NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Provider Contract FAQs

I. Provider Contract Statement and Certification (DOH-4255)

1. ***Question: The previous Provider Contract Statement and Certification form had an option for Regulation 164 where a plan could check off "No, compensation does not fall under Regulation 164". The revised Provider Contract Statement and Certification does not have this question. Please clarify why not.***
   Answer: The Guidelines and DOH-4255 were revised to implement Value Based Payment. As a result, the new Tier review categories were introduced and the checkoff box has been replaced with Section F.4 that is applicable to Tier 3 review. A prepaid capitation contract that falls within DFS Regulation 164 will continue to be reviewed by DFS).

2. ***Question: There are numerous questions in the Provider Contract Statement and Certification (DOH-4255) that are not applicable to every contract submission. For example, Question A.5.b would not be applicable if no behavioral health providers are included in the contract that is being submitted. Will "N/A" be added as an option for these types of questions, including specifically Questions A.5.b., A.6., B.2.c., D.3., F.2., F.3.c., and F.4 of the Provider Contract Statement and Certification (Form 4255)? Without an "N/A" option it will appear that these questions have been missed if neither "Yes" nor "No" is selected.***
   Answer: At this time, there is not a "not applicable" option. When completing the DOH-4255, questions where "not applicable," would apply, **the box marked NO** should be checked. Please do not alter the document to include "N/A" or leave a question unanswered. At the next revision of the DOH-4255, a "not applicable" option may be added to the form.

3. ***Question: In Question B.5. of the Provider Contract Statement and Certification (DOH-4255), does "QHP" refer to commercial individual and small group products offered on the exchange?***
   Answer: Yes, QHP refers to Commercial Individual/Small Group products on the Exchange. The Guidelines and DOH-4255 only apply to certified Article 44 HMOs. If the contract/amendment is being submitted by a certified Article 44 HMO and includes this line of business, Commercial HMO should be checked.

4. ***Question: When a contract with a IPA is submitted for VBP only how should the questions relating to "Initial Payment Stream" be answered? For instance:***
   a. ***We have a base agreement for the provision of health care services that pays providers on a fee for service (or PMPM) basis that has already been submitted and approved by the Department. We are now submitting a subsequent agreement for VBP only. What boxes in C.2.a do we check?***
      Answer: The reimbursement methodology in the base agreement would be checked for initial payment stream and the type of VBP arrangement would be checked for other payment stream.
   b. ***Similarly, for Question D.1. of the Provider Contract Statement and Certification (DOH-4255), should "FFS" be checked as the "initial payment methodology" to indicate that the Shared Savings (for example) is not the sole payment stream for the physicians or should nothing be checked as the "initial***

payment methodology" because the IPA contract does not govern the physicians' FFS payment stream?
Answer: It should be answered consistently, the same as C.2.a.

5. ***Question: For a VBP contract with an IPA, if the IPA providers participating in the MCO's VBP program is only a subset of the providers participating in the IPA generally, how should Question 2.a. of the Provider Contract Statement and Certification (DOH-4255) be answered? For example, if the VBP contract clearly articulates that only the IPA's PCPs are participating in the Total Cost of Care VBP Level 1 program, but there are also specialists, labs, facilities, nursing homes, etc., that are members of that IPA, should only "Primary Care Physician" be checked off or should other service types be checked off?***
Answer: For the "initial payment stream" section in Section C.2.a check off all services that were contained in the base agreement. For "other payment stream", check off only the service(s) that are being covered under the VBP arrangement. In the example above, for "initial payment stream", all services in the base IPA agreement should be checked. For the "other payment stream", only the PCP services would be checked for the applicable VBP arrangement.

6. ***Question: The Provider Contracting Guidelines effective 04/01/2017 (Section VII.C.2.) indicate that forms of financial guarantees other than a "Financial Security Deposit" may be acceptable; however, Question F.3. of the Provider Contract Statement and Certification (DOH-4255) does not provide a place to indicate that an alternative financial guarantee, such as a parental guarantee, withhold, reserve fund, or letter of credit, is being used in lieu of a Financial Security Deposit. How should an alternative financial guarantee in lieu of a Financial Security Deposit be noted on the form?***
Answer: Please provide a brief description of the alternative financial arrangement in the area under Section F.3 of the DOH 4255. If additional space is necessary, please attach a separate sheet describing or detailing the proposed alternate arrangement.

7. ***Question: How do you address VBP contracts that contain risk levels that change over the years? The form does not allow users to check more than one box.***
Answer: Complete the DOH 4255 for multi-level agreements to indicate the **highest** VBP level and **highest** Tier review level. Additionally, provide a description in Section C, question 1 that identifies the changes in VBP levels over the term of the agreement. The submitting MCO may also provide additional information in a separate cover letter.

8. ***Question: Can you define MSO as used in Section B, 2.b on the DOH-4255?***
Answer: MSO stands for Management Services Organization. An MSO is an outside entity that contracts with an MCO to provide permitted management functions in accordance with Part 98.1-11.

II. Financial Review Questions

1. ***Question: In a Level 1 Shared Savings TCGP, upside only arrangement, can the bucket of service for which savings will be shared exclude certain medical services--for example can it include physician services, pharmacy, outpatient services, but exclude inpatient?***
   Answer: No. Generally, in order for it to be considered as a VBP arrangement, it needs to comply with the New York State Roadmap for Medicaid Reform. (Roadmap)
   However, Dental services, Vision services, and medications for high cost specialty drugs and transplant services may be excluded. Submissions omitting these services will not be considered "off menu" under the TCGP VBP requirements.

2. ***Question: In the shared saving, upside only Level 1 model--can a managed care plan distribute 100% of the savings (if there is a savings) to the clinicians with whom we are contracted or must the savings be shared between the MCO and the medical group?***
   Answer: Yes, the plan can distribute 100% of the savings when the quality/efficiency criteria are met. The Roadmap (Appendix X) requires a minimum of at least 40% of shared savings **must** be distributed to the VBP contractor for achieving a high-quality score.

3. ***Question: Will an IPA's/provider's certified audited financials be required for all "Off-Menu" VBP program contracts or only "Off-Menu" Tier 2 and 3 VBP program contracts?***
   Answer: Tier 1 "off Menu" arrangements will not require audited financial statements to be submitted. However, Tier 1 off-Menu submissions cannot be reviewed as File and Use, but will rather require a 90-day review subject to Department approval of the Off-Menu measures.

4. ***Question: Are straight FFS deals considered Tier 1?***
   Answer: Yes, all FFS agreements are considered as Tier 1 reviewable contracts.

5. ***Question: Is a financial security deposit required for any Tier 2 arrangement, or just where the provider is insolvent (i.e., assets less than liabilities)?***
   Answer: A financial security deposit is required for all Tier 2 arrangements. Please see Section VII.2 of the 2017 Provider Contracting Guidelines for additional guidance.

III. General Questions

1. ***Question: Do we have to wait for notification from DOH prior to executing contracts?***
   Answer: Yes. Generally,
   - 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 of the 2017 Provider Contracting Guidelines. The MCO may implement the contract immediately upon said acknowledgement. DOH will provide such acknowledgement within no more than three business days. Once the acknowledgement is received, the MCO may execute and implement the contract.
   - Under Tier 2 – DOH Review, the contract or Material Amendment may be implemented upon receipt of written approval from DOH (or DFS if applicable). However, if the MCO has not received an approval or a "Do Not Implement" letter, the contract may be executed and implemented after 90 days. See Section III.C of the 2017 Provider Contracting Guidelines.

2. ***Question: In Section VII.B.2 of the Guidelines please clarify if the services need to be "directly" provided by the provider assuming the risk.***
   Answer: No, the services do not need to be provided "directly" by the provider assuming risk. This language in Section VII.B.2 of the Guidelines should have also included services provided indirectly by an IPA/ACO as well. We will correct this language with the next revision to the provider guidelines. In the meantime, you may rely on this FAQ for guidance.

3. ***Question: What is the process for submitting a provider contract that includes multiple lines of business, i.e. MLTC, Medicaid Advantage, FIDA, etc.?***
   Answer: Follow the same submission rules as previous rules for multiple lines of business (LOB) contracts or amendment, which is:
   - Mainstream LOB Only – submit to Mainstream BML (contract@health.ny.gov)
   - MLTC LOB Only-Submit to MLTC BML only (MLTCcontract@health.ny.gov)
   - Multi-LOB-Submit to mainstream BML

4. ***Question: Can you elaborate on how prepaid capitation is defined? Such as timing of the payment?***
   Answer: Pre-paid capitation payments are payments made to the health care provider prior to the last day of the month that services are provided. Please refer to DFS Regulation 164 for further guidance.

5. ***Question: Can contracts include an effective date prior to the approval date? What if the MCO and the provider agreed upon rates with an effective date prior to the approval date. Can we still use the following language: e.g. "shall take effect on such date as written approval is provided by the Commissioner of the New York State Department of Health and its terms and conditions shall run retroactive….." .***
   Answer: Yes. However, the contract submitted should not be already implemented or executed. Prior approval is required prior to implementation or execution. See these FAQs, Section III, Question 1.

6. ***Question: If we are signing up providers with an approved template and incorporated the revised clauses and language do we have to submit contract for approval? Do we need new approval letters?***
   Answer: No. Only new contracts, templates, or material amendments should be submitted. On your next material amendment or new contract or template, you will need to submit a new DOH 4255 with the appropriate Tier selected.

7. ***Question: Does an MCO need to submit an amendment to an approved provider template if the amendment is going to include adding some timeframes to the template (i.e. appeals timeframes) when the timeframes are already present in the provider manual (timeframes are not changing just being added to the contract).***
   Answer: As described, it does not appear to be a material change. Please see page 4 of the 2017 Provider Contracting Guidelines for the definition of a Material Amendment. If you are uncertain as to what constitutes a Material Change, please contact DOH for clarification.

8. ***Question: If using a letter of agreement to create somewhat of a virtual panel, whose base agreement would you like to see?***
   Answer: Please see Section III.A.1.e of the Provider Contracting Guidelines for additional guidance for submissions containing multiple contracts with multiple arrangements. NOTE: The Department does not allow Letters of Agreement.

9. ***Question: We are amending a provider contract that includes prepaid capitation. The original contract was reviewed and approved by DOH, and by DFS under Reg. 164. The amendment might include some material changes, but will not include any changes to the payment structure or amounts, other than the routine trending of fees, and will not add any new VBP arrangement. Given that the financial structure is not changing (financial review is not required), can this contract be submitted as Tier 1 (file and use)?***
   Answer: If there are material changes then the contract is required to be submitted for review. The 2017 Provider Contracting Guidelines and the DOH-4255 must be completed, including Section E, which will determine the Tier. If the amendment does not contain material changes, then the amendment does not need to be submitted.

10. ***Question: Is it prohibitive for individual physician practices to share risk together through multiple contractual arrangements with a regional payor without forming an IPA or an ACO?***
    Answer: Yes, an IPA or ACO must be created, or the physicians must join an existing IPA or ACO in order to pool the risk as indicated in the questions.

11. ***Question: Is an extension to the term an amendment that requires submission or merely a clarification of a term that does not rise to the level of a material change?***
    Answer: No it would not be a material amendment. However, if the contract term has expired, then it cannot be extended; a new contract will need to be submitted.

12. ***Question: Do the new Standard Clauses need to be incorporated in any amended contract or only if the contract is materially amended?***

Answer: The Standard Clauses (and revisions to the Provider Contracting 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 provision of the Guidelines and included the new Standard Clauses no later than the following, whichever comes first:

- The next amendment to the contract;
- The next renewal of the contract;
- The deadline specified by DOH as a condition of approving an MCO change of contract, acquisition, merger, expansion, or the like; or
- By March 31, 2018.