Financial Alignment Capitated Readiness Review
Illinois Readiness Review Tool

As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, the Centers for Medicare & Medicaid Services (CMS) and participating States want to ensure that every selected Medicare-Medicaid plan (MMP) is ready to accept enrollment, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population. Every selected MMP must pass a comprehensive joint CMS/State readiness review.

CMS and Illinois have developed a state-specific readiness review tool based on stakeholder feedback received through letters and public meetings, the content of the Memorandum of Understanding signed on February 22, 2013, the Medicare-Medicaid Alignment Imitative (MMAI) Request for Proposals (RFP), and applicable Medicare and Medicaid regulations. The Illinois readiness review tool is attached.

The Illinois readiness review tool is tailored to the requirements of the approved demonstration, and the State's target population. It addresses the following functional areas of health plan operations related to the delivery of Medicare and Medicaid services including:

- Assessment processes
- Care coordination
- Confidentiality
- Enrollee protections
- Enrollee and provider communications
- Monitoring of first-tier, downstream, and related entities
- Organizational Structure and Staffing
- Performance and quality improvement
- Provider credentialing
- Provider network
- Systems (e.g., claims, enrollment, payment, etc.)
- Utilization management

All State readiness review tools will address key areas that directly impact a beneficiary's ability to receive services including, but not limited to: assessment processes, care coordination, provider network, staffing, and systems to ensure that the organization has the capacity to handle the increase in enrollment of the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria also focus on whether a MMP has the appropriate beneficiary protections in place, including but not limited to, whether the MMP has policies that adhere to the Americans with Disabilities Act, uses person-centered language and reinforces beneficiary roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models of behavioral health services. Enrollment functions and systems will be reviewed at a later date.

All readiness reviews will include a desk review, site visit, and a separate network validation review. Additional criteria related to enrollment functions and systems will also be provided with additional guidance. Assessment of all criteria, including enrollment criteria and those in shaded grey, will be completed before MMPs receive enrollment.

Table 1. Assessment Processes

Readiness Review Criteria	Suggested Evidence
A. Transition to New MMP and Continuity of Care	
1. The Medicare-Medicaid Plan (MMP) ensures continuity of care for medical, behavioral, and long-term services and supports (LTSS) upon new enrollment for a period of 180 days. With the exception of Part D drugs, which must follow all Part D transition requirements, the MMP shall: a. Allow enrollees to maintain their current providers; b. Honor all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment for 180 days; and c. Not terminate any prior approved drugs, therapies, or services at the end of 180 days without advance notice to the enrollee and transition to other services, if needed. The MMP may choose to transition enrollees to a network primary care provider (PCP) earlier than 180 days only if: a. The enrollee is assigned to a medical home capable of serving his/her needs appropriately; b. A health screening and/or a comprehensive assessment, if necessary, is complete; c. The MMP determined that the medical home is accessible, competent, and can appropriately meet the enrollee's needs; d. A transition care plan is in place (to be updated and agreed to with the new PCP; as necessary); and e. The enrollee agrees to the transition prior to the expiration of the 180-day transition period. The MMP may choose to transition enrollees to a network specialist or LTSS provider earlier than 180 days only if: a. A health screening and/or a comprehensive assessment, if necessary, is complete; b. A transition care plan is in place (to be updated and agreed to with the new provider, as necessary); and c. The enrollee agrees to the transition prior to the expiration of the 180-day transition period.	Continuity of care plan includes these provisions.
2. For enrollees receiving HCBS waiver services at the time of enrollment, the MMP will maintain the existing service plan for at least 180-days unless changed with the consent and input of the enrollee and only after completion of a comprehensive assessment.	Continuity of care plan includes these provisions.
3. The MMP assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug.	P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug.
4. The MMP assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 30-day supply.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
5. The MMP assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91 day supply, unless a lesser amount is requested by the prescriber.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.

Readiness Review Criteria	Suggested Evidence
6. The MMP provides written notice to each enrollee, within 3 business days after the temporary fill, if his or her prescription is not part of the formulary.	Transition plan P&P defines a time period (within 3 business days) when it must provide enrollees with notice about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary.
7. Within the 180 day transition period, the MMP advises enrollees when they receive care that would not otherwise be covered at an in-network level.	Transition plan P&P defines time period when it must provide enrollees and providers with written notice that they received care that would not otherwise be covered at an in-network level.
8. The MMP offers out-of-network PCPs and specialists providing an ongoing course of treatment Single Case Agreements to continue to care for that enrollee beyond the 180 days if they remain outside the network.	Transition plan P&P discusses this policy.
B. Assessment	
1. The MMP has a process for administering health risk questionnaire (health screening tool) to all new enrollees within 60 days of enrollment. The health screening will collect information about the enrollee's medical, psychosocial, functional and cognitive needs, and medical and behavioral health (including substance abuse) history.	The MMP must submit its health screening tool as part of the readiness review process. Assessment P&P outlines the process by which the MMP will administer the health risk questionnaire (health screening). At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the screening within 60 days.
2. The MMP uses the initial health screening along with predictive modeling and surveillance data to stratify enrollees into the appropriate level of intervention (low-, moderate-, and high-risk). The MMP must stratify no fewer than 5% of enrollees as high-risk and no fewer than 20% of enrollees to moderate- and high-risk levels combined. The MMP analyzes predictive modeling reports and other surveillance data for all enrollees monthly to identify risk level changes.	Assessment P&P includes these requirements for the comprehensive assessment.
3. For enrollees stratified as moderate- or high-risk the MMP has a policy and procedure that it will perform a comprehensive health risk assessment within 90 days of enrollment. The assessment may be done in place of the initial health screening. The MMP's comprehensive assessment tool includes: a. A behavioral health assessment (as appropriate); and b. An HCBS service plan assessment (when applicable);	The MMP must submit its comprehensive assessment tool(s) as part of the readiness review process. Assessment P&P includes these requirements for the comprehensive assessment.
4. The MMP describes how the comprehensive assessment and re-assessments are conducted for enrollees at moderate- and high-risk. The MMP conducts reassessments within required timeframes as follows: a. For enrollees receiving HCBS waiver services or residing in nursing facilities, the MMP completes a face-to-face reassessment each time there is a significant change in the enrollee's condition or the enrollee requests a reassessment; b. When necessary following the review of the care plan which occurs at least every 30-days for enrollee's at high risk, and at least every 90 days for enrollees at moderate risk; or c. At a minimum, annually for all enrollees.	Assessment P&P explains how and in what format the MMP will adapt its risk assessment tool to the specific needs of the target population. Assessment P&P describes the process for determining the frequency of reassessment for low-, moderate-, and high – risk enrollees, which includes the procedures for determining what triggers a reassessment when reviewing care plans at required intervals. Assessment P&P specifies that reassessments are completed at least annually for all enrollees.

Readiness Review Criteria	Suggested Evidence
5. The MMP has policies for staff to document when an enrollee refuses to participate in a health screening and/or comprehensive assessment and to monitor the enrollee.	Assessment P&P explains how staff from the MMP will respond to those enrollees who decline to participate in a comprehensive assessment. Assessment P&P explains how the MMP will monitor those enrollees who decline to participate in the risk assessment process.

Table 2. Care Coordination

Readiness Review Criteria	Suggested Evidence
A. Care Coordinator Assignment and Interdisciplinary Care Team (ICT)	
1. The MMP has a process to ensure that every enrollee who wants an Interdisciplinary Care Team (ICT) to coordinate the delivery of services and benefits will have access to one.	Care coordination P&P includes this assurance.
2. The MMP describes a process for determining the composition of the ICT, including a description of how the enrollee is involved in determining the ICT's composition. For enrollees on a HCBS waiver, if the service coordinator is not the same person as the care coordinator, the service coordinator must be incorporated into the ICT.	Care coordination P&P defines how the MMP builds its ICT and how the enrollee and/or his or her caregiver are involved in determining the ICT.
3. The MMP defines ICT care coordination functions to include, at a minimum, the following: a. Be led by a Care Coordinator who is accountable for coordination of all benefits and services the Enrollee may need. b. Support providers in medical homes, assist in assuring integration of services and coordination of care across the spectrum of the healthcare system, and help provide care management for enrollees; c. Assure appropriate and efficient care transitions, including discharge planning; d. Assess the physical, social, and behavioral risks and needs of each enrollee; e. Provide medication management; f. Provide enrollee health education on complex clinical conditions and wellness programs; g. Assure integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate; h. Maintain frequent contact with the enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to enrollees' needs and risk-level. i. Assist in the development of a person-centered care plan 90 days after enrollment; and j. Assist in the implementation and monitoring of the person-centered care plan.	Care coordination P&P defines the roles and responsibilities of the ICT.

Readiness Review Criteria	Suggested Evidence
4. The MMP has a process for assigning every enrollee to a care coordinator with the appropriate experience and qualifications based on an enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).	Care coordination P&P requires each enrollee to be assigned a care coordinator based on his or her risk level and/or individual needs and outlines the process for assigning such care coordinator. The MMP describes reasonable measures taken to ensure that staff and enrollees are matched based on their expertise and special needs.
5. The MMP has a process to ensure that an enrollee and/or caregiver are able to request a change in his or her care coordinator.	Care coordination P&P describes the process by which an enrollee may request a change in his or her care coordinator (as applicable).
6. The MMP: a. Conducts training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles for ICT members and potential ICT members (i.e., providers and staff qualified to serve on ICTs), initially and on an annual basis; and b. Has a policy for documenting completion of training by ICT members, including both employed and contracted personnel and has specific policies to address non-completion.	Sample training materials for ICT members and potential ICT members include the required topics. Care coordination P&P states that completion of training of ICT members will be documented and defines the consequences associated with non-completion of ICT trainings.
7. Care Coordinators shall maintain contact with Enrollees as frequently as appropriate, but no less frequently than the following: a. Care Coordinators who provide Care Management to High Risk Enrollees shall have contact with such Enrollees at least once every ninety (90) days; and b. Care Coordinators providing Care Management to Enrollees receiving HCBS Waiver services shall maintain contact as follows: i. Persons who are participants in the Elderly Waiver: The Care Coordinator shall have a face-to-face contact with the Enrollee not less often than once every ninety (90) days; ii. Persons with Brain Injury: The Care Coordinator shall have contact with the Enrollee not less often than one (1) time per month; iii. Persons with HIV/AIDS: The Care Coordinator shall contact the Enrollee not fewer than three (3) times per month, and not fewer than one (1) of those contacts shall be face-to-face in the Enrollee's home; iv. Persons with Disabilities: The Care Coordinator shall have a face-to-face contact with the Enrollee no less often than once every ninety (90) days in the Enrollee's home; and v. Supportive Living Program: The Care Coordinator shall contact the Enrollee no less often than one (1) time per year.	Care coordination P&P states that contact with Enrollees will be consistent with this requirement.
B. Care Plan and Service Plan Requirements	
1. The MMP will: a. Work with the enrollee to develop the care plan within 90 days of enrollment; and b. Use the information gathered from the assessments of the enrollee in developing the care plan.	Care planning P&P outlines a process that describes how the MMP will involve the enrollee in developing the plan of care and will use the information gathered from the assessment(s) of the enrollee in developing the plan of care. Care planning P&P states that the MMP intends to provide person-centered care to all enrollees, and describes strategies for assuring this.

Readiness Review Criteria	Suggested Evidence
2. The care plan must: a. Incorporate an enrollee's medical, behavioral health, LTSS, social, and functional needs; b. Include identifiable short- and long-term treatment and service goals to address the enrollee's needs and preferences and to facilitate monitoring of an enrollee's progress and evolving service needs; c. Include, in the development, implementation, and ongoing assessment of the care plan, an opportunity for enrollee participation and for input from the PCP, other providers, a legal representative, and the enrollee's family and/or caregiver, as appropriate; and d. Include, as appropriate, the following elements: i. The Enrollee's personal or cultural preferences, such as types or amounts of services; ii. The Enrollee's preference of Providers and any preferred characteristics, such as gender or language; iii. The Enrollee's living arrangements; iv. Covered Services and non-Covered Services to address each identified need, provided that the MMP shall not be required to pay for non-Covered Services; v. Actions and interventions necessary to achieve the Enrollee's objectives; vi. Follow-up and evaluation; vii. Collaborative approaches to be used; viii. Desired outcome and goals, both clinical and non-clinical; ix. Barriers or obstacles; x. Responsible parties; xi. Standing Referrals; xii. Community resources; xiii. Informal supports; xiv. Timeframes for completing actions; xv. Status of the Enrollee's goals; xvi. Home visits as necessary and appropriate for Enrollees who are homebound (as defined in 42 U.S.C. 1395n(a)(2)), who have physical or Cognitive Disabilities, or who may be at increased risk for Abuse, Neglect, or exploitation; xvii. Back-up plan arrangements for critical services; xviii. Crisis plans for an Enrollee with Behavioral Health conditions; and, xix. Wellness Program plans. e. The MMP shall also identify and evaluate risks associated with the Enrollee's care. Factors considered include, but are not limited to, the potential for deterioration of the Enrollee's health status; the Enrollee's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the Enrollee; and, behavioral or other compliance risks. The MMP shall incorporate the results of the risk assessment into the Enrollee Care Plan. Enrollee Care Plans that include Negotiated Risks shall be submitted to MMP's Medical Director for review. Negotiated Risks shall not allow or create a risk for other Residents in a group setting.	Care planning P&P states that the MMP assures that these elements are incorporated into the care plan.
3. The MMP specifies: a. The frequency for care plan review and revision (at a minimum, annually for all enrollees or as specified in the HCBS waiver); and b. That the care plans for enrollees at high risk are reviewed at least every thirty (30) days, and at least every ninety (90) days for enrollees at moderate risk, and reassessments are conducted and care plans are updated as necessary.	Care planning P&P explains how and when the MMP reviews and revises the contents of an enrollee's care plan depending on whether the enrollee is in the waiver, is high risk or moderate risk.

Readiness Review Criteria	Suggested Evidence
4. The MMP will ensure that the enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, and that the enrollee receives clear information about: a. His or her health conditions and functional limitations; b. How family members and social supports can be involved in the care planning as the enrollee chooses; c. Self-directed care options and assistance available to self-direct care; d. Opportunities for educational and vocational activities; and e. Available treatment options, supports and/or alternative courses of care.	Care planning P&P describes how the MMP will ensure that the enrollee receives necessary assistance and the types of information specified.
5. For enrollees determined newly eligible for HCBS waiver services following enrollment into the MMP, the MMP will develop, implement, and monitor the service plan in compliance with the 1915(c) waiver and in conjunction with the care plan.	Care planning P&P describes how the MMP incorporate the HCBS waiver service plan into the care plan.
6. The MMP accommodates enrollees' cultural considerations and basic enrollee rights in developing the care plan.	Care planning P&P states that the MMP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the care plan.
7. The MMP has a process to implement a method of monitoring its care coordinators. This process should include, but is not limited to conducting quarterly case file audits of beneficiaries on each waiver and quarterly reviews checking that waiver beneficiaries' service plans are completed with each assessment or in between assessments if members needs have changed, service listed on the service plan address members need identified in the assessment, and back-up plans are created for members receiving in-home services and are comprehensive.	Care planning P&Ps articulate how plans will monitor its care coordinators and this meets the waiver requirements.
8. The MMP has a process to compile reports of these monitoring activities related to each HCBS waiver to include an analysis of the data and a description of the continuous improvement strategies the case manager has taken to resolve identified issues. The Plans will provide the state the results of their discovery, remediation and any systems improvement activities during quarterly quality improvement meetings.	Care planning P&Ps articulate how plans will monitor its care coordinators and this meets the waiver requirements.
C. Self-Directed Services	
1. The MMP's care coordinator provides enrollees eligible for self-direction information on personal care services, including choosing and employing personal care providers.	Sample enrollee communications demonstrating that the MMP has provided the information contained within this criterion to enrollees eligible for self-direction. Personal care services P&Ps include state self-direction requirements and support enrollees in directing their own care and care plan development.
2. The MMP's service planning policies for enrollees on the following waivers: the Persons with Disabilities waiver; the Persons with HIV/AIDS waiver; and the Persons with Brain Injury indicate that care coordinators will discuss services available under the waiver, including self-direction. The care coordinator will also determine if the customer has the ability to self-direct. Services provided by a personal assistant will only be provided when it has been determined by the care coordinator that the enrollee has the ability to supervise the personal care provider.	During the service planning process, care coordinators will review many factors to determine if the customer has the ability to self-direct. Examples of items reviewed include medical information, psychological information, and interviews of individual and family.
3. For self-directed services, the MMP maintains a current list of qualified and contracted service providers which is made available to enrollees upon request. The enrollee is also educated that the Plan's vendor list is available on the Plan's website.	Personal care services P&Ps include this requirement.

Readiness Review Criteria	Suggested Evidence
4. The MMP has policies to support enrollees on the appropriate HCBS waivers in self-directing their own care that include: a. Supporting enrollees in their role as co-employers of personal assistants; and b. Assuring that care coordinators or another member of the care team are properly trained and have the skills and resources to be able to train enrollees in employing their own personal assistants.	P&P on enrollees in HCBS waivers includes these roles for HCBS waiver participants.
D. Coordination of Services	
1. The MMP provides integrated primary and behavioral health care services, as appropriate, within its networks.	MMP's P&P details how it provides integrated primary and behavioral health services.
2. The MMP has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting and preserving evaluations and reports for the care coordination program; and b. Communicating these results and subsequent improvements to MMP advisory boards and/or stakeholders.	Care coordination P&P explains how and when the MMP will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to MMP advisory boards and/or stakeholders.
3. The MMP facilitates timely and thorough coordination between the MMP, the primary care provider, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, LTSS, etc.).	Care coordination P&P outlines how coordination between the parties will occur; including the mechanism by which information will be shared and how the MMP will facilitate the coordination.
4. For enrollees on a HCBS waiver, the MMP will provide the full range of care coordination including HCBS waiver service planning, connecting enrollees with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community.	
E. Transitions Between Care Settings	
1. The MMP's outreach materials for enrollees living in institutional settings include explanation of the community supports available to them.	Sample communications the MMP plans to send to enrollees living in institutional settings contain information related to accessing community supports.
2. The MMP has a transition plan that manages transition of care and continuity of care for new Enrollees and for Enrollees moving from an institutional setting to a community living arrangement. The MMP's process for facilitating continuity of care will include: a. Identification of Enrollees deemed critical for continuity of care; b. Communication with entities involved in Enrollees' transition; c. Making accommodations so that all community supports, including housing, are in place prior to the enrollee's move and that providers are fully knowledgeable and prepared to support the enrollee, including interface and coordination with and among clinical services and LTS; d. Environmental adaptations and equipment and/or technology the enrollee needs for a successful care setting transition; e. Stabilization and provision of uninterrupted access to Covered Services; f. Assessment of Enrollees' ongoing care needs; and g. Monitoring of continuity and quality of care, and services provided.	The MMP must submit the transition plan.

Readiness Review Criteria	Suggested Evidence
3. The MMP operates: a. A SNFist program designed to improve health outcomes among nursing home residents, particularly those with high rates of hospitalization; and b. A Hospitalist program, when applicable, designed to minimize admissions and length of stay and ensure adequate discharge planning.	MMPs must submit their SNFist and, if applicable, their Hospitalist program description and/or P&Ps
4. MMP helps enrollees transition to another provider if their provider leaves the MMP's network.	Care coordination P&P and/or provider handbook includes this policy.
5. The MMP transitions enrollee, or has a plan to transition enrollees, from a nursing facility that fails to meet the plans performance standards, prior to terminating the contract with the nursing facility.	Provider Network P&P includes a policy that the plan will transfer beneficiaries out of a poor-performing nursing facility.
6. The MMP transitions enrollees to new providers, if needed, during the transition period and once the transition period is over.	Care coordination P&P and/or provider handbook includes policy.
F. Health Education	
1. The MMP has plans to offer a set of health education programs that use comprehensive outreach and communication methods to effectively educate Enrollees, and their families and other caregivers, about health and self-care and how to access plan benefits and supports.	Health Promotion and Wellness program description meets this requirement.

Table 3. Confidentiality

Readiness Review Criteria	Suggested Evidence
1. The MMP provides a privacy notice to enrollees, which explains the policies and procedures for the use and protection of protected health information (PHI).	Sample privacy notice to be sent to enrollees explains how the MMP will safeguard PHI.
2. The MMP provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers explains how the MMP will safeguard PHI and the provider's role in safeguarding PHI.

Table 4. Enrollee and Provider Communications

Readiness Review Criteria	Suggested Evidence
A. Enrollee and Provider Communications	
1. The MMP maintains and operates a toll-free call center that operates seven days a week at least from 8:00 A.M. to 8:00 P.M. according to the time zones for the regions in which they operate. Plan sponsors are permitted to use alternative technologies to meet the customer service call center requirements for Saturdays, Sundays, and holidays.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS, and drugs.
2. The MMP operates a toll-free call center with live customer service representatives available to respond to providers or enrollees for information related to coverage determinations (including exceptions and prior authorizations), appeals. The call center must meet all requirements in CMS Marketing Guidelines Appendix 5, including that it must operate during normal business hours and never less than 8:00 A.M. to 6:00 P.M., Monday through Friday according to the time zones for the regions in which they operate.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times.

Readiness Review Criteria	Suggested Evidence
3. MMP sponsors' call centers have interpreter services available to call center personnel to answer questions from non-English speaking and limited English proficient individuals. Interpretation services are available free-of-charge to enrollees in all non-English languages spoken by beneficiaries. TTY services or comparable services must be available for people who are deaf or hard of hearing.	P&P includes these requirements.
4. The MMP must require PCPs and specialty Provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.	MMP demonstrates P&Ps related to this requirement.
5. The MMP operates a toll-free advice line, available twenty-four (24) hours a day, seven (7) days a week, through which enrollees may obtain medical guidance and support from a nurse. MMPs shall ensure that the nurses staffing the nurse advice line will be able to obtain Physician support and advice by contacting Demonstration Plan's Medical Director if needed.	MMP demonstrates P&P that describes Nurse Advice Line operations in compliance with these terms.
6. MMP employs customer service department representatives who shall, upon request, make available to enrollees and potential enrollees information and or materials including, but not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Enrollees' rights and responsibilities; c. The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the Demonstration Plan to provide a covered service and to appeal any adverse actions (denials); d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. Information on all Demonstration Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and f. The procedures for an enrollee to change Demonstration Plans or to opt out of the Demonstration.	Materials that show the items listed in the criterion.
7. The MMP or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment; f. Formulary information; g. Pharmacy information, including whether an enrollee's pharmacy is in the MMP's network; h. Provider information, including whether an enrollee's physician is in the MMP's network; i. Out-of-network coverage; j. Claims submission, processing, and payment; k. Formulary transition process; l. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); m. Information on how to obtain needed forms; n. Information on replacing an identification card; and Service area information.	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria.

Readiness Review Criteria	Suggested Evidence
8. The MMP must employ a sufficient number of enrollee service representatives (ESR) who are: a. Trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees; b. Trained in the use of TTY, video relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats; c. Capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service; and d. Capable to answer all inquiries and respond to enrollee complaints and concerns in a timely manner.	ESR P&P includes these elements. Training materials for ESRs includes these elements.
B: Provider Hotline	
1. The MMP or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume resulting from Demonstration enrollments.	The MMP (or PBM) has a staffing plan that shows how it has arrived at an estimated staffing ratio for the pharmacy technical help desk call center and how and in what timeframe it intends to staff to that ratio.
2. The MMP ensures that pharmacy technical support is available at any time that any of the network's pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.

Table 5. Enrollee Protections

Readiness Review Criteria	Suggested Evidence
A. Enrollee Rights	
1. The MMP has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
2. The MMP policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.

Readiness Review Criteria	Suggested Evidence
3. The MMP provides enrollees with the following rights: a. Be treated with respect and with due consideration for his or her dignity and privacy; b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand; c. Participate in decisions regarding his or her health care, including the right to refuse treatment; d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; e. Request and receive a copy of his or her medical records, and request that they be amended or corrected; and f. Receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.	Enrollee rights P&P states that an enrollee has these rights. Staff training on enrollee rights includes these rights.
4. The MMP does not discriminate against enrollees due to: a. Medical condition (including physical and mental illness); b. Claims experience; c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; or g. Disability.	Enrollee rights P&P states that the MMP will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.
5. The MMP informs enrollees that they will not be balanced billed by a provider for any service; this is articulated through policies and procedures and staff and provider training modules.	Enrollee rights P&P explains that the MMP informs beneficiaries that they should not be balanced billed. Training materials for providers and staff cover this rule.
6. The MMP has policies and procedures to inform enrollees of their right to reasonable accommodation.	Enrollee rights P&P states that the MMP informs enrollees of their right to reasonable accommodation.
B. Appeals and Grievances	
1. The MMP notifies enrollees at least annually about their grievances and appeals rights.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on enrollee need.
2. The MMP staff understands enrollee protections, including the MMP's organization and coverage determination and appeals and grievance processes.	Training materials contain information about the MMP's organization and coverage determination processes and the appeals and grievance processes.
3. The MMP provides enrollees with reasonable assistance in filing an appeal or grievance.	Grievances and appeals P&P explains to the extent to which the MMP will assist an enrollee in filing an appeal or grievance.

Readiness Review Criteria	Suggested Evidence
4. The MMP's policies and procedures comply with the following requirements of the CMS-Illinois MOU regarding continuation of benefits pending enrollee appeals: a. The MMP provides and pays for all Medicare Parts A and B benefits pending the resolution of the MMP appeal process; b. For Medicaid-only and Medicare-Medicaid overlap services, if the request for appeal is filed within 10 calendar days from the Notice of Action, the MMP provides services pending resolution of the MMP appeal process; c. For Medicaid-only services, following the MMP appeal process, if the resolution is not wholly in favor of the enrollee and the enrollee files for a State Fair Hearing within 10 calendar days of the Notice of Disposition, the MMP provides and pays for the services in question; and d. For Medicare-Medicaid overlap services where the appeal has been forwarded to the Independent Review Entity (IRE), the MMP provides and pays for services pending a resolution. If the IRE resolution is not wholly in favor of the enrollee and the enrollee files for a State Fair Hearing within 10 calendar days of the IRE Notice of Disposition, the MMP continues to provide and pay for the services.	Grievances and appeals P&P states that the MMP complies with these requirements for continuation of benefits pending enrollee appeals.
5. The MMP maintains an established process to track and maintain records of all appeals.	Screenshots of or reports from the tracking system in which enrollee appeals are kept include these elements.
6. The MMP maintains an established process to track and maintain records on all grievances, received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the MMP notified the enrollee of the disposition.	Screenshots of or reports from the tracking system in which enrollee grievances are kept include these elements. Data summaries or reports detail the types of reporting and remediation steps that are taken to ensure grievances are correctly handled. Grievances P&P define how staff from the MMP should document grievances within the tracking system.
7. The MMP maintains policies and procedures for enrollee grievances that include the following: a. Enrollees are entitled to file grievances directly with the MMP; b. The MMPs tracks and resolves all grievances or reroutes grievances to the coverage decision or appeals process as appropriate; and c. The MMP has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals, and has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.	Grievances P&P includes these specifications.

Readiness Review Criteria	Suggested Evidence
8. The MMP maintains policies and procedures for enrollee appeals for services other than Part D that include the following: a. The MMP accepts appeals from enrollees for up to 60 calendar days from the date of the MMP's notice of action; b. The MMP resolves all initial appeals within 15 business days of their submission for standard appeals and within 24 hours of their submission for expedited appeals; c. For Medicare services, if the MMP upholds the denial, the MMP will automatically send the appeal to the IRE; d. For Medicaid-only services, if the MMP upholds the denial, the MMP will provide the enrollee or his/her authorized representative with a Notice of the Right to Request a State Fair Hearing; and e. Ffor Medicaid-Medicare overlap services, if the IRE upholds the denial, the MMP informs the enrollee of his or her right to a State Fair Hearing.	Appeals P&P includes these specifications.
9. The MMP's Part D appeals process under the Demonstration is consistent with the requirements under 42 CFR § 423.568.	Part D appeals P&P includes these requirements for processing appeals.
C. Enrollee Choice of Medical Home Provider and Service Setting	
1. The MMP notifies enrollees about the process for choosing a provider that serves as the enrollee's medical home. This includes: a. Offering pregnant Enrollees with Chronic Health Conditions, disabilities, or special health care needs the option of choosing a specialist to be their PCP or Medical Home. Such Enrollees or their Providers may request a specialist as a PCP at any time. b. If an Enrollee is homebound or has significant mobility limitations, the MMP shall provide access to primary care through home visits by nurse practitioners or Physicians to support the Enrollee's ability to live as independently as possible in the community.	Provider medical home selection and assignment P&P explains how and when an enrollee may elect a medical home provider.
2. MMP ensures that enrollees have the option to receive long-term services and supports (LTSS) in the least restrictive setting when appropriate, with a preference for the home and the community, and in accordance the enrollee's wishes and care plan	MMP's P&P provides that the MMP offers this assurance to enrollees.
D. Emergency Services	
1. The MMP has a back-up plan in place in case an LTSS provider does not arrive to provide assistance with activities of daily living.	Emergency services P&P explains how the MMP is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.
2. The MMP can connect enrollees with emergency behavioral health services, when applicable.	Emergency services P&P addresses how the MMP is prepared to provide emergency behavioral health services to enrollees in crisis.

Table 6. Monitoring of First-Tier, Downstream, and Related Entities

Readiness Review Criteria	Example Suggested Evidence
1. The MMP has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the MMP.	The MMP's monitoring plan provides information on how the MMP monitors all first-tier, downstream, and related entities.

Table 7. Organizational Structure and Staffing

Readiness Review Criteria	Suggested Evidence
A. Organizational Structure and Staffing	
1. The MMP maintains and updates all required points of contact in the CMS Health Plan Management System (HPMS), including, but not limited to the Chief Executive Officer, Pharmacy Director, Chief Operating Officer, and Chief Financial Officer.	HPMS.
2. The MMP identifies the following key positions: a. Care Coordination/Disease Management Program Manager; b. Community Liaison Manager; c. Member Services Director; d. Provider Service Director; and e. Management Information Systems Director. These positions may overlap with key contacts in HPMS, if appropriate.	Staff resumes indicate that qualified and experienced staff with appropriate expertise fills these positions. Staff may overlap with key contacts in HPMS, if appropriate.
3. The MMP must establish at least one enrollee advisory committee and a process for that committee to provide input to the governing board. The MMP must demonstrate the participation of enrollees with disabilities, within the governance structure of the MMP.	Bylaws governing the MMP's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the MMP), and that the committee has a process for providing input to the MMP's governing board.
4. The MMP has a utilization management (UM) committee that exhibits an expertise in the range of services provided by the plan, in particular, behavioral health and LTSS.	UM committee members are appropriate based on the target population described in the CMS-Illinois MOU. Note: For MMP Plans with current UM committees, review will focus on the change in composition to address the new services (e.g., LTSS and behavioral health).
5. The MMP has a Quality Assurance Plan Committee that is responsible for overseeing the MMP's provider credentialing process and that is experienced and qualified to oversee provider credentialing and re-credentialing for the full range of providers (e.g., medical, LTSS, behavioral health, and pharmacy.	The MMP's bylaws or policies and procedures state that the MMP has a Quality Assurance Plan Committee that is responsible for overseeing the provider credentialing process and that meets the qualifications stated in the criterion.
B. Sufficient Staff	
1. The MMP has a staffing plan that demonstrates that it will have sufficient employees and/or contractors to complete enrollee assessments as required (including at least annually), in a timely manner for all enrollees through its staffing plan and explains: a. Its estimate of sufficient staffing for this function; and b. The timeframe in which the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
2. The MMP staff, contractors, or providers performing enrollee-assessments have the appropriate education and experience for the subpopulations (e.g., experience in LTSS or behavioral health).	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description requirements.

Readiness Review Criteria	Suggested Evidence
3. The MMP has a staffing plan that demonstrates it will have sufficient Care Coordinators to perform the care coordination functions required under the Demonstration that includes: a. Estimates of sufficient staff based on the following care coordination ratios: i. For enrollees identified as needing intensive Care Management services (high risk enrollees)– 1:75; ii. For enrollees identified as needing supportive Care Management services (moderate risk enrollees) – 1:150; iii. For enrollees identified as needing prevention and wellness (low risk enrollees)– 1:600; and iv. For Enrollees in the Persons with Brain Injury waiver or the Persons with HIV/AIDS waiver, the caseloads shall not exceed 1:30; and b. The timeframe in which the MMP will staff to the levels it has estimated.	MMP's staffing plan includes an estimation of sufficient staff based on the specified ratios and the MMP's approved methodology, as well as a timeframe for in which the MMP will staff to that level.
4. The MMP and/or contractor care coordination staff have the appropriate education and experience to meet requirements and the service needs of the population consistent with the enrollee's risk level. A care coordinator assigned by the MMP to a waiver participant must have at least one of the following education or license levels: a. Registered Nurse (RN), b. Licensed Clinical Social Worker; c. Licensed Marriage and Family Therapist; d. Licensed Clinical Professional Counselor; e. Licensed Professional Counselor; f. PhD; g. Doctorate in Psychology; h. Bachelor or Masters prepared in human services related field; or i. Licensed Practical Nurse.	Care coordinator qualifications P&P includes the requirements specified in the criterion.
6. The MMP demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight, and explains: a. Its estimation of sufficient staffing for this function; and b. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
7. The MMP demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances and explains: a. Its estimate of sufficient staffing for this function, and b. The timeframe in which the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
8. The MMP demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations through its staffing plan and explains: a. Its estimate of sufficient staffing for this function; and b. The timeframe in which the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.

Readiness Review Criteria	Suggested Evidence
9. The MMP Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. Job description for the medical director includes this responsibility.
C. Staff Training	
1. The MMP has a cultural competency and disability training plan to ensure that staff delivers culturally-competent services, in both oral and written enrollee communications (e.g., person-first language, target population competencies).	MMP cultural competency and disability training plan (or P&P) identifies which staff receive this training and how often, and includes a schedule of training activities for new staff. MMP training materials include training on cultural competency and disability.
2. The MMP staff is adequately trained to handle critical incident and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports providers.	The MMP's training materials include training on critical incident and abuse reporting and include these topics.
3. MMP staff is trained on the person-centered planning processes, cultural and disability competencies, compliance with the Americans with Disabilities Act, and independent living and recovery.	MMP P&P on care coordinator training is consistent with the criterion.
4. The MMP's staff is trained on confidentiality guidelines and has received training to meet HIPAA compliance obligations.	The MMP's training materials include training on HIPAA compliance and confidentiality guidelines.
5. The MMP ensures that enrollee services telephone line and pharmacy customer service hotline staff have been adequately trained in the following areas: a. Explaining the operation of the MMP and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Assisting enrollees to obtain services and make appointments; d. The identity, locations, qualifications, and availability of providers; e. Enrollees rights and responsibilities; f. The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the Demonstration Plan to provide a covered service and to appeal any adverse actions (denials); g. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; h. Information on all Demonstration Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and i. The procedures for an enrollee to change plans or to opt out of the Demonstration.	Content from training programs or orientation modules demonstrates staff from the MMP trains its enrollee services telephone line staff and pharmacy customer service line personnel on these topics. Step-by-step procedures or a flow chart showing how staff from the MMP would walk through assisting enrollees in explaining or selecting services.

Table 8. Performance and Quality Improvement

Readiness Review Criteria	Suggested Evidence
Performance and quality improvement	
1. The MMP reports critical incidents and abuse for enrollees who are residents of nursing facilities or who are participants in the HCBS waiver in accordance with state law.	QI program description explains how the MMP tracks incidents and cases of abuse for enrollees receiving LTSS.
2. The MMP is prepared to report all Year 1 quality measures required under the Demonstration, including all Medicare Advantage (Part C) required measures, HEDIS, HOS and CAHPS data, as well as measures related to behavioral health; care coordination/transitions; LTSS, as required by the CMS-Illinois MOU.	QI program description details how the MMP collects these measures for its enrollees.
3. The MMP collects prescription drug quality measures consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.	QI program description explains the MMP's means of collecting and reviewing drug quality measures

Table 9. Provider Credentialing

Readiness Review Criteria	Suggested Evidence
1. The MMP's policies and procedures for credentialing and recredentialing state that it adheres to: a. The federal standards in 42 CFR §438.214 and 42 CFR §422.204; and b. The credentialing and recredentialing guidelines defined in the ILCS (410 ILCS 517) and the Illinois Administrative Code (77Ill. Adm. Code 965).	Provider credentialing P&P includes these requirements.
2. Prior to contracting with a new provider, the MMP verifies the following: a. A valid license to practice medicine, when applicable; b. A valid DEA certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. Malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions; i. Medicare or Medicaid programs are in good standing; and j. Have not been terminated from either Medicare or Medicaid, or placed on the Ineligible Provider List.	Provider credentialing P&P states that the MMP will review these documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.
3. The MMP requires all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The MMP submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.

Table 10. Provider Network

Readiness Review Criteria	Suggested Evidence
A. Establishment and Maintenance of Network, including Capacity and Services Offered	
1. The MMP has a set of procedures that govern participation in the medical, behavioral, pharmacy, and LTSS (including HCBS) provider networks, including written rules of participation that cover: a. Terms of payment; b. Credentialing; and c. Other rules directly related to participation decisions.	The MMP's rules for participation for medical, behavioral, pharmacy, and LTSS and HCBS provider networks include all necessary items and specify that written notice of material changes in the rules will be submitted to CMS and the state prior to changes taking effect.
2. The MMP has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including pharmacies and LTSS providers; d. Whether providers are accepting new enrollees; e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides access for enrollees; f. Access to primary care services for enrollees within a reasonable distance of enrollees' residence; g. Access to specialty care services for enrollees within a reasonable distance from enrollees' places of residence; h. Access to pharmacy services for enrollees within a reasonable distance from enrollees' places of residence; i. Access to facility services for enrollees within a reasonable distance from enrollees' places of residence, including outpatient dialysis; j. Out-of-network providers; and k. All state Medicaid requirements regarding network adequacy.	Provider network P&P defines expected number of Demonstration enrollees and required number of providers. Provider network P&P defines specialties covered and how they relate to the specific needs of the target population.
3. The MMP has a policy and procedure that states that it will utilize: a. Medicare standards for network adequacy for Medicare prescription drugs and for other services for which Medicare is primary; and b. Illinois Medicaid network adequacy standards in establishing and maintaining its provider network for: i. Behavioral health services where Medicare is not primary; and ii. Home health and durable medical equipment and any other services for which Medicaid and Medicare may overlap, so long as the State can show that such standards are at least as stringent and beneficiary-friendly as the Medicare standards.	MMP's provider network P&P includes these provisions.

Readiness Review Criteria	Suggested Evidence
4. The MMP has a policy and procedure that states that: a. For the first year of the Demonstration, it will offer contracts to all nursing facilities and supportive living facilities, as well as any willing LTSS provider in its service area(s) that renders covered services so long as such provider meets all applicable state and federal requirements for participation in the Medicaid program and meets the qualifications of the applicable HCBS waiver; and b. After the first year of the Demonstration, the MMP may contract with only those providers that meet the quality standards it has established provided that: i. The State has approved the quality standards; ii. All contracting providers are informed of any such quality standards no later than 90 days after the start of the first year of the Demonstration; and iii. Any such quality standards that are not established within 90 days after the start of the Demonstration are in effect for 12 months before the MMP may terminate a contract of a provider based on a failure to meet such quality standards.	MMP's provider network P&P includes these provisions.
5. The MMP has a policy and procedure that states that: a. The MMP maintains contracts with a set of HCBS providers that provided at least eighty percent (80%) of the fee-for-service services during CY 2012; b. For counties where there is more than one provider of covered services, the MMP maintains contracts with at least two of such providers, even if one served more than eighty percent (80%) of the current clients; and c. HCBS services subject to this standard include: i. Adult Day Care; ii. Homemaker; iii. Day Habilitation (BI waiver); iv. Supported Employment (BI waiver) ; v. Home Delivered Meals; vi. Home Health Aides; vii. Nursing Services; viii. Occupational Therapy; ix. Speech Therapy; and x. Physical Therapy.	MMP's provider network P&P includes these provisions.
6. The MMP's policy states it will offer to contract with every FQHC, RHC or CMHC that is willing to accept the MMP's standard rates and contractual requirements and meets the MMP's quality standards.	Provider network P&P explains that it offers to contract with every willing FQHC, RHC and CMHC that meets its quality standards.
7. The MMP has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS, and pharmacy providers are trained in cultural competency for delivering services to the target populations.	Provider network P&P explains how its primary care, specialty, behavioral health, LTSS, and pharmacy providers are prepared to meet the additional competencies necessary to serve enrollees within the target population. Provider training materials for all of these groups include modules on cultural competency when serving target populations.

Readiness Review Criteria	Suggested Evidence
8. The MMP has a policy and procedure that states that it maintains a primary care network from which an enrollee may choose a provider that acts as a medical home. Medical homes must provide evidence-based primary care services, acute illness care, behavioral health care (where appropriate), chronic health condition management, and referrals for specialty care and LTSS. Medical homes will be supported by health information technology (HIT) and be a part of the interdisciplinary care team (care team) to assist in coordinating care across the full spectrum of available services, including behavioral health care, and managing transitions between levels of care.	The MMP's P&P on provider networks includes these requirements. P&P for the future implementation of health information technology (HIT) if it is not already in place.
9. The MMP has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.
10. The MMP has a policy and procedure to reimburse out-of-network providers of emergent or urgent services, as these services are defined by 42 CFR §424.101 and 42 CFR §405.400, respectively, at the Medicare or Medicaid FFS rate applicable for that service n cases when the service would traditionally be covered by Medicare FFS, the Medicare FFS rate applies.	Provider network P&P includes a provision for paying out-of-network providers at applicable rates in urgent or emergency situations.
11. The MMP provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.
12. The MMP ensures that enrollees have access to the most current and accurate information by updating its online provider directory content on a timely basis and enhancing search functionality timely once a need has been determined.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).
B. Accessibility	
1. The MMP has a policy that states that: a. The MMP contracts with providers that accommodate the physical access and flexible scheduling needs of their enrollees; and b. The MMP and its providers communicate with enrollees in a manner that accommodates the enrollee's individual needs (e.g., interpreters for those who are deaf or hard of hearing and accommodations for enrollees with cognitive limitations).	Provider network P&P includes these requirements to accommodate enrollees with disabilities.
2. Medical, behavioral, and LTSS providers provide linguistically- and culturally-competent services.	Provider training includes training on cultural competency.
3. Medical, behavioral, and LTSS providers exhibit competency in the following areas: a. Utilize waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities; b. Accessibility along public transportation routes, and/or provide enough parking; and c. Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities.	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees. Templates require providers to take these actions as condition for participation. MMP P&P on monitoring includes a review of accessibility and accommodations.

Readiness Review Criteria	Suggested Evidence
C. Provider Training	
1. The MMP requires disability literacy training for its medical, behavioral, and LTSS providers, including information about the following: a. Various types of chronic conditions prevalent within the target population; b. Awareness of personal prejudices; c. Legal obligations to comply with the ADA requirements; d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; e. Types of barriers encountered by the target population; f. Training on person-centered planning and self-determination, the independent living and wellness philosophies, and the recovery model; g. Use of evidence-based practices and specific levels of quality outcomes; and h. Working with enrollees with mental health diagnoses, including crisis prevention and treatment.	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.
2. The MMP trains providers about: a. Care coordination; and b. The roles and responsibilities of the interdisciplinary care team, including: i. Communication pathways between providers and the interdisciplinary care team; ii. Care plan development; iii. Consumer direction; and iv. Any HIT necessary to support care coordination.	Provider training materials include modules on coordination of care, behavioral health services, LTSS, and community supports (see also care coordinator training in the care coordination section).

Readiness Review Criteria	Suggested Evidence
3. Consistent with the ICP-required provider training, prior to any enrollment of Enrollees under the Demonstration and thereafter, the MMP conducts provider education regarding the MMP's policies and procedures as well as the MMAI program. These include: a. Provider Orientation: The MMP conducts orientation sessions for contracted providers and their office staff. b. Medical Home: The MMP educates contracted providers about the Medical Home model and the importance of using it to integrate all aspects of each Enrollee's care, as well as how to become a Medical Home. c. Cultural Competency. The MMP will provide the cultural competency requirements at orientation, training sessions, and updates as needed. d. Provider Directory: The MMP shall make its Provider Directory available to Providers via the MMP's web-portal. e. Provider-based Health Education for Enrollees. The MMP shall encourage PCPs to provide health education to Enrollees: The MMP shall ensure that Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care. f. Health, Safety and Welfare Education: As part of its Provider education, the MMP shall include information related to identifying, preventing and reporting Abuse, Neglect, exploitation, and critical incidents. g. DHS HCBS Waiver Provider Education: The MMP shall distribute Provider packets, which the State or its designee will provide, to Enrollees and educate each Enrollee regarding the Enrollee's responsibility to provide the Provider packets to Personal Assistants and all other individual providers who provide Covered Services under the Persons with Disabilities HCBS Waiver, Persons with HIV/AIDS HCBS Waiver, or Persons with Brain Injury HCBS Waiver. The MMP shall further educate Enrollees that such Providers may not begin providing Covered Services until the fully and correctly completed packets have been returned to and accepted by the local DHS-DRS office.	Provider training materials include modules to meet this requirement.
D. Provider Handbook	
1. The MMP prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. MMP contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; and h. Provider billing and reporting.	Each of the listed elements is included in the provider handbook.
2. The MMP makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers who work with enrollees that require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on MMP website, information about local organizations serving specific subpopulations of the target population).

Readiness Review Criteria	Suggested Evidence
E. Ongoing Assurance of Network Adequacy Standards	
1. The MMP ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, HCBS, and pharmacy, are convenient to the population served and do not discriminate against MMP enrollees (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that plan services are available 24 hours a day, 7 days a week, when medically necessary.	Provider contract templates include provisions requiring non-discrimination against enrollees and convenient hours of operation.
2. The MMP has a policy and procedure that states that the provider network arranges for necessary specialty care, LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care. List of network providers includes specialties in all geographic regions.
3. The MMP has policies and procedures requiring the following timeframes for appointments: a. For routine and preventive care, appointments are available within five (5) weeks from the date of request for such care; b. Enrollees with more serious problems not deemed Emergency Medical Conditions shall be triaged and, if necessary or appropriate, immediately referred for urgent Medically Necessary care or provided with an appointment within one (1) Business Day of the request: c. Enrollees with problems or complaints that are not deemed serious shall be seen within three (3) weeks from the date of request for such care: d. Initial prenatal visits without expressed problems shall be made available within two (2) weeks after a request for an Enrollee in her first trimester, within one (1) week for an Enrollee in her second trimester, and within three (3) days for an Enrollee in her third trimester: and e. MMPs shall require that Providers offer hours of operation that are no less than the hours of operation offered to persons who are not Enrollees.	Provider network P&Ps include this requirement.

Table 11. Systems

Readiness Review Criteria	Suggested Evidence
A. Data Exchange	
1. The MMP has developed a system to electronically exchange data with CMS, the state, subcontractors, and providers. Specifically, the MMP has: a. Established the appropriate External Point of Contact (EPOC); b. Has a plan for authorizing EPOC submitters and other users; and c. Completed connectivity testing with the MAPD Help Desk.	Baseline documentation should include data architecture/data exchange diagram that illustrates connectivity to CMS, the state or any applicable subcontractor, with data exchange protocols (e.g., SFTP). Supporting documentation should include: 1. EPOC designation letter or other proof that MMP has established an appropriate EPOC. 2. Screenshot or other demonstration of connectivity with MAPD Help Desk. 3. P&P showing process by which EPOC will approve other submitters.

Readiness Review Criteria	Suggested Evidence
2. The MMP is able to electronically exchange the following types of data: a. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data; b. Claims data (including paid, denied, and adjustment transactions); c. Financial transaction data (including Medicare C, D, and Medicaid payments); d. Third-party coverage data; e. Enrollee demographic and assessment information; f. Provider data; g. Electronic lab values; h. Health information from provider electronic medical record systems; and i. Prescription drug event (PDE) data.	Baseline documentation should illustrate the types of data that can and will be electronically exchanged along with policies and procedures for securing, processing, and validating the exchange of data including EDI system specifications for transmitting ANSI compliant file formats—e.g., 834, 835, 837 transactions. Supporting documentation should include: 1. Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports. 2. Documentation of rejection thresholds and data reconciliation processes. 3. File layouts for transmitted data illustrating compliance with transmission of required data elements (e.g., Items 2a-2i). 4. Documentation of MMP's transaction sets with CMS, the State, and other third party vendors, including where transaction are compliant with HIPAA versioning standards—e.g., HIPAA Version 5010.
3. The MMP's contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the true out-of-pocket (TrOOP) Facilitator.	Baseline documentation should include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. Supporting documentation should include transaction facilitator certification documentation for its FIR.
4. The MMP's contracted PBM is able to make timely and accurate submissions of Part D pricing data for posting on the Medicare Plan Finder.	Baseline documentation should include PBM (Pharmacy Systems Contractor) P&Ps that detail the processes and data requirements to ensure timely and accurate submission of pricing data for posting on the Medicare Plan Finder. Supporting documentation should include screenshots or other demonstrations of successful transmission of data to the Medicare Plan Finder.

Readiness Review Criteria	Suggested Evidence
B. Data Security	
1. The MMP has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation should include a copy of the MMP's disaster recovery and business continuity plan and an inventory of the core systems specifically used to operate this Demonstration. Supplemental documentation may include: 1. Summary of systems recovery priorities; 2. Proof of disaster recovery plan validation and testing P&Ps for communicating business continuity requirements to subcontractors—e.g., copy of the Disaster/Business Continuity plans for third party systems vendors-e.g., PBMs.
2. The MMP facilitates the secure, effective transmission of data.	Baseline documentation should include: 1. Data architecture/data exchange diagram detailing file exchange protocols; 2. MMP's Data Security and Privacy P&P; and 3. MMP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. Supplemental documentation may include: 1. List of network monitoring tools utilized to detect/ mitigate potential compromises to systems security. 2. Documentation of processes to document a breach in data integrity and any associated corrective actions.
3. The MMP maintains a history of changes, adjustments, and audit trails for current and past data systems.	Baseline documentation should include Change Management P&Ps. Supplemental documentation may include: 1. Log of changes, adjustments, and audit trails for a sample of historical data. 2. List of department team members authorized to make system changes and managers responsible for oversight.
4. The MMP complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	Baseline documentation should include: 1. MMP P&P noting compliance with NPI standards, specifications, and requirements. 2. Screenshot of provider data/records illustrating that the NPI data field is consistently populated in provider contracting, claims, and other applicable systems.

Readiness Review Criteria	Suggested Evidence
C. Claim Processing	
1. The MMP processes timely, accurate, and HIPAA-compliant claims and adjustments and can calculate adjudication rates.	Baseline documentation should include: 1. Claims processing P&P that details claims processing turnaround timeframes, steps for managing pended claims, and methods for ensuring claims processing accuracy. 2. Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.). Supplemental documentation may include: 1. Overview of claims department that includes the number of staff and years of claims processing experience, as well as anticipated staffing for the Demonstration. 2. Information related to claims edits (first fill, emergency, OON), as they are adjudicated, noting whether the edits are performed pre- or post-payment, are manual, or if they're automated.
2. The MMP processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding retroactive medical and LTSS services.	Baseline documentation should include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and long term services.
3. The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation should include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation should highlight the basis for MMP estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by MMP staff without affecting performance standards. Supplemental documentation may include statistics on average claims processed per processor, annual average of claims per enrollee (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity.
4. The claims system and operational workflows will be configured to accommodate a fee schedule that includes all medical, LTSS and HCBS Medicare and Medicaid services.	Baseline documentation should illustrate the following: 1. MMP's process and plan for loading and validating the Demonstration fee schedules. 2. Identification of the individuals or department responsible for configuring new fee schedules. 3. Screen shots of the modules where the fee schedules will be configured and identify how medical, LTSS and HCBS Medicare, and Medicaid services are captured within the system.

Readiness Review Criteria	Suggested Evidence
5. The claims processing system will be configured to properly adjudicate claims for prescription and over the counter drugs.	Baseline documentation should include: 1. The MMP's oversight procedures for monitoring pharmacy claims processing including the PBM's plan to configure, test, and implement the benefits and adjudication rules to properly process prescription and over-the-counter drugs for the Demonstration. 2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs. 3. Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs.
D. Claims Payment	
1. The MMP pays 95% of "clean medical, HCBS, and LTSS claims" within 30 days of receipt.	Baseline documentation should include: 1. Claims P&P that describes clean claims payment requirements and standards. 2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims. Supplemental documentation may include examples of provider contracts that detail the MMP's turnaround time commitment for claims payment.
2. The MMP pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims. The MMP pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	Baseline documentation should include: 1. PBM claims P&Ps that describe clean claims payment procedures and requirements for meeting processing standards. 2. PBM P&Ps that define distinct interest payment requirements for clean electronic and all other claims. PBM produced claims payment report sample that reports the average number of days between receipt and payment of current clean claims as well as metric specifications (e.g., definition of a clean claim).
3. The MMP's PBM ensures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement.	Baseline documentation should include PBM pharmacy network provider P&Ps that detail the timeframe for submission of Part D sponsor claims from long term care facilities.

Readiness Review Criteria	Suggested Evidence
4. The MMP's claims processing system applies logic edits to identify erroneous claims.	Baseline documentation should include a description of system edits as well as proscriptive and retrospective reporting to identify claims processing trends and anomalies used to identify erroneous claims. Note: If this validation is performed outside of the MMP, please provide evidence of the contract with the external vendor, as well as oversight P&Ps, and any performance standards. Supplemental documentation may include a process flow, screenshot, or sample report indicating the identification and evaluation of erroneous claims.
5. The MMP's claims processing system checks for pricing errors to identify erroneous payments.	Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous payments. MMPs should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits. Note: If this validation is performed outside of the MMP, please provide evidence of the contract with the external vendor, as well as oversight P&Ps. Supplemental documentation may include a process flow, screenshot, or sample report indicating the identification and evaluation of potential pricing errors.
E. Provider Systems	
1. The system generates and maintains records on medical provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. Accessibility of provider office; k. Competency of provider staff to serve enrollees of the target population; l. Credentialing information; and m. Proximity to public transportation.	Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots. Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of how this information will be captured in the system along with an implementation timeline.

Readiness Review Criteria	Suggested Evidence
2. The MMP promotes 'meaningful use' of healthcare information technology (HIT) with its network providers by: a. Exchanging health information with network providers that have functioning EMRs; b. Exchanging health information with network providers that do not have functioning EMRs; and c. Providing HIT related resources to network providers particularly in the area of behavioral health.	Baseline documentation should include a data exchange strategy and related data diagram for sharing health information with network providers. If additional development is required, or enhancements are underway, provide a project plan that outlines the implementation timeline and key milestones for overall objectives. For behavioral health information, outline the additional steps and procedures taken to ensure regulatory and industry standards for data security and privacy.
F. Pharmacy Systems	
1. The MMP ensures that the PBM generates and maintains records on the pharmacy networks, including locations and operating hours.	Baseline documentation should include: 1. PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours. 2. A screenshot or sample of how this information is collected, maintained, and made accessible to enrollees.
2. The MMP ensures that the PBM updates records of pharmacy providers and deletes records of no longer participating providers.	Baseline documentation should include the PBM's P&P for updating/maintaining pharmacy provider network information. Supplemental information may include the specifications or workflow diagrams that describe any automated/manual processes to update pharmacy records, so that changes to pharmacy data cascade to other systems, as applicable.
3. The MMP audits the PBM's pharmacy system on a regular basis.	Baseline documentation should include the MMP's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring. Supplemental documentation may include the auditing tools and metrics used by the MMPs, or the MMP's contract if audits are outlined in documents.
4. The MMP ensures that the PBM submits Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation should include: 1. PBM P&P that defines the processes and data submission requirements for Part D PDE reporting. 2. MMP's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.
5. The MMP ensures that the PBM is prepared to ensure pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits	Baseline documentation should include the PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers.

Readiness Review Criteria	Suggested Evidence
6. The MMP ensures that the PBM's system: a. Distinguishes between enrollees filling prescriptions for Part D drugs and non-Part D drugs; b. Appropriately meets the 90-day Part D and the 180-day non-Part D transitional fill requirements; and c. Makes appropriate outreach efforts related to the transitional fills.	Baseline documentation should include the MMP's P&P for filling prescriptions during the transition period for both Part D drugs and non-Part D drugs including documentation of how enrollees and different transition periods are identified and maintained in pharmacy systems. Additionally, documentation should also include an MMP's P&Ps for meeting the provider and enrollee outreach requirements for transition fills.
7. The PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine Part D and Medicaid-covered drugs and coordinate benefits properly in the event of systems downtime.	Baseline documentation should include information about the PBM's disaster recovery and business continuity plan of ensuring the proper identification of benefit coverage and continued coordination of benefits with secondary payers.
G. Care coordination and Care Quality Improvement Systems	
1. The system generates and maintains records necessary for care coordination including, but not limited to: a. Enrollee data (from the enrollment system); b. Eligibility data; c. Provider network; d. Interdisciplinary care team membership for specific enrollees; e. Care coordination assignments; f. Enrollee assessments including the tracking of risk status; g. Enrollee plans of care; h. Authorizations; i. Interdisciplinary care team case notes; j. Medication reconciliation information; k. Claims information; l. Pharmacy data; m. HCBS waivers; n. Colbert and Williams status; and o. Identification of Colbert transition administrator or Williams provider, if applicable.	Baseline documentation should include: 1. An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements. 2. Description of software solutions (e.g., care management solutions) that will be used to support the systems infrastructure of the care coordination process. This includes documentation of enhancements made to customize systems to facilitate management of the demonstration population. 3. Screen shots of the application(s)/modules(s) that support these requirements. 4. Description of processes used to profile, measure and monitor enrollee profiles.
2. The MMP maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include: 1. The MMP's Help Desk P&Ps for tracking, escalation, and resolution of systems-related issues. 2. The MMP's Change Management P&Ps for modifying/updating existing systems and IT processes to facilitate operational needs. Supplemental documentation may include the MMP's Business Continuity Plan for operations when the Care Coordination system is down or inaccessible to external care team members.

Readiness Review Criteria	Suggested Evidence
3. The MMP verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include: 1. MMP's P&Ps related to the monitoring and resolution of data quality issues. Note: this should include the process and controls for ICT members (internal and external) with access to update existing data entries. 2. Screen shots of inherent data quality validation features in the applications used to track care management information (e.g., data driven selections for assessment responses, field masks and validation, etc.). 3. Description of processes to monitor ongoing the accuracy and validity of information in the care coordination system along with resolution steps.
4. The MMP ensures that plans of care are available to the interdisciplinary care team (ICT), provider network and enrollee with the following considerations: a. If care plans are provided via hard copy, either in its original form or as copies, the care plans are maintained in accordance with industry practices and State and Federal regulatory requirements for privacy, security and preservation from destruction. b. If care plans are provided via electronic media, access will be maintained in accordance with industry standards and State and Federal regulatory requirements for privacy and security.	Baseline documentation should include: 1. An outline of the care coordinate system that highlights data elements from the care plan that will be available to the ICT, provider network and enrollee. 2. The policies and procedures for distributing and securing this information, and the assignment and monitoring of system access. 3. A description of who will and how they will access information in the care coordination system. 4. Description of software solutions (e.g., Web-based EMR or Care Management solutions) that will be used to support the systems infrastructure of the care coordination process. 5. Screen shots of the application(s)/modules(s) that will support these workflows and data requirements, if available. 6. Sample business and data use agreements, and confidentiality policies that govern access to information. 7. A description of how medical homes will be supported by health information technology and how this will impact their access to the care plan.

Readiness Review Criteria	Suggested Evidence
5. The care coordination system includes a mechanism to alert interdisciplinary care team members of ED use or inpatient admissions.	Baseline documentation should include: 1. The MMP's P&Ps for monitoring emergency department and inpatient admissions. 2. A description of the MMP's process for notifying the ICT members when an enrollee is admitted to the hospital including communication timing guidelines. Supplemental documentation may include screen shots of the systems and/or triggers that will utilized to notify the ICT members of these hospital related events, as well as sample reports.
6. The MMP's Care Coordination System has the functionality: a. To identify and track assessments, interventions, and management of chronic health conditions; and. b. Ensure that enrollees and providers have web-based access to the care coordination system within federal and state HIPAA and HITECH standards for accessing protected health information no later than 12 months from initial enrollment.	Baseline Documentation should include: 1. Screen shots of care coordination system demonstrating information captured with reference to assessments, interventions, and management of chronic health conditions. 2. Demonstration of system capability (e.g. enrollee and role based authentication, VPN accessibility) to allow web-based access to care coordination system by enrollees and providers. 3. Policies and procedures that outline process for providing access to, monitoring, and securing access to the care coordination system by enrollee's and providers. This policy should also address the timeframe for providing access to these external parties.
7. The MMP has: a. Predictive modeling techniques in place to stratify enrollees into three levels: low, moderate, high risk; and b. Tools and processes in place to proactively identify high-risk enrollees and monitor gaps in care.	Baseline documentation should include: 1. Documentation demonstrating proposed methodology and tools to stratify enrollees. 2. P&P demonstrating policy for monitoring high-risk enrollees. 3. Screenshot of care coordination system data fields that will be utilized to track enrollees identified as high risk.

Table 12. Utilization Management

Readiness Review Criteria	Suggested Evidence
A. The MMP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services	
1. The MMP specifies procedures under which the enrollee may self-refer services.	The UM program descriptions for the MMP explains for which services an enrollee can self-refer.

Readiness Review Criteria	Suggested Evidence
2. The MMP defines medically necessary services as services that are: a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y; b. For Medicaid services: a service, supply, or medicine that is appropriate, covered by the state, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with the MMP guidelines, policies, or procedures based on applicable standards of care and as approved by HFS if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the enrollee's ability to attain, maintain, or regain functional capacity, or to achieve appropriate growth.	The MMP's UM program description includes these definitions of medical necessity.
3. The MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.	The UM program description includes these definitions of medical necessity.
4. The MMP has policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description for the MMP includes these elements.
5. The MMP has a methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The UM program descriptions for the MMP explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines).
6. The MMP outlines its process for authorizing out-of-network services; if specialties necessary for enrollees are not available within the network, the MMP will make such services available.	Out-of-network service authorization P&P explains how an enrollee or provider may obtain authorization for a service being provided by a provider outside of the MMP's network.
7. The MMP describes its processes for communicating to all providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The MMP's provider materials describe prior authorization requirements and procedures.
9. The MMP policies for adoption and dissemination of practice guidelines require that the guidelines: a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the MMP's enrollees; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and enrollee education and service coverage.	The MMP's practice guidelines P&P include these requirements.

Readiness Review Criteria	Suggested Evidence
B. The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.	
a. The MMP has a policy and procedure for appropriately informing enrollees of coverage decisions, including tailored strategies for enrollees with communication barriers.	Plan management guidelines or the MMP's UM program describes the type of communications sent to enrollees, regarding their receipt or denial of referrals of service authorizations.
b. For the processing of requests for initial and continuing authorizations of covered services, the MMP shall: a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consult with the requesting provider when appropriate.	The UM program descriptions for the MMP explains the process for obtaining initial and continuing authorizations for services.
3. The MMP ensures that prior authorization requirements are not applied to the: a. Emergency and post-stabilization services, including emergency; behavioral health care; b. Urgent care; c. Crisis stabilization, including mental health; d. Family planning services; e. Preventive services; f. Communicable disease services, including STI and HIV testing; g. Post-stabilization care services; h. Out-of-area renal dialysis services; and i. Other services as specified in the CMS-Illinois MOU.	The UM program descriptions for the MMP lists those services that are not subject to prior authorization and this list is consistent with the required elements.
4. The MMP follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §422.568, 422.570 and 422.572. Timing for overlap services will be consistent with the three-way contract.	The UM program description for the MMP includes these requirements.
5. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment.	The UM program description for the MMP includes this requirement. Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply MMP policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.