



**Department  
of Health**

**Office of  
Health Insurance  
Programs**

**New York State Department of Health**

**Provider Contract Guidelines  
for Article 44  
MCOs, IPAs, and ACOs**

Revised April 1, 2017

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## Introduction

The purpose of these *Provider Contract Guidelines for Article 44 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. Reference to the New York State Value Based Payment Roadmap (Roadmap) applies to Medicaid lines of business only. However, MCOs with commercial lines of business may use, in its own discretion, concepts from the Roadmap.

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 provider 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, Shared Risk, or Value Based Payment arrangement, **other than** the routine trending of fees or other reimbursement amounts that does not change the Tier or make the arrangement off-menu;
- Any change to performance measures or quality targets that are inconsistent with the applicable Clinical Advisory Group Playbook (described in the Roadmap) or previously approved off-menu arrangement;
- 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/termination of an approved delegation of the above contractual, statutory or regulatory responsibilities.

**Authority: 10 NYCRR §98-1.2(aa)**

### **Model Contract**

Shall refer to the model contract that governs the various Managed Care Organization product lines that are authorized as:

- Traditional health maintenance organizations certified pursuant to NYS PHL §4403; or
- Special purpose MCOs, also known as prepaid health services plans (PHSP), certified pursuant to NYS PHL §4403-a; or
- HIV Special Needs Plans (HIV SNP) certified pursuant to NYS PHL §4403-c; or
- Managed Long Term care plans (MLTC) certified pursuant to NYS PHL §4403-f.

### **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 Article 44 plans and providers that contract with such plans, and who are a party to the contract are bound to honor the Standard Clauses except to the extent applicable law requires otherwise.

### **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 Risk Arrangement**

Shall mean a payment method in which a health care provider or IPA assumes liability by means of a capitation arrangement or other mechanism whereby the provider, IPA, or ACO assumes financial risk from the MCO for the delivery of specified health care services to enrollees of the MCO.

**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/ACO 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 and providers 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, Shared Risk arrangements, bundles, fee-for-service for a limited set of preventative care activities tied to quality measures, and approved off-menu arrangements, as referenced in the Roadmap).

**Value Based Payment (VBP) Arrangement**

Shall mean a payment method in which a portion of the compensation is dependent on quality and/or cost outcomes. VBP agreements can include traditional fee-for-service arrangements as well as Shared Savings and Shared Risk arrangements provided that a portion of compensation is dependent on provider performance.

## 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/ACO and another IPA/ACO, 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 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 April 1, 2017, and apply to new contracts, templates, and amendments, to existing approved contracts, submitted to DOH for review on or after April 1, 2017. They shall not apply to previously approved contracts, templates, or amendments, in effect as of April 1, 2017, or to contracts, templates or amendments, submitted to DOH for review and approval and received by close of business April 1, 2017.

All existing contracts, templates, and amendments, approved or submitted by close of business April 1, 2017, 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 March 31, 2018.

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).

## Section III – Contract Review Process

### A. Submission Requirements

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.**

**Note: All contracts, including File and Use, are not considered received by DOH unless submitted through one of the email addresses above. Contract submission solely to the plan manager is NOT acceptable.**

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 Technical and Administrative Services only (see Section II.B).
  - (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) If arrangements for payment to the provider (including payment for Shared Savings, Shared Risk, or Value Based Payment) are contained in multiple contracts, then all such contracts must be included with the submission and the additional agreements must be properly incorporated and made part of the main provider agreement. The payment methodology must be described for such arrangements.

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

2. A completed DOH-4255 Contract Statement and Certification, for each contract, template, or Material Amendment including an electronic copy of the DOH-4255 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-4255.

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-4255), the MCO must submit a new, corrected, and signed DOH-4255. 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-4255 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. DOH will provide such acknowledgement within no more than three business days. 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-4255 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 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 may be implemented 90 days after submission that meets the requirements of Section III, provided the MCO was not directed by DOH to not implement. 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)**

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-4255 certification form;
- The DOH-4255 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.

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.

The following changes/revisions to previously approved templates are not considered material changes and do not need to be submitted to DOH for approval, included but not limited to:

- 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);

- 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.

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 Determination (Section E – DOH-4255) 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.

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-4255).
  - 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-4255), 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. Notwithstanding any provision in Section III to the contrary, pursuant to 10 NYCRR §98-1.17 (a), DOH may request the production and/or submission of any MCO, IPA/ACO, or provider contracts subject to these Guidelines, including contracts based on approved templates, and may withhold or revoke approval of said contracts pending or as a result of DOH's review.
  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.

## 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 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 §§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

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<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 laboratories 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 laboratories 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.

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

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 Shared 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. The prior approval of the DOH Commissioner is required for assignment of the following agreements:
    - (i) 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
    - (ii) 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. **(SC §B.3).**

- (b) Termination or Non-renewal. Notice by the MCO to the DOH Commissioner is required when:
- (i) 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
  - (ii) 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 by the MCO to the Commissioner.
  - (iii) an agreement between a MCO or IPA/ACO with a medical group provider in which termination or non-renewal of such agreement 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 Joint Commission 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).**

- (c) 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.

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); (b) to the extent permitted by DOH and DFS, a High Deductible Health Plan (HDHP) combined with a health savings account (HSA); or (c) as otherwise allowed or approved by DOH. 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 Medicaid 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.
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/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, contract, 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.

Notwithstanding the above, nothing herein shall preclude the parties from agreeing to exceptions or alternatives to the MCO's general rules, policies and procedures provided that any exceptions or alternatives do not prevent the MCO from meeting required obligations.

## **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 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 (applies to Tier 1, Tier 2 and Tier 3);
  - (b) The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents requested by the MCO as necessary to assess the IPA/ACO's progress towards achieving Medicaid 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 (applies to Tier 2 and Tier 3); and
  - (c) The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); 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 (applies to Tier 2 and Tier 3).

## 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 and/or Model contracts.

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/ACO 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 or Shared Risk Arrangement.

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 regulations 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 certain prepaid capitation arrangements whereby an insurer transfers all or part of its financial risk to a health care provider. See Section B below.
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<sup>2</sup>

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

*Note: For additional reference, please see Appendix: Provider Contract Review Process and Appendix: DOH Review Tier Payment Threshold.*

### 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 the DFS submission requirements pursuant to Regulation 164; 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;

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<sup>2</sup> Payment at risk and financial risk referenced in the Tiers relate to downside risk only (such as withholds, capitation payments, and other situations where the provider would have a financial liability). It would not include bonuses or shared savings (such as VBP Level 1 arrangement with upside only shared savings).

- (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 the DFS submission requirement pursuant to Regulation 164; 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

Contracts shall be submitted to DFS in accordance with Regulation 164. DOH may conduct its own financial review, in its sole discretion, but may also defer to DFS as

applicable. 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 subject to review per the requirements of Regulation 164; 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 by DOH, the provider must establish and provide evidence of a financial security deposit in the amount of 7.25 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.

DOH will defer to DFS for the amount of the financial security deposit for arrangements that trigger Regulation 164.

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

### **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**

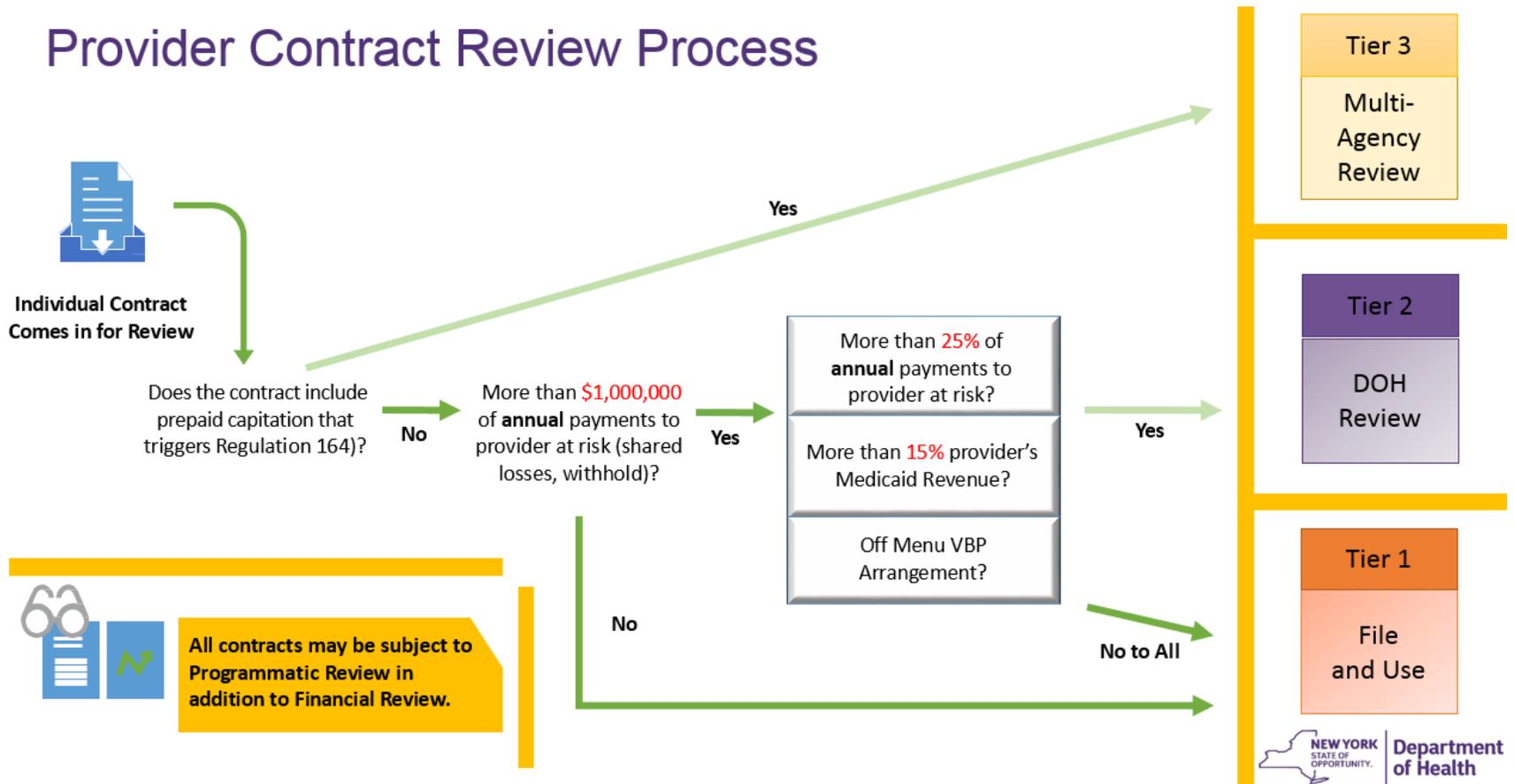
- (a) The MCO must submit the complete text of the proposed IPA/ACO contract(s) and all attachments thereto.
- (b) The MCO and the IPA/ACO must demonstrate to the satisfaction of DOH that the proposed arrangement will not constitute improper incentives to providers, in accordance with physician incentive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

Appendix: Provider Contract Review Process

# Provider Contract Review Process



Appendix: DOH Review Tier Payment Threshold

- This **\$1,000,000** annual payment threshold is applied to:
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only

- This **25%** payment threshold is applied to:
  - Only the individual contract that is coming in for review
  - Medicaid Managed Care components of the contracts only
- The ratio is expressed as:

$$\frac{\text{Annual Medicaid Payments at Risk for this Contract}}{\text{Total Value of All Medicaid Contracts between this MCO and Provider}}$$

- This **15%** revenue threshold is applied to:
  - All MCOs that contract with the provider
  - All Medicaid (inclusive of Medicaid Managed Care and Medicaid FFS) contracts
- The ratio is expressed as:

$$\frac{\text{Value of This Contract's Projected Medicaid Revenue}}{\text{Total Projected Annual Medicaid Revenue for Provider}}$$