NYS VBP Innovator Program

Documents for Review:

A) VBP Innovator Program Summary
B) VBP Innovator Application
C) VBP Innovator Financial Viability Template
D) VBP Innovator Financial Viability Template Instructions
E) VBP Innovator Financial Viability Certification
F) VBP Innovator Acknowledgement Form
G) VBP Innovator Quarterly Reporting Template

APRIL 2017

A) VBP Innovator Program Summary

New York Department of Health

APRIL 2017

Innovator Program Review Summary

The VBP Innovator Program will support experienced VBP contractors who are continuing to chart the path into value based payments. It is a voluntary program for VBP contractors prepared to participate in VBP Level 2 (full risk or near full risk) or Level 3 Total Care for General Population and/or Subpopulation arrangements. By taking on further management and administrative functions, contractors approved as Innovators will be eligible for an increased premium pass through. To become an Innovator, VBP contractors must provide all the information summarized below and meet the documented criteria (both of which are outlined in more detail in the application).

All criteria must be met in order for applicants to be considered as viable candidates for the Innovator Program; however, submission of a complete application will not guarantee an applicant's approval.

VBP Innovator Application Criteria

Prospective Innovators must submit applications that provide sufficient information to demonstrate proficiency across five criteria:

1) A commitment to contracting for a high or full risk VBP Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement;
2) Upholding health plan network adequacy;
3) Past success in VBP contracting for TCGP or Subpopulation arrangements;
4) The ability to meet minimum attribution thresholds; and
5) Financial solvency and appropriate net worth.

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1) A commitment to contracting a high or full risk VBP Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement

Prospective innovators must list the VBP arrangements that they will aim to contract, as well as the proposed VBP Level for each arrangement. Eligible arrangements will include Total Cost for General Population (TCGP) or Subpopulations (HIV/AIDS, HARP, and MLTC). Eligible VBP Levels here will include Level 2 (upside/downside risk) and Level 3 (prepaid capitation). To be considered a high-risk Level 2 arrangement, the minimum percentage of potential losses to be allocated to the provider is 60%, with a minimum cap[1] of 35% or more of the target budget.

If a prospective Innovator's organization is not yet contracting at the Level required for Innovator Program participation (i.e., high or full risk Level 2 or Level 3), it must provide a written demonstration of its commitment to meeting this requirement including the steps that it will take in order to reach this requirement. Innovator status can only be granted when the required risk level is achieved.

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2) Upholding health plan network adequacy

While health plans contracting with Innovators are ultimately responsible for state network adequacy requirements, Innovator applicants must attest that they will not violate health plan network adequacy requirements by limiting or impeding patient choice under this program. Prospective Innovators must also provide a description of the depth and breadth of the care provided to Medicaid members and an explanation of how these services reflect the needs of the community served.

[1] Losses cannot be capped at less than 35% of the target budget.

3) Past success in VBP contracting for TCGP or Subpopulation arrangements

Prospective Innovators must provide a description of the contractor's VBP experience to date. Sufficient VBP contractor experience will be determined by the following criteria: (1) two or more years of experience in a Level 2 or 3 type VBP program; and/or (2) three years or more of a Level 1 type VBP program. In both of these cases, the Innovator must demonstrate that both the financial results and quality outcomes were positive throughout these years.

For the purpose of this criteria, suitable VBP programs may include, but are not limited to:

- Medicare models: ACOs, Bundled Payment for Care Improvement (BPCI), other experimental models (e.g., Independence at Home, Primary Care innovation models);
- Contracts with commercial insurers such as Alternative Payment Contract (APC) models, bundled payment models, partial/full capitation models, gain sharing models with primary care providers; and
- Contracts with Medicare Advantage or Medicaid Managed Care organization such as partial/full capitation models or gain-sharing models with primary care providers.

The prospective Innovator should also describe how the experience will be leveraged to assure the VBP Innovator's success.

4) The ability to meet minimum attribution thresholds

Prospective Innovators must provide National Provider Identifier (NPI) information suitable to demonstrate their ability to meet the following minimum attribution thresholds (excluding dual eligible members) aggregated across **all plans**:

- ≥ 25,000 Medicaid members for a TCGP contract
- ≥ 5,000 Medicaid members for HIV/AIDS, Health and Recovery Plans (HARP), and Managed Long-Term Care (MLTC)* Subpopulation arrangements

*MLTC DOES include dual eligible members

5) Financial solvency and appropriate net worth

Prospective Innovators must submit to the DOH historical financial statements and current year *pro forma* information using the template included in the Innovator application packet. Additionally, the prospective Innovator must submit a certification from its CEO or CFO confirming the accuracy of the organization's financial information.

The prospective Innovator must provide a detailed description of how it would remain financially viable in the case of a maximum conceivable loss given the proposed VBP Arrangement, drawing on reserves, a letter of credit, stop-loss or other reinsurance, or other arrangements. The maximum conceivable loss is determined by the shared savings/losses percentage proposed by the prospective Innovator and the total dollar amount of the proposed VBP arrangement(s). Financial arrangements such as stop-loss or capped maximum loss with the health plan can be included (but are limited by the entry criteria for the Innovator program as stated in Criteria 1 above) as well as a potential financial security deposit required

by the Department of Financial Services (DFS) and/or the DOH. In the application, the prospective Innovator is expected to include an estimate of the expected financial security deposit(s) (see below), as well as evidence that the prospective Innovator will be able to fund this deposit. The adequacy of the estimated value of the deposit will play no role in the evaluation of innovator status.

DFS Regulation 164 (Tier 3 review) is triggered when a contract between a MCO and a VBP Contractor includes prepaid capitation in amounts that exceed DFS exemption thresholds. This will be the case for all Level 3 VBP innovators, but high risk Level 2 VBP Innovator candidates will likely also aim for partial prepaid capitation. See the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs at: http://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm

B) VBP Innovator Application

APRIL 2017

VALUE BASED PAYMENT INNOVATOR PROGRAM: APPLICATION FORM

SECTION I – INTRODUCTION AND OVERVIEW

A. Introduction

The VBP Innovator Program is intended to support experienced VBP contractors who are continuing to chart the path into value based payments. It is a voluntary program for VBP contractors prepared to participate in Level 2 (full risk or near full risk)[1] or Level 3 Total Care for General Population and/or Subpopulation arrangements. By taking on further management and administrative functions, contractors approved as Innovators become eligible for an increased premium pass through. To become an Innovator, VBP contractors must provide the information requested in this form to confirm that they meet the documented criteria.

All criteria must be met in order for applicants to move forward in the process; however, submission of this form does not guarantee entry into the Innovator Program.

For more information, refer to the VBP Roadmap: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

B. Innovator Program Criteria

The requirements related to each of the following Innovator Program criteria are documented within the form. All potential Innovators must:

- Demonstrate commitment to contracting a high or full risk Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement
- Upholding health plan network adequacy
- Meet the following attribution minimums (excluding dual eligible members) in aggregate across **all plans**:
  - ≥ 25,000 Medicaid members for a TCGP contract
  - ≥ 5,000 Medicaid members for HIV/AIDS, Health and Recovery Plans (HARP), and Managed Long-Term Care (MLTC[2]) Subpopulation arrangements
- Be financially solvent and establish appropriate net worth in DOH's discretion

C. Application Process

Following the accurate submission of all information required in the application, the applicant will be notified within 30 business days of their status. Once approved as an Innovator, the applicant may move forward with contracting.

D. Attachments

In completing this form, please ensure that attachments are numbered and that the numbers are listed in the corresponding place on the form *(For example: an attachment in this section would be titled 1.D.)*

E. Application Support

Should you have any questions regarding the application process, please contact the Bureau of Managed Care Fiscal Oversight at bmcfhelp@health.ny.gov, subject line "Innovator Application".

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[1] To be considered a high-risk Level 2 arrangement, the minimum percentage of potential losses to be allocated to the provider is 60%, with a minimum cap of 35% of the target budget.

[2] MLTC DOES include dual eligible members.

SECTION II – APPLICANT INFORMATION

A. Contact Information

Contact Name _____
Contact Organization _____
Contact Title _____
Contact Phone _____
Contact Email _____

B. Contracting Entity Information

Legal Contracting Entity Name _____
Legal Contracting Entity Name
(Individual Provider, IPA, ACO) _____
Legal Contracting Entity Location _____
Legal Contracting Entity Region _____

Please list the participating organizations and/or physicians/practitioners you expect to partner with:

Attachment #:_____

C. Governance Structure

Please provide an overview of the governance structure that the VBP contractor intends to use in contracting the VBP arrangement. *(If your organization does not have a unifying structure, please provide a brief overview of how you will ensure alignment (clinically, financially, information sharing, etc.) for the purposes of this arrangement).*

Attachment #:_____

SECTION III - CONTRACTING INFORMATION

A. Arrangement Information

1. Please list the VBP arrangements that the VBP contractor aims to contract, as well as the proposed VBP Level for each arrangement *(Eligible arrangements include: Total Cost for General Population or Subpopulation (HIV/AIDS, HARP, and MLTC). Eligible VBP Levels are Level 2 – upside/downside risk and Level 3 – prepaid capitation or bundle.)*

Type of Arrangement	VBP Level

2. If your provider organization is not yet contracting at the Level required for Innovator Program participation (high or full risk Level 2 or Level 3) please document your commitment to meeting this requirement and the steps that will be taken to reach the requirement (not to exceed two pages).
Attachment #:_____

B. Payer Information

1. Please list the information of any payers with whom you contract as well as the estimated Medicaid patient volume per payer.

Payer Name	**Estimated Medicaid Volume (non-dual*) for Contracting Payer (CY 2014)**

*MLTC DOES include dual members

2. Please provide an overview of any Innovator-related discussions with payers you have had to date.
Attachment #:_____

C. VBP Contracting Experience (3 pages max)

Please provide a brief description of the contractor's VBP experience to date, including a description how that experience will be leveraged to ensure the VBP Innovator's success. The VBP contractor's experience will be judged by the following criteria:

1. A VBP Innovator must demonstrate convincingly that it has successful experience in value based payment programs/contracts of a similar nature as the proposed Innovator Program. 'Successful experience' means either:
   - two or more years of experience in a Level 2 or 3 type VBP program
   - three years or more or a Level 1 type VBP program

In both cases, the Innovator must demonstrate that both financial and quality results were positive throughout these years.

2. For the purpose of the criteria in #1, suitable VBP programs include:
   - Medicare models: ACOs, Bundled Payment for Care Improvement (BPCI), other experimental models (e.g. Independence at Home, Primary Care innovation models)
   - Contracts with commercial insurers such as Alternative Payment Contract (APC) models, bundled payment models, partial/full capitation models, gain sharing models with primary care providers

Contracts with Medicare Advantage or Medicaid Managed Care organization such as partial/full capitation models or gain-sharing models with primary care providers. *This list is not intended to be exhaustive.*

3. The State recognizes that there will always be smaller or larger differences between the experience with existing VBP programs and the New York State VBP arrangement:
   - The Medicaid population has significantly different characteristics

than commercial or Medicare populations
- Maternity bundled payment arrangements and VBP arrangements focusing on the populations that are eligible for HARP, HIV/AIDS and/or MLTC managed care are rare outside Medicaid
- The NYS Medicaid environment will have unique regulatory features
- The financial characteristics of the different business lines will be different from the proposed Innovator's perspective

The State recognizes these differences and will take them into account in evaluating the proposed Innovator's information. The proposed Innovator is requested to pay sufficient attention to all of these (and other relevant) differences.

4. The Proposed Innovator should detail how it will ensure that the experience gained will be translated in success as a VBP Innovator:
   - improvement in the population's health outcomes
   - positive financial results for the VBP Innovator

Small expected losses in the 'ramp up' phase are acceptable if the VBP Innovator sufficiently establishes how it will ensure that these losses will not negatively affect either the improvement of health outcomes or the short, mid, and longer term financial soundness of the VBP Innovator.

5. Proposed Innovators may be new IPAs or ACOs, which may not have much of a history. In these instances, please use the underlying organizations' performance as input. IPAs or ACOs with a significant proportion of providers (generating > 15-20% of expected total member attribution) without sufficient VBP program experience will not be accepted. IPAs or ACOs with 10-20% expected attribution associated with such providers must elaborate how they will mitigate this potential risk and ensure success.

Attachment #:_____

SECTION IV – ATTRIBUTION AND NETWORK

A. Participating Providers - National Provider Identifier (NPI) Information

Please provide an attachment with the NPIs* of all providers that will be included in the VBP Innovator arrangement.

**Note – please do not include Tax Identifier Numbers (TINs) in this list*

Attachment #:_____

Explanation of NPI information for Data Analysis

For TCGP and HIV/AIDS Arrangements

The data analysis for Total Cost for General Population (TCGP) and HIV/AIDS subpopulation VBP arrangements are based on the Medicaid member population attributed to the primary care provider (PCP) by the MCO. The potential population of members in your VBP arrangement will be identified based on the PCP NPIs you provide. Include all PCPs that will be part of your Innovator network.

HARP Population

To identify the potential population of members in your HARP VBP arrangement, please provide us with all HARP member IDs of the individual HARP members assigned to the Health Homes that you would like to include in the arrangement. The HARP member ID drives the HARP data analysis. Alternative attribution methods for the HARP population require specific approval by DOH.

Managed Long Term Care (MLTC) Subpopulation

The data analysis for the MLTC VBP arrangement uses member assigned home care provider or nursing home (depending on the residential status of the member) to drive attribution for the MLTC subpopulation. The MLTC Population does include dual eligible members.

SECTION V: INNOVATOR READINESS AND NETWORK ADEQUACY

A. Comprehensive Member Care (3 pages total)

1. Innovators should be exemplary in the standard of care that they provide to their patients. Please provide a description of the depth and breadth of care available to Medicaid members through the applicant's network, and an explanation of how these services reflect the needs of the community served. Within this documentation, please attest that the applicant will not violate health plan network adequacy requirements by limiting or impeding patient choice.

Attachment #:_____

B. Community Engagement Requirements (5 pages total)

As stated in the VBP Roadmap, all Level 2 and 3 VBP contractors are required to show a commitment to addressing Social Determinants of Health (SDH) and working with Community Based Organizations (CBOs). The Innovator Program supports these standards and, as such, providers in the program must show a commitment to:

1. *Implementing an intervention on a minimum of one Social Determinant of Health (SDH).* Applicants must submit a report explaining which social determinant the VBP contractors will address within their Innovator contract, why the social determinant was selected, and outlining the proposed intervention. The selection should be based on information such as, but not limited to, the community needs assessment, Prevention Agenda priorities, results of an SDH screening tool, the attributed member population and/or other pertinent information with respect to the needs of the community the Innovator applicant serves. The report should also indicate metrics that will be used to measure the intervention's success.

   Attachment #:_____

2. *Identifying a minimum of one Tier 1 (non-profit, non-Medicaid billing) Community Based Organization (CBO) with whom they are or will be contracting for support in their eligible VBP arrangement.*
   Applicants must list the information of any CBOs with whom the VBP contractors already contract, or with whom they plan to contract. It is recommended that potential Innovators partner with organizations that have objectives aligning with their own, the community needs, and member goals. The CBO should work with the potential Innovator to deliver interventions that support SDH and advance DSRIP goals. If CBOs do not exist within a reasonable distance to the Innovator applicant (as may be the case in some regions of New York State), the Innovator may ask for a rural exemption to this standard.

   Attachment #:_____

C. Financial Solvency Requirements

1. The prospective Innovator must provide a detailed description how it would remain financially viable in the case of a maximum conceivable loss given the proposed VBP

Arrangement, drawing on reserves, a letter of credit, stop-loss or other reinsurance, or other arrangements. The maximum conceivable loss is determined by the shared savings/losses percentage proposed by the prospective Innovator and the total dollar amount of the proposed VBP arrangement(s). Financial arrangements such as stop-loss or capped maximum loss with the health plan can be included (but are limited by the entry criteria for the Innovator program), as well as a potential financial security deposit required by the Department of Financial Services (DFS) and/or the DOH. In the application, the prospective innovator is expected to include an estimate of the expected financial security deposit(s) (see below). The adequacy of the estimated value of the deposit will play no role in the evaluation of the application.

Attachment #:_____

2. The VBP contractor must exhibit financial solvency by submitting the information requested below in order to provide DOH with reasonable certainty that the provider will be able to fulfill its obligation to provide medical coverage to the attributed population. For all Tier 2 and Tier 3 VBP Contracts, the DOH and/or DFS will focus on the following four metrics: (1) operating margin, (2) days cash on hand, (3) operating cash flow margin, and (4) current ratio. In certain circumstances, such as for newer IPAs or provider groups, a letter of credit may be required in lieu of, or in addition to, financial statements.

   Legal Contracting Entity Name:

   Please state whether your organization uses a fiscal or calendar year:

   Please provide your organization's:

   - Most recent certified annual audited financial statements; and
   - Interim financial statements (see template) for the current calendar year through August 31, 2016. Interim financial reports should be submitted using the template and corresponding instructions that were included as attachments with this form.

   Attachment #:_____

3. Ongoing Financial Solvency Requirements

   Applicants will be required to submit quarterly financial information that will allow the department to monitor the financial solvency of the organization on an ongoing basis. Please see the submission template and corresponding instructions that were included as attachments with this form.

D. Financial Security Deposit Requirements

All Providers, IPAs, ACOs, or Provider Networks that participate in risk sharing arrangements that trigger Department of Financial Services Regulation 164 or fall under the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs and qualify as a Tier 2 or Tier 3 contract arrangement must meet all applicable financial security deposit requirements. Tier 2 review is triggered when:

- more than 25% of the projected total annual payments made to the provider by the MCO across all contracts between that provider and that MCO for Medicaid Managed Care or MLTC lines of business are at risk; *or*
- the provider's projected payments under this contract consist of more than 15 percent of the provider's projected overall Medicaid revenue from all MCOs.

DFS Regulation 164 (Tier 3 review) is triggered when a contract between a MCO and a VBP Contractor includes prepaid capitation in amounts that exceed DFS exemption thresholds. This will be the case for all Level 3 VBP innovators, but high risk Level 2 VBP Innovator candidates will likely also aim for partial prepaid capitation.

DOH may require a financial security deposit in accordance with the Provider Contract Guidelines for Article 44 MCOs, IPAs, and ACOs at: http://www.health.ny.gov/health_care/managed_care/hmoipa/hmo_ipa.htm

Function	Ability to Provide (Y/N)
Capable of generating the financial security deposit?	

Describe how the proposed Innovator intends to meet this financial security deposit requirement. Examples include securities placed in trust, funds placed in escrow, funds held by an insurer. This information will be validated during the contract review process upon submission of an Innovator Program contract to DOH and/or DFS for approval.

Attachment #:_____

E. Innovator Program Functions

To be eligible for Innovator status, the first three functions below must be performed solely by the lead contracting provider entity. In order to be eligible for the *maximum* premium pass through amount of 95%, claims administration and credentialing functions must be fully delegated as well. Please mark which functions the VBP contractor can wholly provide:

Function	Ability to Provide (Y/N)
Utilization Review (UR) (requires UR agent registration)	
Utilization and Care Management (UM)	
Disease Management (DM)	
Claims Administration (requires adjuster's license)	
Credentialing	

The lead contracting provider entity must also have four or more of the following seven functions partially delegated to them. The percentage of premium pass through will be dependent upon individual negotiations, as well as the number of functions delegated and degree of delegation to the lead contracting entity. Please mark which functions the lead contracting entity can perform:

Function	Ability to Provide (Y/N)
Drug Utilization Reviews (DUR) (requires UR agent registration)	
Appeals and Grievances	
Member/Customer Service	
Network Management	
Provider Services Helpdesk	
Provider Relations	
Data Sharing	

C) VBP Innovator Financial Viability Template

Please see Excel file:

VBP Innovator – C – Financial Viability Template.xlsx

D) VBP Innovator Financial Viability Template Instructions

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

INSTRUCTIONS FOR COMPLETING THE VALUE BASED PAYMENT (VBP) INNOVATOR FINANCIAL VIABILITY TEMPLATE

Enrollment and financial projections should be completed by the VBP contractor as part of the fulfillment of its financial solvency and viability. The instructions will assist in the completion of the Value Based Innovator Financial Viability Template for contractors who are continuing to chart the path into value based payments for the Medicaid Managed Care (MMC) and/or Health and Recovery Plan (HARP) program(s). Additional projections may be required depending on individual circumstances.

Please submit the completed template, along with the completed Value Based Payment Innovator CEO or CFO Certification, to the Bureau of Managed Care Fiscal Oversight BMCFO at the following email address: bmcfhelp@health.ny.gov

Schedule A – Value Based Payment Identification Page

Enter the name of the VBP Innovator's Legal Name, along with the contact information and projected start date of the program.

Schedule B – Value Based Payment Innovator Enrollment

Enter the projected membership for end of Year 1, Year 2 and Year 3 for each of the counties.

Schedule C – Projected Revenue and Expense Counties - MMC

Schedule C includes schedules C1 – C6 and includes MMC revenue and expenses statement by month for the first 36 months of operation or break even in the counties, whichever is longer. Schedules C4, C5 and C6 will auto-populate the Per Member Per Month (PMPM) amounts from Schedules C1, C2 and C3.

Schedule D – Projected Revenue and Expense Counties - HARP

Schedule D includes schedules D1 – D6 and includes HARP revenue and expenses statement by month for the first 36 months of operation or break even in the counties, whichever is longer. Schedules D4, D5 and D6 will auto-populate the Per Member Per Month (PMPM) amounts from Schedules D1, D2 and D3.

Schedule E - Projected Revenue and Expense Consolidated MMC and HARP Projections

Schedule E includes schedules E1 through E6 are summary revenue and expense projections for MMC and HARP. This sheet will auto-populate from Schedule C and D.

Schedule F - Projected Balance Sheets Using Statutory Accounting Principles (SAP)

Schedule F includes a pro-forma balance sheet as of "day 1" of the initial enrollment in the program and the balance sheet for the for the next three year ends. These balance sheets must include the total assets, liabilities and net assets for the VBP Innovator for all business operating under that legal entity. In addition, the balance sheets should be reported using Statutory Accounting Principles (SAP).

Applicants must also include the source of any additional capitalization that may be needed to support the program to maintain solvency during the first three years. See for details the VBP Innovator Program Application Form.

E) VBP Innovator Financial Viability Template Certification

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF MANAGED CARE FISCAL OVERSIGHT (BMCFO)

Value Based Payment Innovator Interim Financial Report Certification

VBP Innovator Legal Name: _____

Certification for the Period Ending: _____

_____, Chief Executive Officer, **or**
_____, Chief Financial Officer (or person having charge of the financial records of the Plan) of_____(VBP Innovator), being duly sworn, each for themselves deposes and says that they are the above described officers of said Innovator, and that on the reporting period stated above, all of the assets as specified, contained, and submitted herein as the Interim Financial Report were the absolute property of said Innovator, free and clear from any liens or claims, thereon, except as herein stated, and that this Statement is a full and true statement of all the assets and liabilities and of the condition and affairs of said Innovator as of the reporting period stated above, and of its income and deductions there from for the period reported, and have been completed in accordance with applicable instructions, according to the best of the information, knowledge and belief, respectively.

Misrepresentation or falsification of any information contained in this Interim Financial Report may be punishable by fine and/or imprisonment under New York State Law and Federal Law.

Certified by:

_____
(signature)
Chief Executive Officer

Date: _____

Certified by:

_____
(signature)
Chief Financial Officer

Date: _____

F) VBP Innovator Acknowledgement Form

Applicant Acknowledgement

NYS Department of Health – Value Based Payment (VBP) Innovator Program

Instructions: Providers who wish to participate in the Department's Value Based Payment (VBP) Innovator Program must complete this form and submit it to the Department along with the provider's program application. This form must be completed by someone that has executive authority for the provider applicant, such as the CEO, COO, General Counsel, or an agent or representative who has been granted such authority to act on the provider applicant's behalf with respect to the VBP Innovator Program pursuant to a Board Resolution or Unanimous Written Consent from the Board of Directors.

I,_____, acting in my executive capacity for or as an agent or representative of_____(hereinafter "Applicant"), and having sufficient authority to act on behalf of Applicant with respect to the VBP Innovator Program such that completion of this form is imputable to the Applicant, acknowledge and agree to the following:

- That the Applicant understands that it is required to complete this form and submit it in connection with its application to the VBP Innovator Program, and that the Department may pend review of the application until this form is submitted.

- That the Department may review Applicant's VBP Innovator Program application, and that the Department has the discretion to determine whether Applicant meets the requirements to become or remain designated as a VBP Innovator.

- That the Applicant must meet financial and programmatic requirements in order to be selected as and remain a VBP Innovator, and that the Department may rely on financial and programmatic requirements that are the same or similar to those that apply to entities certified under Article 44 of the Public Health Law, such as where Applicant is fulfilling similar roles and responsibilities as such entities.

- That the Department may, at any time upon notice, revoke the Applicant's designation as a VBP Innovator where the Department has a reasonable basis to believe that the Applicant no longer meets applicable financial or programmatic requirements, has acted in a manner contrary to the provisions in this acknowledgement, or if the Department determines that the Applicant has taken, or will take, any action that threatens the health, safety, or welfare of any individual(s) in the assigned population or other Medicaid participant(s).

Applicant Acknowledgement

NYS Department of Health – Value Based Payment (VBP) Innovator Program

- That the Department may revoke the Applicant's designation as a VBP Innovator for any other reason upon thirty (30) days prior notice.

- That should the Applicant wish to contest a determination made by the Department with respect to Applicant in connection with the VBP Innovator Program, that the Applicant shall request an administrative review within ten (10) days of receiving notice.

- That if approved, the Applicant will negotiate with Medicaid Managed Care and/or Managed Long Term Care Plans in good faith to amend its contractual and payment arrangements as may be necessary, and agrees to include or incorporate any VBP Innovator standard clauses issued by the Department into such arrangements.

- That the Applicant's designation as a VBP Innovator is contingent on whether it has appropriate arrangements with Medicaid Managed Care and/or Managed Long Term Care Plans, and may be limited to those payors where appropriate arrangements are in place.

- That the Applicant shall maintain sufficient relationships with other providers in order to meet the service needs for the applicable assigned population.

- That the Applicant shall make regular reports to the Department no less than quarterly, and in a time and fashion and containing such information as determined by the Department.

_____ _____

Name (print): Title:

_____ _____

Signature: Provider Applicant (legal entity name):

_____

Date:

G) VBP Innovator Quarterly Reporting Template

Please see Excel file:

VBP Innovator – Quarterly Reporting Template.xlsx