Total Care for General Population (TCGP) Checklist for Fully Capitated MCOs

(Updated 1/2020)

1	**Plan Name**			
2	**IPA/ ACO/ Provider Name**			
#	**Verifying Questions**	**Review (at least one box per category must be checked)**	**Description**	**Specify Contract Page Number**
(1) Type of Arrangement (as per the Roadmap)	Does the contract match the Roadmap arrangement definition?	▫	All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals).	
(2) Definition and Scope of Services	Does the scope of services state that it will match the VBP Roadmap definition?	▫	*Roadmap (page 44)* All Medicaid covered services for all members eligible for mainstream managed care and not eligible for one of the subpopulations (excluding duals). **If the contract carves out any services, then this is an OFF-MENU arrangement, it will be reviewed by the Off-Menu Committee. The inclusion of dental and/or vision services are not required as part of this ON-MENU arrangement.**	
	OR does the contract list all of the episodes (see "Description" column)?	▫		
(3) Quality Measure Reporting	Does the contract commit to reporting on all Category 1 quality measures approved by the State?	▫	*Roadmap (page 43)* The State mandates the reporting of all reportable Category 1 Measures in on-menu contracts. Inclusion of Category 2 measures is optional. Additional measures, beyond those outlined in Categories 1 and 2, may be added to the contract. **If at least one (1) reportable Category 1 measure is missing, this is an OFF-MENU arrangement It will be reviewed by the Off-Menu Committee (inclusion of Category 2 measures is optional).**	
(4) Quality measure utilization for Shared Savings/Losses	Does the contract align with quality measure requirements for shared savings/losses?	▫	*Roadmap (page 43) & 2020 TCGP Measure set, which will be updated annually.* TCGP VBP arrangements must base shared savings and risk distribution on quality measures that include at least one Category 1 P4P measure from each of the following domains: ***Always required:*** I.Primary Care II.Mental Health III.Substance Use Disorder ***Required if the population is included in the contract:*** IV.HIV/AIDS V.Maternity VI.Children's The TCGP measure set which includes the measures for the above listed domains can be found on the VBP Resource Library under the VBP Quality Measures section for the respective measurement year: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/	
(5) Risk Level	Does the contract describe the level of risk chosen by the contracting parties?	▫ ..	*Roadmap (page 91)* - Level 1: FFS with Retrospective Reconciliation – Upside Only Risk - Level 2: FFS with Retrospective Reconciliation – Up- and Downside Risk - Level 3: Prospective Payments (PMPM or Bundled Payments; fully capitated or prospectively paid bundles). These arrangements may also include additional risk mitigation strategies like risk corridors, stop loss, withholds, etc. The VBP Roadmap requires a minimum amount of risk be adopted per level. In order to be labeled a certain risk level arrangement, it must match definitions listed in Appendix VIII of the Roadmap: Definitions of Level 1, 2 and 3 VBP Arrangements.	
(6) Shared Savings/Losses	Does the risk level correspond with the shared savings/losses minimums?	▫	*Roadmap (page 91)* a. While the State does not mandate a specific shared savings/losses distribution methodology, the following minimums must be met in order align with VBP Level definitions: - Level 1: Minimum of 40% of shared savings must be allocated to the provider - Level 2: Minimum of 20% of potential losses must be allocated to the provider, with a minimum cap of 3% of the target budget in the first year of the Level 2 contract and 5% from the second year on. Below these levels, the VBP arrangement is counted as a Level 1 arrangement. - Level 3: N/A	
(7) Attribution	Does the contract describe the attributed population?	▫	*Roadmap (page 29-30):* While the State does not mandate a specific methodology to be used to attribute members to an arrangement, the contract should specify the attribution methodology.	
(8) Target Budget	Does the contract describe the Target Budget in this arrangement?	▫	*Roadmap (page 30-35):* The State does not mandate a specific methodology to be used to calculate Target Budget (TB) for an arrangement. However, the contracts should specify that a target budget will be used. MCOs and VBP Contractors with more than one line of business in one contract need to establish target budgets separately for each line of business contained within a contract.	
(9) Social Determinants of Health Intervention	If this is a Level 2 or higher contract, does it commit to implementing at least one intervention to address Social Determinant(s) of Health?	▫	*Roadmap (page 41):* VBP contractors in Level 2 or Level 3 agreements will be required, as a statewide standard, to implement at least one social determinant of health intervention.	
(10) Contracting with Community Based Organizations (starting January 2018)	If this is a Level 2 or higher contract, does it commit to contract with at least one Tier 1 Community Based Organization?	▫	*Roadmap (page 42):* It is a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 Community Based Organization. Tier 1 - Non-profit, non-Medicaid billing, community based social and human service organizations (e.g. housing, social services, religious organizations, food banks). Exception: The State recognizes that CBOs may not exist within a reasonable distance to providers in some regions of New York. In such situations, providers/provider networks can apply to the State for a rural exemption.	