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TO: **Memo Distribution List**

LeadingAge New York

FROM: Hinman Straub P.C.

RE: Final Revised Health Department Provider Contract Guidelines

DATE: March 20, 2017

NATURE OF THIS INFORMATION: This is information explaining new requirements you need to implement.

DATE FOR RESPONSE OR IMPLEMENTATION: April 1, 2017

HINMAN STRAUB CONTACT PEOPLE: Raymond Kolarsey

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #2 Providers and payments to them Suggested Key Word(s):

The Department of Health recently released revised "Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs" (the "2017 Revised Guidelines"), and related revised "Standard Clauses for Managed Care Provider/IPA Contracts" (the "4/1/17 Standard Clauses"), and "Contract Statement and Certification Form" (the "2017 Certification Form"). Copies of each are available at https://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm.

The 2017 Revised Guidelines will apply to any provider or IPA contract, contract template or material amendment submitted to the Department for approval on or after April 1, 2017.

The 4/1/17 Standard Clauses must be utilized as follows:

(1) Any new contract submitted to the Department for review and approval on or after April 1, 2017 must contain the 4/1/17 Standard Clauses;

(2) Any material amendment to an existing approved contract submitted to the Department for review and approval on or after April 1, 2017 must contain the 4/1/17 Standard Clauses;

(3) Any previously approved template used with a new provider on or after April 1, 2017 must include the 4/1/17 Standard Clauses; and

(4) Any previously-approved contract, any contract/material amendment currently under review by the Department, and any contract/material amendment submitted for approval by close of business on March 31, 2017, will need to be amended to add the 4/1/17 Standard Clauses upon the earlier of (a) the next material amendment, (b) the next contract renewal date (e.g., December 31st for evergreen contracts that renew annually on a calendar year basis), (c) a deadline specified by the Department as a condition of approving an MCO change in control, acquisition or merger, or (d) March 31, 2018 (this means that a previously-approved contract with a fixed term that extends beyond March 31, 2018 will need to be amended to add the 4/1/17 Standard Clauses prior to the end of its term).

As with the implementation of prior revisions to the Standard Clauses, the Department is taking the position that adding the 4/1/17 Standard Clauses, without more, would not constitute a material amendment requiring Department approval.

The key changes to the 2017 Revised Guidelines, 4/1/17 Standard Clauses, and the 2017 Certification Form are described below.

2017 Revised Guidelines

The 2017 Revised Guidelines incorporate the recommendations of the Value Based Payment Workgroup's Regulatory Impact Subcommittee. The primary purpose of the 2017 Revised Guidelines is to implement changes to facilitate the financial review of Medicaid Managed Care value based payment ("VBP") arrangements that must be implemented to comply with the DSRIP-related NYS VBP Roadmap (the "Roadmap"), as approved by the Centers for Medicare

and Medicaid Services. Under the Roadmap, Medicaid Managed Care plans must have VBP arrangements in place that apply to 80-90% of their network provider payments by 2020.

To facilitate an efficient and timely review of the large number of VBP arrangements that are expected to be submitted to the Department in response to the Roadmap requirements, the 2017 Revised Guidelines implement a new 3-tiered approach to the financial review of risk-sharing arrangements. The new 3-tiered financial review criteria contain different requirements for risk arrangements applicable to Medicaid Managed Care products and commercial products. Most of the changes apply to Medicaid Managed Care product-related risk arrangements, with the criteria applicable to commercial-product risk arrangements remaining very similar to the prior financial review criteria.

New Financial Review Tiers

The 2017 Revised Guidelines subject VBP arrangements to either a Tier 1, Tier 2, or Tier 3 review. As described in more detail below, risk arrangements qualifying for Tier 1 review are subject to "file and use" review. Risk arrangements qualifying for Tier 2 review are subject to a detailed financial review, including a provider/IPA financial solvency review, and the potential for the requirement of a financial security deposit (i.e., a reserve). Risk arrangements subject to Tier 3 review are limited to prepaid capitation arrangements, and are subject to the existing review and approval requirements set forth in the Department of Financial Services' (DFS) Regulation 164.

As used in the 2017 Revised Guidelines, "Tier 1", "Tier 2", and "Tier 3" refer only to the applicable level of financial review of the risk arrangement imposed by the Department as a condition of provider contract approval. The DOH financial review tiers are distinct from the VBP "levels" as defined in the Roadmap, which reflect whether the VBP risk arrangement is upside only (VBP Level 1), upside and downside (VBP Level 2), or prepaid risk (VBP Level 3). VBP Level 1, 2 and 3 arrangements must be assessed against the financial review criteria in the 2017 Revised Guidelines to determine whether Tier 1, 2 or 3 review criteria apply.

Tier 3 Review. A VBP arrangement will be subject to Tier 3 review only if it contains a prepaid capitation arrangement subject to Regulation 164. In this regard, prepaid capitation arrangements are subject to the same review and approval requirements that previously existed. In particular:

- The capitation arrangement must be on a prepaid basis;
- The annual capitation amount must be equal to or greater than $1 million; and
- The agreement is subject to approval by the Health Department from a programmatic basis, and subject to DFS approval from a financial perspective.

A prepaid capitation arrangement involving a capitation amount that is less than $1 million, and that is therefore exempt from DFS approval under Regulation 164, will qualify for a Tier 1 review.

Contracts subject to Tier 3 review cannot be implemented until prior written approval is received from both the Health Department and DFS.

Tier 2 Review. A VBP arrangement will be subject to Tier 2 review if the following criteria are met:

- The projected annual amount of payment to the provider or IPA that is at risk is more than $1 million, AND
- For Medicaid contracts, at least one of the following is true:
  - More than 25% of the projected annual payments to the provider or IPA by the MCO under the contract at issue are at risk; or
  - The provider or IPA's projected payments under the contract at issue is more than 15% of the provider or IPA's projected overall Medicaid revenue from all payors; or
  - The VBP arrangement is an "off menu" arrangement not previously approved by the Department under the Roadmap criteria.
- For commercial contracts, more than 25% of the projected annual payments under the submitted contracts to the provider or IPA are at risk. Notably, while similar to the Department's previous rule that risk transfers of less than 25% do not require any financial review, the previous limitation that applied the 25% rule to only withholds or bonuses has now been expanded to apply to any type of risk sharing arrangement, including those based on a year-end budget reconciliation.

If a Tier 2 review applies, the contract submission must include evidence of the provider's or IPA's financial viability in the form of certified audited financial statements or comparable means (such as an accountant's compilation). The 2017 Revised Guidelines do not specify what constitutes an acceptable level of capital and solvency, but historically the Department has applied a test of assets greater than liabilities. The Department will also consider the existence of parental guarantees, stop loss insurance, or contractual risk corridors in determining financial responsibility.

Risk arrangements subject to Tier 2 review may also be subject to a financial security deposit in the amount of 7.25% of the estimated annual medical expenses covered under the risk arrangement. This reserve amount has been decreased from the 12.5% amount that previously applied to be consistent with the reserve requirements currently applicable to HMOs under Part 98 of the Department's regulations.

Notably, and despite the urging of stakeholders to do so, the 2017 Revised Guidelines do not state under what circumstances a reserve will be required, and will apparently be determined by the Department on a case-by-case basis. We expect the Department to follow its historical approach of requiring a reserve in any case where the provider or IPA assuming risk is not solvent (i.e., its assets do not exceed its liabilities) and no parental guarantee or reinsurance policy is in place. What other circumstances, if any, that might trigger a reserve requirement remains to be seen.

Contracts subject to Tier 2 review cannot be implemented without the prior written approval of the Health Department. However, a contract subject to Tier 2 review can be implemented 90 days after submission if the Department has not directed the MCO not to implement.

Tier 1 Review. A VBP arrangement will be subject to Tier 1, file and use, review if the following criteria are met:

- Projected annual payments to the provider or IPA at risk is expected to be less than or equal to $1 million; OR
- Projected total annual payments to the provider or IPA is expected to be more than $1 million, but NONE of the following are true:
    - For Medicaid Managed Care contracts:
        - More than 25% of the projected total annual payments made to the provider or IPA by the MCO are at risk; or
        - The provider's or IPA's projected payments under the contract at issue are more than 15% of the provider's or IPA's projected total revenue from all payors; or
        - The VBP arrangement is an "off menu" arrangement under the Roadmap.
    - For Commercial contracts:
        - More than 25% of the projected total annual payments made to the provider or IPA are at risk. As previously noted, the Department's previous rule that only risk transfers of less than 25% do not require any financial review has been expanded to apply to any type of risk transfer arrangement, not just withholds or bonuses.

The Department will not generally conduct any financial review under Tier 1. Rather, the review will be limited to an abbreviated programmatic review to assure that the 2017 Standard Clauses are attached and a 2017 Certification Form has been completed.

Although Tier 1 review is termed "file and use", Tier 1 contracts cannot be implemented until the MCO receives an acknowledgement from the Department that it has received the filing and that it meets the criteria for Tier 1 review, which the Department indicates will typically be provided no more than three (3) business days after submission.

Upside Only Arrangements Are No Longer Considered Financial Risk Transfer Arrangements

The 2017 Revised Guidelines eliminate the Department's previous position that upside only, or surplus sharing, arrangements constitute a transfer of financial risk subject to financial review. As so revised, upside only arrangements (i.e., VBP Level 1 arrangements) will not be considered a financial risk transfer subject to financial review, financial viability assessment, or a financial security deposit requirement.

Material Amendments and Extensive Non-Material Extensive Amendments

Material amendments to approved contracts continue to require the Department's prior approval. The definition of a "material amendment" has been revised to include (1) any change to a VBP arrangement other than routine trending of fees or other reimbursement amounts that do not change the Tier or make the arrangement off menu under the Roadmap, and (2) any change to performance measures or quality targets that are inconsistent with the Clinical Advisory Group Playbook as described in the Roadmap, or that make the arrangement "off menu".

The 2017 Revised Guidelines also now include a non-exhaustive list of examples of amendments that are not material. These largely mirror the types of changes that were previously considered "Non-Material Extensive Amendments", and include the following:

- Technical changes to clarify a provision, identify parties, or to specify the contract for use with particular parties;
- Extension of the contract term of an approved contract;
- The addition of clauses required by the NCQA;
- The addition of Medicare Advantage-required clauses, or FIDA-required clauses;
- The addition of clauses that apply only to lines of business that are not regulated by State law (e.g., self-funded products); and
- The addition of clauses required by a parent corporation.

Under the prior guidelines, the Department required that "Non-Material Extensive Amendments" be filed with the Department. Under the 2017 Revised Guidelines, the definition of Non-Material Extensive Amendments and the related filing requirements have been eliminated.

Contracts Not Subject to the 2017 Revised Guidelines

The 2017 Revised Guidelines generally apply to any contract with a provider or IPA that relates to covered services under a commercial subscriber contract or under the Medicaid Managed Care Model Contracts. The following, however, are not considered covered services, and contracts relating solely to these services are not subject to the 2017 Revised Guidelines and the related approval requirements:

- Medicaid Health Home contracts;
- MLTC Care Management contracts; and
- Fiscal intermediary contracts for the Consumer Directed Personal Assistance Services program.

Exceptions to Compliance With MCO's Policies and Procedures

The 4/1/17 Standard Clauses continue to contain a provision that requires providers and IPAs to comply with all of the MCO's policies and procedures related to UM, QM, member grievances and provider credentialing. However, the 2017 Revised Guidelines have been revised to state that the parties are not precluded from agreeing to "exceptions or alternatives" to the MCO's policies and procedures so long as those exceptions/alternatives do not prevent the MCO from meeting its requirements under applicable law, regulations or DOH/DFS guidelines.

Mandatory Incorporation By Reference Language

While the Department previously recommended acceptable language that incorporates the Standard Clauses by reference, the 2017 Revised Guidelines now require MCOs to use the following incorporation by reference language verbatim:

> *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 Article 44 plans and providers that contract with such plans, and who are a party 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.

VBP-Related Financial Reporting/Monitoring Requirements

The 2017 Revised Guidelines now include the following additional VBP-related reporting/monitoring requirements:

- For a Tier 2 or Tier 3 arrangement:
  - The contract must provide for the MCO's ongoing monitoring of the provider or IPA's financial capacity and/or periodic financial reporting to the MCO;
  - The contract must address circumstances where the provider's or IPA's financial condition indicates an inability to continue accepting risk;
  - The contract must address the MCO's monitoring of the financial security deposit, if applicable; and
  - The contract must include a provision that the provider or IPA will submit any additional documents or information related to its financial condition to the MCO and, if requested to DOH.
- For any contract with an IPA or ACO:
  - The parties must expressly agree to terminate or amend the agreement if directed to do so by DOH;
  - The IPA or ACO must submit quarterly and annual financial statements to the MCO, as well as any additional information required by the MCO to assess and ensure the IPA's or ACO's progress towards achieving VBP goals consistent with the Roadmap;
  - The IPA or ACO will must submit any additional documents or information related to its financial condition to the MCO and, if requested to DOH; and
  - The parties agree that, in the event of a payment default by the IPA or ACO, the IPA/ACO participating providers will not demand payment from the MCO for any covered services for which payment was made by the MCO to the IPA/ACO.

To facilitate the incorporation of the foregoing requirements into provider contracts, each of the foregoing requirements has been added to the 4/1/17 Standard Clauses.

The 4/1/17 Standard Clauses

The 4/1/17 Standard Clauses contain primarily technical changes (e.g., replacing references to "IPAs" with "IPAs/ACOs"). The key substantive changes are as follows:

VBP-Related Financial Reporting/Monitoring Requirements

As previously, the new VBP-related provider reporting/monitoring requirements contained in the 2017 Revised Guidelines have been included in the 4/1/17 Standard Clauses at Section C.11 and 12.

Compliance with Model Contract Requirements

The Standard Clauses have always contained a clause that requires providers to comply with the terms of the Medicaid Model Contract. The provider trade associations urged the Department to eliminate this requirement, and the health plan trade associations objected to its elimination.

As a compromise, the clause requiring providers to comply with the terms of the Model Contract was left in the 4/1/17 Standard Clauses without change, but the Department agreed that before making any changes to the Model Contract that are not required by Federal or State law or regulation, the Department will provide the provider trade associations a 30-day comment period.

2017 Certification Form

The 2017 Certification Form is now posted on the Department's website in a fillable pdf format at:

https://www.health.ny.gov/forms/doh-4255.pdf

The 2017 Certification Form has also been revised to include the following additional information related to VBP arrangements:

- The Roadmap VBP Level involved;
- Whether the VBP arrangement involves total care for the general population, integrated primary care, chronic or maternity bundle, or off-menu arrangements;
- For contracts with OMH and OASAS providers, whether the fee-for-service rates are equivalent to the Medicaid fee-for-service APG rates;
- Information to determine whether the financial risk arrangement falls under DOH review Tiers 1, 2 or 3; and
- If applicable, information related to the financial viability of the provider or IPA and, if applicable, the amount of the financial security deposit.

Please do not hesitate to contact us if you have any questions.