition of "value-based payment" may also require clarification. The term "value-based payment" in the Draft Guidelines is used principally to describe the contracts (and the elements of contracts) that must be submitted to DOH and the applicable mandatory contract provisions. In the draft, value-based payment (VBP) is defined to include arrangements that involve "both quality and cost outcomes." Under both the State's Roadmap and the DOH-4255 form, VBP arrangements may involve 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 involve 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.

Submission Requirement

The Draft Guidelines, in Section II(A), require submission of drafts of all contracts related to the provision of health care services "for approval." However, as indicated in Section III(B), certain contracts are subject to a file and use process and do not require approval. We recommend revising Section II(A) as follows:

> A. An applicant shall submit to the Department of Health (DOH) ~~for approval~~ drafts of all contracts (including but not limited to material amendments or non-material extensive amendments to such contracts, shared savings arrangements,

[2] This sentence is derived largely from the recently adopted federal Medicaid managed care regulations. *See* 42 CFR §438.2.

risk arrangements, or value based payment arrangements) related to the provision of health care services.

General Contracting Requirements and Prohibitions

Section V implies that MCOs 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, we recommend revising this section as follows:

> An MCO may contract with the following entities, only if arrangements with such entities to New York enrollees comply with federal fraud and abuse requirements and New York law:
>
> - 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;
> - a sister or subsidiary MCO or other MCO operating within New York to make available services and discounted rates to its enrollees incidentally when traveling within New York but outside of the MCO's New York service area; or
> - purveyors of pharmaceutical supplies to purchase such supplies at discounted rates, and with entities performing laboratory testing to obtain discounted rates.~~, provided that arrangements with providers of such services to New York enrollees comply with federal fraud and abuse requirements and New York law.~~

Section V also prohibits contracting with unlicensed entities, consistent with the ban on corporate practice of medicine. However, in its list of permissible contractors, it includes IPAs but not ACOs. ACOs should be added to the following paragraph:

> The prohibition against the unauthorized corporate practice of medicine precludes any corporation or unlicensed entity from providing or arranging to provide professional services 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~~ IPAs or accountable care organizations (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.

ACOs should also be added to the appropriate provisions in Sections VI and VII.

Financial Review Criteria for Risk Tiers

Additional clarity is needed regarding the factors that trigger review under each tier. For example, in order to qualify for Tier 1 review, if the total annual payment to a provider at risk is more than $1 million, a Medicaid contract must not represent: "more than 25 percent of the annual Medicaid Managed Care or Medicaid Managed Long Term Care payments at risk;" nor "more than 15 percent of the provider's overall Medicaid revenue;" nor an off-menu arrangement. First, the Draft Guidelines do not define the term "at risk," and it is difficult to anticipate the amount "at risk" under many VBP arrangements, unless the contract includes risk corridors or stop loss. The Guidelines should describe how to calculate the amount at risk and should clarify that the opportunity for shared savings does not constitute or contribute to an amount at risk. Thus, contracts for shared savings only should qualify for Tier 1 review.

Further, the numerators and denominators of the 25 percent and 15 percent thresholds are not clear. Is the numerator the payments at risk under this contract or under all contracts with this entity and any of this affiliates, or under all contracts? Is the denominator all Medicaid managed care and MLTC payments under this contract, under all contracts with this entity and its affiliates, or under all Medicaid managed care and MLTC contracts? The final report of the Regulatory Impact Subcommittee included the formulas for the 25 percent and 15 percent thresholds on page 34, Figure B. They are as follows:

- 25%: $\frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}}$
- 15%: $\frac{\text{Value of this Contract's Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}}$

The denominator for the 15% revenue threshold is intended to include both managed care and fee-for-service revenue. It would be helpful to include these formulas in the Guidelines.

Financial Viability and Financial Security Deposits

The Draft Guidelines require managed care plans submitting Tier 2 contracts to supply sufficient information to demonstrate that the contracting provider or IPA (or presumably ACO) is "financially responsible; capable of assuming such risk; and has satisfactory insurances, reserves, or other arrangements to support the expectation that it will meet its obligations. However, the Guidelines do not specify the standards by which financial responsibility and capability is

determined. In addition, the Guidelines provide that risk corridors and stop loss provisions may reduce any required financial security deposit. The Guidelines do not, however, explain how the Department evaluates risk mitigation provisions and the extent to which they may replace financial security deposits. It would be helpful for providers and plans to be aware of these standards and how they are applied, as they develop VBP arrangements. Additional transparency regarding the Department's evaluation practices would also reduce the number of disapproved contracts, discussions with the Department, and contract revisions, as plans could more accurately anticipate the Department's likely response.

Thank you again for the opportunity to submit comments. Please don't hesitate to contact me or our counsel, Sean Doolan, with any questions or concerns.

Sincerely yours,

Karen Lipson
Executive Vice President for Innovation Strategies

Cc: Sean Doolan