Provider Contract Statement and Certification

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. If additional space is needed, attach a continuation page and identify the question(s) by number.
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

Date: _____

1. Check one: ☐ Contract ☐ Contract Template (Tier 1 only) ☐ Material Amendment

Original Contract # _____

Original Approval Date: _____

Original Effective Date: _____

2. Anticipated Effective Date: _____

3. MCO unique Contract or Amendment ID# _____
(Required, must also be indicated on each page of the contract)

4. Standard Clauses attached.
The main body of the contract must expressly incorporate the Appendix using the mandatory language found in the Guidelines and state that in the event of inconsistencies the Appendix controls. Identify the relevant provisions.

Contract Page: _____ Clause: _____

5. a. Does this contract contain an "exclusivity", "exclusion", or "most favored nation" clause as described by item #4 in Section VI.A in the MCO, IPA, and ACO Provider Contract Guidelines?

☐ Yes (If yes, identify the relevant contract provisions) ☐ No

Contract Page: _____ Clause: _____

b. Additional requirements for agreements with behavioral health providers:
Does the agreement contain an "all products" clause? ☐ Yes ☐ No

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

☐ Yes (If yes, identify the relevant contract provisions) ☐ No

Contract Page: _____ Clause: _____

Section B: Contracting Parties

1. MCO Name: _____

Contact Person: _____ Phone #: _____

Email Address: _____

2. a. Agreement between: ☐ MCO and IPA/ACO* ☐ MCO and Provider
☐ IPA/ACO 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/IPA agreements. A separate Contract Statement and Certification is required for each agreement.

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

c. If either the IPA or ACO or MSO is performing Claims Adjudication/Payment, 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/ACO Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____

4. Provider/IPA/ACO Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone #: _____

Note: If more than one Provider/IPA/ACO, complete Additional Provider/IPA/ACO section on page 9.

5. Check all lines of business covered by contract:

☐ Child Health Plus
☐ Commercial HMO
☐ Essential Plan
☐ FIDA
☐ FIDA IDD
☐ HARP
☐ HIV SNP
☐ Medicaid
☐ Medicare Advantage
☐ MLTC Partial
☐ MLTC MAP
☐ MLTC PACE
☐ QHP
☐ Other

6. Type of Provider:

☐ ACO
☐ FQHC
☐ Hospital
☐ Individual Practitioner
☐ IPA
☐ OASAS Certified or Designated
☐ OMH Licensed or Designated
☐ Medical Group
☐ 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							
Chiropractic							
Dental							
Durable Medical Equipment (DME)							
Home and Community Based Services (HCBS)							
Home Health Care							
Hospital							
Laboratory							
Mental Health							
Nursing Home							
Orthopedics							
Outpatient							
Personal Care							
Pharmacy							
Physical Therapy							
Primary Care Physician							
Private Duty Nursing Services							
Specialist Physician							
Substance Use Disorder							
Radiology							
Vision							
Other **than listed** (Describe below)							

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:[1]

☐ Total Care for General Population

☐ 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:[1]

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

d. Please answer the following:

Do the arrangements have quality measures? ☐ Yes ☐ No

Do the quality measures included meet the arrangement type requirements as documented in the VBP Quality Measure Sets? ☐ Yes ☐ No

Please indicate the location of the Quality Measures in the Contract Language:

Contract Page: _____ Clause: _____

e. Quality Measure Race and Ethnicity Stratification

In MY2022, NCQA added race and ethnicity stratification (RES) for several HEDIS measures to help promote transparency in health plan performance. By doing so, NCQA hopes to identify better where disparities exist so that they can be addressed. They also hope to identify and learn from top performers in areas where disparities don't exist. To align with this initiative, NYS requires payers and providers to incorporate race and ethnicity measure stratification in Value-Based Payment (VBP) arrangements. As noted in the **VBP Quality Measure sets**:

All new contracts submitted on or after July 1, 2022, must meet this requirement to be approved by NYS DOH. As of April 1, 2023, all other existing contracts were to be updated/amended at the end of the contract's current measurement period and before the contract's next measurement period began.

1. Payers are **required** to include **at least one** of the VBP Quality Measures in **all level 1 or higher** VBP contracts and stratify results by race and ethnicity categories as outlined in the HEDIS specifications

2. Payers are required to include the following detail in the table below.

a. Indicate what measure(s) will be included for race and ethnicity stratification (RES).

b. Indicate how the stratified measure results for applicable measures will be shared with the VBP contractor.

1. For a definition of "on-menu VBP arrangement types", and "Value Based Payment (VBP) levels", please refer to the most current version of the VBP Roadmap at: https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm.
2. The VBP Quality Measure sets are located at: https://www.health.ny.gov/health_care/medicaid/redesign/vbp/index.htm in the VBP Quality Measures section.
3. https://www.ncqa.org/health-equity/.
4. HEDIS® Volume 2 Technical Specifications for Heath Plans in the General Guidelines section, page 28.

Please list below the measures that will be included for RES based on the contract's arrangement type. For a list of the current NCQA RES measures please refer to the table on the VBP website.

NCQA Measure Name(s)	

Please indicate how the stratified measure(s) results for applicable measures will be shared with the VBP contractor:

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

2. a. Additional payment methodology to provider: ☐ Yes ☐ No

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

☐ Shared Savings (with target budget)

☐ Bonus (no target budget)

- ☐ Up to 25% of IPA/Provider payment
- ☐ Greater than 25% of IPA/Provider payment

☐ Shared Risk (with target budget)

☐ Withhold (no target budget)

- ☐ Up to 25% of IPA/Provider payment
- ☐ 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 following box, that parties agree to comply with the applicable 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

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 an amount requiring submission to DFS for review under Regulation 164; ***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. <u>For Medicaid Contracts only</u>:

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. <u>For Non-Medicaid Contracts only</u>:

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 is expected to be less than an amount requiring submission to DFS for review under Regulation 164; ***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 an amount requiring submission to DFS for review under Regulation 164.

If this contract is entirely prepaid capitation, proceed to Section F, question 4. If this contract includes additional reimbursement methodologies, proceed to Section F, question 3.

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 7.25% 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: $ _____

[0.0725 X (12-month Projection – Out of IPA/Provider Network Payments) = Financial security deposit]

0.0725 X (_____) – (_____) = _____

c. The MCO must monitor the security deposit to ensure it is sufficient to cover 7.25% 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. Applicability of Department of Financial Services (DFS) Regulation for Capitation Agreements:

Does this contract's compensation FALL UNDER DFS Regulation 164 definition of prepaid capitation?

☐ Yes, this contract REQUIRES APPROVAL under Part 101 of Title 11 of NYCRR (Regulation 164)

If Yes, provide date contract submitted for DFS approval: _____ and check one below.

☐ DFS approval Letter has been received and is attached

☐ DFS approval not yet received

☐ No, this contract is exempt because 12-month payments are:

☐ less than $250,000 ☐ less than $1,000,000

Additional Provider/IPA/ACO

Provider/IPA/ACO Name: ______________________________
Address: ______________________________
City: ______________________ State: ________ ZIP: ________
Phone #: ______________________

Provider/IPA/ACO Name: ______________________________
Address: ______________________________
City: ______________________ State: ________ ZIP: ________
Phone #: ______________________

Provider/IPA/ACO Name: ______________________________
Address: ______________________________
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Phone #: ______________________

Provider/IPA/ACO Name: ______________________________
Address: ______________________________
City: ______________________ State: ________ ZIP: ________
Phone #: ______________________

Section G: Certification

The undersigned herby 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: _____

Title: _____

Officer's or Counsel's Address: _____

City: _____ State: _____ ZIP: _____

Direct Telephone Number: _____ Email Address: _____

MCO Unique Contract/Amendment ID# (**REQUIRED**): _____

Notary: _____