

INNOVATOR PROGRAM FREQUENTLY ASKED QUESTIONS

I. General

1. ***Can the Innovator submit an application for multiple arrangements at once?***

If a prospective Innovator is considering multiple arrangements, one combined application may be submitted.

2. ***Given the page limitations, what (if any) format requirements accompany the page limitations: margins, font, single vs. double spacing, etc.?***

DOH requests standard one inch margins, 12 point type, single spacing.

3. ***Will attribution be based on 2014 data? Can more recent data be used for attribution?***

The default method for attribution is the Managed Care Organization (MCO)-assigned PCP for most members. Innovators and MCOs should include the method and sources of the attribution data, in accordance with the Roadmap (e.g., page 23).

4. ***Will DOH consider Level 0 and Level 1 Value Based Payment (VBP) arrangement as sufficient experience for entities that have past success in serving special populations?***

The Innovator Program is geared towards experienced VBP providers interested in engaging in higher risk arrangements with MCOs. Sufficient VBP 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. The prospective Innovator must demonstrate that both the financial results and quality outcomes were positive throughout these years.

5. ***Will unmasked claims data be available to Innovators?***

The sharing of unmasked claims data between the MCO and Innovator should be negotiated in the contract.

6. ***Are MCOs required to contract with designated Innovators?***

If the MCO and Innovator were already contracted prior to the Innovator designation, the MCO is required to negotiate a contract amendment or new contract with the designated Innovator.

7. ***Will Innovators be guaranteed that there will be no downward adjustments during the contract period, to ensure that success is not punished?***

The premium MCOs receive is subject to upward or downward updates related to budget actions, and these adjustments will be passed through the MCO to the Innovator. Otherwise, if the VBP arrangements are successful and other Roadmap quality, performance and efficiency goals are met, it is unlikely that the Innovator would be subject to a downward adjustment. However, should the premiums be reduced due to specific legislative savings actions; the premiums passed down to Innovators would be impacted accordingly.

8. ***Will DOH and DFS allow Innovators to participate in the NYS reinsurance program on an equal footing with MCOs?***

The State's reinsurance program is for participating MCOs only.

II. Financial Solvency

1. ***Since MCOs are passing through risk to the provider, are the reserve requirements for the plan reduced accordingly?***

In accordance with the DOH Regulations Part 98 (§ 98-1.119(e)) MCOs are required to maintain contingent reserve at 7.25% of net premium income generated from Medicaid. As providers (Innovators) take on more risk and produce a financial security deposit, the MCO may adjust their reserve requirement accordingly.

2. ***Can financial solvency be established through the financial security deposit process alone? If not, what additional criteria will need to be satisfied?***

No. The Innovator program is for experienced VBP contractors with well-established financial status. The financial security deposit is not intended to replace or be used in lieu of documenting provider financial stability and solvency and therefore cannot replace customary financial solvency documents such as ops margin, days cash on hand, ops cash flow margin, current ratio, provider balance sheet with three years of projections, etc.

3. ***Can a Letter of Credit be used as a sufficient substitute for satisfaction of the four metrics (ops margin, days cash on hand, ops cash flow margin, current ratio) as suggested in document?***

No, a letter of credit cannot be used as a substitute for the four metrics. A letter of credit could be entertained as an option the State can utilize to mitigate the financial security deposit.

4. ***For a new IPA without a financial history, what information should be submitted (in addition to the “four metrics” and identification of the source of reserve funding) to support the application regarding the financial stability and soundness of the organization?***

The Innovator program is geared towards experienced VBP providers interested in engaging in higher risk Level 2 or Level 3 arrangements with MCOs. One of the five criteria is financial solvency and appropriate net worth. Besides financial statements, the Innovator should include a detailed plan to maintain financial viability if maximum loss occurs under the proposed arrangement(s) and information as to how the financial security deposit will be met.

5. ***Please define what is meant by “demonstrating that both the financial results and quality outcomes were positive throughout the years” means: given the page limitation for responses, what detail is required to satisfy this requirement? Must responses include contract-specific performance information, or is summary data sufficient? May responses report at the IPA experience level, or must individual provider experience be included?***

DOH would expect a description of the IPA/ACO level of experience in quality and financial results. Experience of individual providers could be added to reinforce the overall description, but is not required.

6. ***For newly created contracting entities which do not have “historical financial statements”, what substitute for historical financial statements will be accepted?***

DOH would expect to see a detailed plan to maintain financial viability of maximum loss occurs and an estimate of and ability to fund the financial security deposit. Financial

statements of sponsors of the newly created entity could support the establishment of financial viability.

- 7. If a financial security deposit is accrued with one year after start of a VBP contract, what cadence is required for the accrual? May it be accrued in arrears, or must it be in advance of the quarter?**

DFS Regulation 164 states that the minimum financial security deposit amounts are required at the end of the three month, six months, nine month and twelve month periods.

- 8. Is there a distinction between “reserves” and “financial security deposits”? If so, what is it?**

Reserves are an MCO requirement. The financial security deposit is a requirement for providers who are taking on significant risk under a contract with the MCO.

- 9. Given that there is no intention to require “double reserving”, is it permissible for the MCO reserves to stay in place rather than being replaced by a provider-funded reserve, assuming the parties contract to account for that substitution of MCO funds in lieu of provider funds?**

Under Public Health and Insurance Laws, providers who take on risk must produce a financial security deposit. The MCOs reserve is typically adjusted as its contracted providers take on more risk.

- 10. Will DOH consider scaling up the financial security deposit from 5% to 7.25% over several years for Innovators?**

DOH will maintain the 7.25% financial security deposit requirement it applies to providers taking on risk, whether the provider is designated as an Innovator or not. DOH will defer to DFS for the financial security deposit for arrangements subject to Regulation 164.

- 11. Is it permitted for MCOs to leave their existing reserves in place, rather than have the provider replace those reserves (i.e. produce a financial security deposit)?**

No. The provider is required to produce a separate financial security deposit equal to 7.25% of the estimated annual medical cost for the health care services covered under the risk arrangement (see question 7 above).

- 12. Is it permitted for the Innovator to produce the financial security deposit over a longer period of time than the 12 months?**

Please see FAQ #7 above. For VBP contracts subject to Regulation 164, the accrual of the financial security deposit is not to exceed twelve months. For contracts not subject to DFS Regulation 164 for which a financial security deposit is required by DOH, the entire amount of the financial security deposit must be available prior to contract approval in accordance with the *Provider Contract Guidelines for Article 44 MCOs, IPAs and ACOs*.

- 13. What options are available to mitigate the financial security deposit?**

DOH will defer to DFS for the financial security deposit for arrangements that trigger Regulation 164. The financial security deposit must consist of cash and/or short-term marketable securities and must be held by the MCO. For arrangements not subject to Regulation 164, DOH will consider mitigation of the financial security deposit under limited circumstances such as a parental guarantee, risk corridors, caps on provider losses, or letter of credit.

III. Premium Pass Through

1. ***Will the 90-95% pass through premium apply to the whole premium or will carve outs for services delegated to other providers be allowed, thus reducing the 90-95% pass through rate?***

The Innovator program is for providers who wish to contract for a population based VBP arrangement, either Total Care for General Population or Subpopulation. It would not be expected that services included in these arrangements would be carved out of an Innovator-MCO agreement. From the VBP Roadmap, page 11:

“The population based arrangements include the total care and costs of that care for the included members, irrespective of where, how, or for what reason, the care was delivered. VBP contractors assume responsibility for the outcomes and costs across all conditions and types of care for these members.”

2. ***Is the 90-95% premium pass through amount calculated before or after taxes?***

The premium pass through amount in most risk arrangements is calculated before taxes as the MCO would be responsible for paying the taxes on the premium.

3. ***Will KICK and separate lump sum payments be included in the Innovator premium pass through?***

This may be negotiated between the MCO and Innovator.

4. ***Will the Innovator premium pass through incorporate risk scores of the attributed members?***

Many MCOs and providers currently adjust for risk in risk based arrangements and it is expected that this concept will continue when a provider becomes an Innovator. The Roadmap suggests that premium may be based on historical experience and the Innovator and MCO may choose to incorporate risk scores into the negotiated premium pass through.

5. ***Will the 90-95% pass through premium be uniformly assumed based on the delegated functions or is the 90-95% rate subject to negotiations with each individual health plan?***

The amount of premium pass through is negotiated between the Innovator and the MCO.

IV. Network

1. Will Innovators be able to negotiate their own contracts with network providers, or will they be subject to existing MCO contracts?

The Innovator may negotiate its own contracts with network providers only if it is designated as an IPA or an ACO, or it can make arrangements with the MCO.

2. Will Innovators need to direct attributed members to MCO specific network providers or do they have the flexibility to develop and utilize their own network for attributed members?

Members must continue to have access to all providers in their MCO's network, regardless of whether the network providers are participating in an Innovator arrangement or not.

3. Is the Innovator expected to assume risk bearing relationships with all MCO partners, or can it gradually take on additional MCO populations over time?

Once designated, the Innovator is required to engage in higher risk Level 2 and Level 3 arrangements as described in its application. It may expand to additional arrangements with MCOs in the future. Lower risk Level 2 and Level 1 arrangements are not included in the Innovator program.

4. Is the Innovator applicant a health care provider or can the entity be a new company either wholly owned or under the same license as the provider?

The Innovator, like other VBP contractors, is a provider based entity and is typically formed as an IPA or ACO.

5. Are Innovators able to manage attributed populations outside of their licensed regions?

The Innovator must manage all attributed populations regardless of a parent company's regionally based provider licensing. However, receiving Innovator designation does not change any of the licensure standards or limitations currently imposed on providers.

6. Is there a definition of Network Adequacy for the application? Is there information required in addition to the "Comprehensive Member Care" and "Community Engagement Requirements" to satisfy Network Adequacy?

The Innovator must include a list of partners and participating providers with the application, and also attest that they will not limit member access to their MCO provider network.

7. For Section IV – Attribution and Network: what is meant by the NPIs of all providers? Does that require NPIs for all providers, just physician providers, or some other specified sub-set of providers? Just providers paid under the specific contract/ rider, or all network providers, even if contracted directly to the health plan (e.g., pharmacies, hospitals, etc.)?

The list of providers should include all of the providers needed for the TCGP and/or Subpopulation arrangement (see Roadmap for full description of these arrangements).

8. Assuming individual physician NPIs are required, should estimated patients associated with the NPIs also be submitted?

DOH identification of 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. The Innovator may provide a summary count of attributed members for verification purposes.

9. *In situations where the VBP Innovator doesn't provide all of the services for an attributed population because the MCO has carved out the provision of specific services to other vendors/providers, how will the pass through be calculated?*

The arrangement must include the minimum management and administrative services per the Innovator application. The pass through is negotiated between the Innovator and the MCO.

V. Managed Long Term Care

1. *Does the 90-95% premium pass through apply to MLTC arrangements, subpopulations and plans?*

Yes, the Innovator premium pass through applies to all contracting arrangements, including TCGP and Subpopulations, within Mainstream, HARP, HIV-SNP and MLTC products.

2. *Does the MLTC attribution apply to LHCSAs and CHHAs?*

The attribution method is described in the VBP Roadmap (page 23) and applies to all VBP arrangements, including Innovator-MCO contracts. LHCSAs and CHHAs are considered home care providers so members may be attributed to them.

3. *How will attribution be updated to account for beneficiary transitions across home care providers?*

Updating of attribution occurs according to terms of the contract and the Roadmap.

4. *Is the VBP Innovator responsible for managing the Medicare benefit as well as the Medicaid benefit for duals?*

At this time, the Medicaid premium dollars are what is managed currently in MLTC partial capitation VBP arrangements. The Innovator should continue to coordinate with Medicare providers.

5. *What is the reserve requirement for the MLTC subpopulation?*

The reserve requirement for MLTCs remains the same, 5%

6. *If a LHCSA or a provider is the Innovator entity, are there any safeguards for the entity to prevent MCOs from making changes to or terminating contracts or networks?*

There are no additional safeguards for Innovators regarding termination of contracts by an MCO other than which already exist under Public Health Law.