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Rhode Island Readiness Review Tool

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
I. Assessment		
A. Transition to New MMP and Continuity of Care		
101.	For all items and services other than nursing facility services, non-Part D drugs, and Part D drugs, the MMP must allow enrollees to maintain their current providers and service levels at the time of enrollment until the later of: a. Six months after enrollment; or b. For enrollees determined to be low- or moderate-risk, when an Initial Health Screen (IHS) has been completed by the MMP; or c. For enrollees determined to be high risk, when a Comprehensive Functional Needs Assessment (CFNA) and an ICP have been completed by the MMP.	Continuity of care plan includes these provisions.
102.	An enrollee residing in a nursing facility at the time enrollment may remain in the facility for the duration of the Demonstration as long as he or she continues to meet the RI EOHHS criteria for nursing facility care.	Continuity of care plan includes these provisions.

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103.	During the transition period, the MMP may change an enrollee's existing provider only under the following circumstances: a. The enrollee requests a change; b. The IHS and/or CFNA and ICP are complete, and the enrollee agrees to the change; c. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid; or d. The MMP, CMS or the State identifies provider performance issues that affect an enrollee's health and welfare, including but not limited to, exclusion of that provider from the Medicare and/or Medicaid program.	Continuity of care plan includes these provisions
104.	If during the transition period, the MMP proposes a reduction, suspension, denial or termination of a previously authorized service, the MMP shall provide to the enrollee notice of: a. The action; b. The right to appeal; c. The right to have an authorized service continued pending the appeal, and d. The right to a fair hearing if the MMP renders an adverse determination.	Continuity of care plan includes these provisions.
105.	During the applicable transition period, the MMP is required to: a. Provide or arrange for all medically necessary covered services, whether by sub-contract or by single-case agreement, in order to meet the needs of the enrollee; and b. Reimburse enrollees' current providers at no less than the Medicare or Medicaid rate equivalent.	Continuity of care plan includes these provisions.
106.	The MMP assures that, in outpatient settings, 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. Consistent with the requirements of Chapter 6 of the Prescription Drug Benefit	MMP or PBM P&P articulates this Part D policy.

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	Manual, the temporary supply must be for at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days.	
107.	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.	MMP or PBM P&P articulates this Part D policy.
108.	The MMP provides written notice to each Enrollee, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary.	MMP or PBM P&P articulates this Part D policy.
B. Assessment		
109.	For enrollees who reside in the community and are not eligible for LTSS and have not otherwise been determined to be high risk, the MMP administers a telephonic IHS to determine if the enrollee is in the low-, moderate-, or high-risk stratification category.	Risk stratification P&P includes these requirements.
110.	The MMP determines whether an enrollee is high risk using predictive modeling results, the IHS or CFNA, and/or state-established minimum required determinants of health status.	Risk stratification P&P includes these requirements.
111.	a. The MMP utilizes predictive modeling software to stratify enrollees for whom claims history exists into low-, moderate-, and high-risk categories. b. The predictive modeling software: i. Uses claims data and evidence-based algorithms to categorize enrollees; and ii. Identifies enrollees at risk for poor health outcomes who may benefit from care management services.	Risk stratification P&P includes these requirements.
112.	Enrollees who are determined to be at high-risk include, but not be limited to, individuals with complex medical conditions and/or social support needs that may lead to the need for high-cost services, deterioration in health status, or, institutionalization.	Risk stratification P&P includes these requirements.
113.	The MMP: a. Develops an IHS tool, which must be approved by EOHHS; b. For enrollees who are not LTSS-eligible or otherwise determined to be high-risk:	IHS P&P includes these requirements. The actual IHS.

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	i. During the first six months of the Demonstration, administers a telephonic IHS within one hundred-eighty (180) calendar days of effective enrollment; ii. After the first six months of the Demonstration, administers the IHS within forty-five (45) calendar days of effective enrollment; c. Re-administers the IHS for an enrollee based on the enrollee's condition or needs, including as indicated by predictive modeling or provider- or self-referral; and d. If the enrollee or enrollee's caregiver requests an IHS, completes the IHS within 15 calendar days of the request.	
114.	At a minimum, the IHS tool shall include: a. Complete demographic information about the enrollee, including, but not limited to mailing address, phone number, the enrollee's preferred language, age/date of birth, living arrangement, and current residence status (community or facility-based); b. Strength-based needs and preferences; c. Self-reported health status; d. Emergency room utilization in the last six months; e. History of hospitalizations in the last year; f. Presence of co-morbid chronic conditions; g. Availability of an informal caregiver; h. Prior nursing facility admissions; i. Ability to perform activities of daily living (ADLs); and j. Perceived risks (e.g., of falls);	IHS P&P includes these requirements. The actual IHS
115.	Upon initial enrollment, enrollees who reside in the community, are not eligible for LTSS, and have not otherwise been determined to be high risk, will receive a telephonic IHS to risk stratify them into a low-, moderate-, or high-risk category.	Risk stratification P&P includes these requirements.
116.	The MMP: a. Incorporates the results of the IHS into the enrollee's ICP as applicable; and b. Distributes the revised ICP to appropriate ICT members, including, but	Health risk assessment P&P includes these requirements.

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	not limited to, enrollees and their caregivers; and c. Distributes IHS results for low-risk enrollees to the PCP as appropriate.	
117.	The MMP shall develop and submit to EOHHS for approval a CFNA tool and scoring methodology to identify high-risk enrollees who require Intensive Care Management (ICM) services.	Health risk assessment P&P includes these requirements.
118.	The CFNA tool must include, but not be limited to: a. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement, and other key factors as they relate to care; b. Self-reported health status; c. Utilization history for emergency room services, inpatient services, community-based LTSS, and nursing facility services within the last 18 months; d. Medical and behavioral health history including all chronic conditions and history of exacerbations within the prior 12 months; e. Medications and medication management needs; f. Mental health screening and history including, but not limited to, cognitive functioning; g. Alcohol, tobacco, and other drug use; h. Ability to perform Activities of Daily Living (ADLs); i. Fall risks, home safety evaluation, home modifications needed; j. Advance directives; k. Cultural and linguistic preferences; l. Evaluation of visual and hearing needs and preferences; m. Caregiver resources and involvement; n. Informal and community support systems; o. Nutritional status and availability of appropriate food based on the Enrollee's medical needs and preferences; p. Housing, social service, and legal needs; q. Potential to avoid institutional care (e.g. housing status, availability of an informal caregiver); r. Interest in vocational rehabilitation, employment, or volunteer work; and s. Barriers to meeting goals or complying with the ICP.	Health risk assessment P&P includes these requirements. The actual CFNA tool

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119.	a. For enrollees who are non-LTSS high risk, the MMP shall complete the CFNA: i. In person in the enrollee's home (with the enrollee's consent); and ii. No later than 15 days after IHS completion; b. For enrollees who are community-based LTSS and were not enrolled in an Rhode Health Options (RHO) plan immediately prior to the Demonstration, the MMP shall complete the CFNA: i. In-person in the enrollee's home (with the enrollee's consent); and ii. During the first six months of the Demonstration, no later than 180 calendar days after the effective enrollment date; and iii. After the first six months of the Demonstration, within 15 days of the effective enrollment date; c. For enrollees who are eligible for LTSS and who were enrolled in an RHO plan immediately prior to the Demonstration, the MMP shall: i. Share the assessment conducted by the RHO plan with the ICT within 30 days of enrollment; and ii. If the RHO assessment was completed within 180 days prior to enrollment, reassess the enrollee according to the applicable timeframe for that enrollee, using the RHO plan assessment date as the starting point.	Health risk assessment P&P includes these requirements.
120.	For enrollees who reside in a nursing facility at the time of enrollment and do not have a desire to return to the community, the MMP shall complete a Wellness Assessment within 120 days of enrollment. The Wellness Assessment shall include, but not be limited to: a. Enrollee strength-based preferences and needs for care delivery, housing, caregiver involvement, and other key factors related to care; b. Health status; c. Utilization history for inpatient services and other acute care needs within the prior 18 months; d. Medical and behavioral health history; e. Mental health screening and history, including but not limited to depression and cognitive functioning;	Health risk assessment P&P includes these requirements.

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	f. Ability to perform ADLs; g. Fall risks; h. Advance directives; i. Cultural and linguistic preferences; j. Evaluation of visual and hearing needs and preferences; k. Nutritional status; and l. Barriers to meeting goals or complying with the Wellness Plan.	
121.	The MMP shall conduct comprehensive reassessments within the following timeframes: a. For enrollees who are non-LTSS high risk, by phone or in person at least annually; b. For enrollees who are community LTSS, in person (or by phone if necessary), at least every 90 days; and c. For enrollees who were previously enrolled in an RHO, according to the applicable timeframe for that enrollee using the RHO assessment date as the starting point.	Health risk assessment P&P includes these requirements.
122.	For enrollees who are non-LTSS high risk, eligible for community LTSS, or who were previously enrolled in a RHO plan, the MMP is required to conduct reassessments sooner than the standard reassessment timeframe in the following circumstances: a. An in-person reassessment must be conducted within 5 days of discharge from a hospitalization; and b. An in-person reassessment must be conducted within 15 calendar days of identifying one or more of the following significant changes in the enrollee's condition, needs or circumstances: i. Significant changes in medication; ii. Change in, or loss of, a caregiver; iii. Medical, psychosocial or behavioral health crisis; iv. Excessive emergency department utilization; v. Other major changes in the enrollee's psychosocial, medical, behavioral condition; or	Health risk assessment P&P includes these requirements.

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	vi. A major change in housing.	
123.	a. The comprehensive reassessment will have the same content as the initial CFNA. b. The MMP will revise the enrollee's ICP to incorporate the results of the comprehensive reassessment; and c. The MMP will distribute the revised ICP to appropriate ICT members including, but not limited to, the enrollee and his/her caregivers.	Health risk assessment P&P includes these requirements.
124.	The MMP shall assure that the CFNA and reassessments are administered by a licensed clinician.	Health risk assessment P&P includes these requirements.
125.	a. At least quarterly, the MMP shall identify nursing facility residents who may have the desire and/or opportunity to return to the community, based on, but not limited to, self- or provider referral, MDS results, and predictive modeling. b. The MMP shall conduct a Discharge Opportunity Assessment for these enrollees within 30 days of enrollee identification or referral.	Health risk assessment P&P includes these requirements.
126.	For enrollees residing in nursing facilities who are identified as having the desire and/or opportunity to return to the community, the MMP shall: a. Develop a person-centered Community Transition Plan that includes, but is not limited to: i. Identification of community supports; ii. Availability of housing; iii. Safety assessment of residence; iv. Identification of home modification needs; and v. Identification of durable medical equipment needs; b. Assign the enrollee a Transitions Care Manager (TCM) who will: i. Participate in discharge planning meetings; ii. Develop a plan of care; iii. Facilitate referrals to community providers; iv. Conduct a home safety evaluation; and v. Follow the enrollee upon discharge, including a face-to-face home visit within 24 hours of the discharge.	Health risk assessment P&P includes these requirements.
II. Care Coordination		

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A. Care Coordination and Interdisciplinary Care Team		
201.	For enrollees who are eligible for community LTSS or are otherwise determined to be high-risk, the MMP shall: a. Assign a Lead Care Manager (LCM); and b. Make ICM services available.	Care management P&P includes these requirements.
202.	ICM services include, but are not limited to: a. Person-centered care management and coordination from an LCM with physical and/or behavioral health expertise, based on the enrollee's strength-based preferences and needs; b. Creation of an ICP; c. Coordination of a range of home and community-based services as needed, including but not limited to, Peer Navigator services, to the extent that MMP care management staff determines such supports to be necessary and beneficial; d. For enrollees with intellectual and developmental disabilities (I/DD) who are receiving out-of-plan services excluded from the capitation rates, coordination of those out-of-plan services as part of the ICP; e. Home safety checks as determined by a CFNA; and f. Provider payment incentives by the MMP to support ICM goals and objectives.	Care management P&P includes these requirements.
203.	The LCM will: a. Conduct the CFNA; b. Oversee creation of the ICT with appropriate participants, reflecting both in- and out-of-plan services, as appropriate; c. Convene a telephonic or in-person meeting of the ICT, if appropriate and necessary, to discuss the enrollee's needs and preferences; d. Hold in-person or telephonic ICT meeting(s) on an as needed basis, including any time the enrollee experiences a significant change in condition (e.g. hospitalization or loss of caregiver) and qualifies for ICM; e. Develop and implement the ICP in collaboration with the ICT; f. Share the ICP with the enrollee, the enrollee's family and/or caregiver	LCM P&P includes these requirements.

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	(with enrollee consent), and appropriate members of the ICT; g. Coordinate service delivery among all providers associated with the enrollee's care, including but not limited to providers of medical, LTSS, and behavioral health services, and providers or out-of-plan services; h. Follow up with providers to obtain necessary test and treatment results, or other information about the enrollee's health status; i. Provide or link enrollees to self-management and disease management education; j. Review and update the ICP periodically as needed, assessing progress toward achieving enrollee-centered goals and outcomes, and making appropriate revisions in collaboration with the enrollee and the enrollee's providers as the enrollee's condition and needs change; k. Provide information and engage in discussion with enrollees to help inform decisions about use of medical resources, including the emergency room; and l. Make referrals for services and assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies.	
204.	Care coordination for low- and moderate-risk enrollees includes, but is not limited to: a. Routine support from Enrollee Services staff, who will facilitate contact with care management services as requested or needed by the enrollee; b. Wellness services, provided and documented by the PCP at least annually in the enrollee's medical record; c. As appropriate, sharing of health and wellness information with the ICT, the enrollee, a caregiver if desired by the enrollee, the PCP, and any other relevant providers as determined by the PCP or the enrollee; d. Peer Navigator services, to the extent that MMP Care Management staff determines such services to be necessary and beneficial; and e. Targeted support from MMP Care Management or Enrollee Services staff, to be designated by the MMP at the time the enrollee is identified as	Care management P&P includes these requirements.

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	being in need of support.	
205.	The MMP shall assemble an ICT for each enrollee based on the enrollee's person-centered needs. The ICT will: a. Serve as a communication hub to coordinate both in-plan and out-of-plan services across the full continuum of care, including but not limited to primary, specialty, behavioral health, and LTSS; b. Support transitions from hospital or nursing facility to community, under the direction of the LCM, as applicable; c. Collaborate across all physical, behavioral, and social support disciplines with attention to coordinated provision of: i. Enrollee education and self-management support; ii. Behavior change techniques and motivational interviewing practices when delivering services to enrollees; iii. Medication management; iv. Coordination of community-based services and supports; v. Referrals, as desired by the enrollee and as appropriate, to end-of-life services and supports; and vi. Changes in the enrollee's condition when additional multidisciplinary planning is necessary and potentially beneficial; d. Promote the delivery of care management services in an integrated fashion at the practice level; and e. Promote the use of performance data at the individual and the population-based level to promote incentives to improve care delivery.	ICT P&P includes these requirements.
206	The MMP will provide training to LCMs on: a. Interdisciplinary care coordination; and b. Key LCM responsibilities.	P&P for LCM training includes these topics.
207	For Enrollees eligible for LTSS or otherwise determined to be high-risk: a. The ICT shall include: i. The enrollee; ii. The LCM; and	P&P for ICT includes these requirements.

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	iii. The PCP. b. The ICT may include, as appropriate and applicable: i. Family members and/or caregivers; ii. Behavioral health specialist; iii. Peer Navigator; iv. Pharmacist; v. Physical, occupational and/or speech therapists; vi. LTSS providers; vii. Health Home care manager, if applicable; and viii. Other key medical specialist or human service providers.	
208	For enrollees not eligible for LTSS and not otherwise determined to be high-risk, the ICT shall include individuals based on the enrollee's needs and preferences, including but not limited to: a. The enrollee; b. Family members and/or caregivers; c. PCP; d. Health Home care manager, if applicable; and e. Behavioral health specialist, if appropriate.	P&P for ICT includes these requirements.
B. Interdisciplinary Care Plan		
209	The MMP shall: a. Develop an ICP for each enrollee eligible for community LTSS or otherwise determined to be at high risk; b. Complete the ICP within 5 calendar days of completion of the CFNA, or sooner, based on the enrollee's needs; and c. Modify the ICP, if necessary, within 5 days after a hospitalization.	Care planning P&P includes these requirements.
210	The ICP shall include, but not be limited to: a. Short- and long-term goals and expected outcomes and measures, including timelines for achievement of goals, and reference to any goals, outcomes, and measures listed in other clinical care plans the enrollee may have outside of the MMP;	Care planning P&P includes these requirements.

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	b. Barriers to service delivery and strategies to address such barriers; c. Measures taken to reduce risks without restricting the enrollee's autonomy to undertake risks to achieve goals; and d. Medical, behavioral, and psychosocial support needs and ICM interventions, including but not limited to: i. Integrated interventions that incorporate medical, behavioral health, LTSS, social service, and community living support needs; ii. Plans for known or anticipated care transitions; iii. Disease management/chronic condition management including, but not limited to, self-management and education; iv. Prevention and wellness goals and strategies; v. Home safety needs, issues, and interventions; vi. Availability of informal support systems, including factors that put the enrollee's informal supports at risk; vii. Specific person(s) and/or any provider agency responsible for delivering LTSS, including back-up plans to the extent possible; viii. Self-directed services and supports; ix. Advanced care planning, if desired by the beneficiary; x. Other needed interventions (e.g. housing, legal, recreational); xi. Signatures (or other indications of consent, where applicable) of all people with responsibility for ICP implementation, including the enrollee and the enrollee's designee, if applicable and with the enrollee's consent, and a timeline for enrollee and/or LCM ICP review signifying ICP acceptance and an intention to follow the ICP; and xii. An emergency after-hours backup plan that ensures that an informal caregiver is available, if needed, from a contracted agency in person 24 hours per day, seven days per week. Such emergency situations include but are not limited to significant change in Enrollee condition, unexpected caregiver absence, fire, or flood.	
211	The MMP shall:	Care planning P&P includes these requirements.

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	a. Distribute copies of the original ICP and ICP updates to the enrollee, the enrollee's family or caregiver, and providers, as appropriate and with enrollee consent; b. For enrollees who were in a RHO plan immediately prior to the Demonstration and who enroll in an MMP not operated by the individual's previous RHO plan, the MMP must obtain the current ICP from the previous RHO plan.	
212	The MMP shall: a. Develop the ICP with an emphasis on leveraging existing caregivers and services and avoiding duplication with existing resources, including but not limited to sources of care management outside of the MMP; b. Write the ICP in a culturally and linguistically appropriate manner that enhances the enrollee's health literacy while considering the enrollee's overall capacity to learn and be self-directed; c. Ensure that the ICP considers processes and strategies for resolving conflict or disagreement within the ICM and care coordination processes; d. Maintain clear conflict of interest guidelines for all ICM participants, as well as a method for the enrollee to request ICP revision; and e. Inform enrollees of their rights and the process to appeal the denial, termination, or reduction of a service.	Care planning P&P includes these requirements.
213	The MMP shall develop a Wellness Plan for enrollees receiving facility-based LTSS who do not desire to return to the community. The Wellness Plan will include, but not be limited to: a. Short- and long-term goals and expected outcomes and measures, including timelines for achievement of goals and reference to any goals, outcomes, and measures listed in other clinical care plans the enrollee may have outside of the MMP; b. Barriers to service delivery and strategies to address such barriers; c. Measures taken to reduce risks without restricting the enrollee's autonomy to undertake risks to achieve goals; and	Care planning P&P includes these requirements.

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	d. Medical, behavioral, and psychosocial support needs, including but not limited to: i. Plans for known or anticipated care transitions; ii. Prevention and wellness goals and strategies; iii. Advanced care planning, if desired by the beneficiary; and iv. ADL needs, goals, and strategies.	
214	The Wellness Plan must be: a. Developed within fifteen (15) calendar days of completion of the Wellness Assessment, or sooner, based on the enrollee's needs; and b. Be modified, if necessary, within five (5) days after a hospitalization.	Wellness Plan P&P
D. Coordination of Services		
215	For enrollees who receive care management from a Health Home, the MMP's LCM will be required to coordinate with the Health Home for both Health Home and MMP services. The Health Home care manager will be a member of the ICT and any Health Home care plan will be integrated into the ICP. The MMP will work with the Health Home to ensure there are no gaps or duplication in services provided to enrollees.	Care coordination P&P describes coordination with Health Homes
216	The MMP has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting 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 includes these requirements.
F. Transitions between Care Settings		
217	The MMP has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning.	Care setting transitions includes these requirements.

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218	For enrollees residing in nursing facilities who wish to move to the community, the MMP will comply with the "Nursing Home Transition Including Rhode to Home" guidelines issued by RI EOHHS regarding nursing facility transitions. The MMP ensures that all community supports, including housing, are in place prior to the enrollee's transition, and providers are knowledgeable and prepared to support the enrollee, including interface and coordination with and among clinical services and community-based LTSS.	Care setting transitions P&P includes these provisions.
III. Confidentiality		
301	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.
302	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.
IV. Enrollee and Provider Communications		
A. General Customer Service & Coverage Determination Hotline		
401	The MMP shall operate a toll-free enrollee services telephone line call center that meets the following requirements: a. The line will be available nationwide for a minimum of 8 am to 8 pm Eastern Time, seven days per week; b. Customer service representatives must be available in sufficient numbers to support enrollees and meet CMS and State-specified standards; and c. The MMP makes oral interpreter services available to enrollees and prospective enrollees in all non-English languages spoken by enrollees free-of-charge.	Enrollee services telephone line P&P includes these provisions.
402	The MMP's customer service representatives shall, upon request, make available to enrollees and potential enrollees information 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/or provider(s) to challenge or appeal the failure of the MMP to provide a requested benefit and to appeal any adverse actions (denials);	Enrollee services telephone line P&P includes these provisions.

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	d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. The process by which an enrollee can access the Enrollee Ombudsman and 1-800-Medicare; f. Information on all MMP-covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and g. The procedures for an enrollee to change MMPs or to opt out of the Demonstration.	
403	The MMP shall employ customer service representatives (CSRs) who are trained: a. To answer inquiries and concerns from enrollees and prospective enrollees; b. In the use of TTY, video relay services, remote interpreting services, and how to provide accessible PDF materials, and other alternative formats; and c. To speak directly with, or arrange for someone else to speak with, enrollees in their primary language or through a telephone translation service.	Enrollee services telephone line P&P includes these provisions.
B. Pharmacy Technical Support Hotline		
404	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)'s documentation demonstrates that the PBM is prepared for increased call volume resulting from Demonstration enrollments.
405	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.
V. Enrollee Protections		
A. Enrollee Rights		
501	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.
502	The MMP notifies enrollees of their rights and protections at least annually and 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.

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		Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability to understand.
503	The MMP will cooperate with and assist the Enrollee Ombudsman in the performance of Ombudsman functions.	P&P includes these requirements.
504	The MMP does not discriminate against enrollees due to: a. Medical condition; 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 addresses that the MMP will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.
505	The MMP informs providers and its claims processing, member services, and billing staff of the prohibition against balance billing. This is articulated through: a. Policies and procedures; b. Staff training modules; and c. Provider training modules.	Enrollee rights P&P explains that the MMP informs beneficiaries that they should not be balanced billed. Training materials for both providers and staff cover this rule.
506	The MMP staff receives training on enrollee protections, including but not limited to: a. The MMP's organization and coverage determinations; b. The MMP's appeals and grievance processes; and c. The role of the Enrollee Ombudsman.	P&P on enrollee protections training includes these topics.
507	The MMP informs enrollees of their right to reasonable accommodations.	Enrollee rights P&P states that the MMP informs enrollees of their right to reasonable accommodations.
B. Appeals and Grievances		
508	The MMP provides enrollees with reasonable assistance with: a. Filing appeals and grievances; and b. Contacting the Enrollee Ombudsman.	P&P explains to the extent to which the MMP will assist an enrollee in filing an appeal or grievance and contacting the Enrollee Ombudsman.
509	The MMP has a P&P for addressing enrollee grievances that includes the following:	Grievances P&P includes these specifications.

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	a. Enrollees are entitled to file grievances directly with the MMP; b. The MMP resolves all grievances, or reroutes improperly filed grievances to the coverage decision or appeals process as appropriate; c. The MMP has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals; and d. The MMP has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.	
510	The MMP maintains P&Ps for enrollee appeals other than Part D appeals that include the following: a. The MMP accepts appeals from enrollees for up to 90 calendar days from the date of denial notice to file a MMP Appeal; b. Initial appeals must be filed with the MMP; c. If the MMP upholds its initial denial of a Medicare service (after two consecutive levels of non-emergency medical care Appeals), it will automatically forward the appeal to the Medicare Independent Review Entity (IRE); d. For Medicaid-only benefits, if the resolution following the MMP appeal process is not wholly in favor of the enrollee, the enrollee or his/her authorized representative may request a State Fair Hearing within 30 calendar days from the MMP's notice of disposition; e. For services for which Medicare and Medicaid overlap, if the resolution following the MMP Appeal process is not wholly in favor of the enrollee, the MMP will forward the appeal related to these services to the IRE; and f. In the case of a decision where both the State Fair Hearing agency and the IRE issue a ruling, the MMP shall be bound by the ruling that is most favorable to the enrollee.	Appeals P&P includes these requirements.
511	a. The MMP is required to continue Medicare benefits other than Part D pending the resolution of the MMP internal appeal process and the Medicare IRE process. b. The MMP is required to continue Medicaid-only and Medicare-Medicaid overlap benefits pending the resolution of the MMP appeal process if the appeal is filed with the MMP within 10 calendar days of the Notice of Action	Appeals P&P includes these requirements.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
	or prior to the date of the action. c. The MMP is required to continue Medicaid-only benefits pending the resolution of the State Fair Hearing process if the enrollee files an appeal with the State Fair Hearing agency within 10 calendar days of the Notice of Disposition from the MMP or prior to the date of the action. d. The MMP is required to continue Medicare-Medicaid overlap benefits pending resolution of the State Fair Hearing process, if the resolution of the Medicare IRE is not wholly in favor of the enrollee, and the enrollee files an appeal with the State Fair Hearing agency within 10 calendar days of the IRE's notice of decision.	
512	a. For appeals of non-emergency medical care, the MMP must decide the appeal within fifteen (15) calendar days of all necessary information being received by the MMP. b. If the initial decision is against the enrollee, the MMP must offer the enrollee a second level of appeal, which the MMP must decide within fifteen 15 calendar days of all necessary information being received by the MMP. c. When the MMP determines, or a treating provider who serves the enrollee indicates, that application of the time frames for a standard appeal could seriously jeopardize the Enrollee's life, health, or ability to maintain or regain maximum function, the MMP must decide the appeal within 2 calendar days. d. For Medicare-Medicaid overlap services, if the Enrollee requests a State Fair Hearing for his/her Medicaid benefits, the MMP will resolve standard appeals will be resolved within ninety (90) calendar days of the date the Enrollee filed the hearing request, not including the number of days the Enrollee took to file for a State Fair Hearing; or 72 hours.	Appeals P&P that includes these specifications.
513	The MMP's Part D appeals process under the Demonstration is consistent with the requirements under 42 CFR § 423 Subpart M.	Part D appeals P&P that include these requirements for processing appeals.
C. Enrollee Choice of PCP		
514	The MMP notifies enrollees about the process for choosing their primary care provider (PCP), including the enrollee's right to select his or her PCP and the right to select a specialist who performs primary care functions as a PCP.	PCP selection and assignment P&P includes these provisions.
VI. Organizational Structure and Staffing		

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
A. Organizational Structure and Staffing		
601	Each MMP must establish at least one enrollee advisory committee: a. For which there is a process for the committee to provide input to the MMP's governing board; b. That meets quarterly and is open to all enrollees; and c. The membership of which reflects the diversity of the Demonstration enrollee population, including enrollees who have disabilities.	P&P for enrollee advisory committee meets these requirements.
602	The MMP's Quality Improvement (QI) committee includes physicians, behavioral health providers, and providers with expertise in LTSS, geriatrician, and others, who represent a range of health care services used by enrollees in the target population.	QI committee charter or P&P demonstrates that the MMP meets this requirement.
B. Sufficient Staff		
603	The MMP demonstrates that it has sufficient employees and/or contractors to complete IHS' and CFNAs for enrollees within the required timeframes through its staffing plan. The staffing plan must explain: a. The MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
604	The MMP staff, contractors, and providers performing enrollee assessments have the appropriate education and experience for the subpopulations (e.g., experience in LTSS or behavioral health).	Job descriptions or P&P includes these requirements.
605	The MMP demonstrates that it has sufficient employees and/or contractor staff to meet the care management needs of the target population through its staffing plan. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the MMP believes will be needed to perform the function; c. In what timeframe the MMP will staff to the level indicated; and d. Ratios of care managers to enrollees, and how those ratios were	The MMP demonstrates that it meets the requirements of the criterion.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
	established	
606	a. For Enrollees with a primary medical condition(s), the LCM must be a qualified individual with physical health expertise. b. For enrollees with a primary mental illness or substance use disorder, the LCM must be a qualified individual with behavioral health expertise.	LCM P&P includes the required qualifications.
607	The MMP demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the MMP believes will be needed to perform the function; c. How the MMP derived that estimate; and d. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
608	The MMP demonstrates that it has sufficient employees and/or contractor staff to handle its enrollee services phone line through its staffing plan. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the MMP believes will be needed to perform the function; c. How the MMP derived that estimate; and d. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
609	The MMP Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	P&P or medical director job description includes requirement includes these medical director responsibilities.
C. Staff Training		
610	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.	The MMP's P&P on cultural competency and disability training meets these requirements.
611	The MMP staff is 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	The MMP's P&P describes training on critical incident and abuse reporting and includes these topics.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
	supports providers.	
612	The MMP's staff is trained on HIPAA compliance obligations and the MMP's confidentiality guidelines.	The MMP's P&P addresses training on HIPAA compliance and confidentiality guidelines.
613	The MMP or PBM has scripts for its 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 o. Service area information.	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See State specific MOU for details)
614	The MMP trains enrollee services telephone line staff 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 PCP; c. Knowledge of services available through the MMP; d. Assisting enrollees to make appointments; e. How to refer to emergency and crisis services; and f. Handling or directing enrollee inquiries, grievances, and appeals.	P&P or training modules demonstrate that the MMP trains its enrollee services telephone line staff personnel on these topics.
VII. Performance and Quality Improvement		

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
701	The MMP collects and tracks reports of critical incidents and abuse of enrollees receiving LTSS in a home and community-based setting.	P&P describes the MMP's system for collecting and tracking such reports.
VIII. Provider Credentialing		
801	MMP credentialing and re-credentialing standards must be consistent with 42 CFR §438.214, 42 CFR §422.204, and NCQA standards. In order to minimize administrative burdens on MMPs and providers, MMPs must employ a single, uniform provider credentialing application that will be developed with the input from MMPs and stakeholders and be approved by the State.	Provider credentialing P&P includes these requirements.
802	Prior to contracting with a new provider, the MMP considers and/or verifies the following information about the provider: a. The provider has a valid license to practice medicine, when applicable; b. The provider has a valid DEA certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. The provider has malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss, when applicable; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions, when applicable; i. Medicare or Medicaid sanctions; and j. Malpractice history, when applicable.	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.
803	The MMP requires that 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.
IX. Provider Network		
A. Establishment and Maintenance of Network, including Capacity and Services Offered		
901	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	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.

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	providers required to furnish the contracted services, including LTSS providers; and d. Whether providers are accepting new enrollees.	
902	The MMP has a P&P that states that it establishes a panel of PCPs from which enrollees may select a PCP.	P&P describes PCP requirements and minimum required numbers of PCPs for counties or other plan areas and for sub-populations of enrollees if applicable.
903	The MMP has a P&P 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.
904	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 opinions from in-network and out-of-network providers.
905	The MMP ensures that enrollees have access to the most current and accurate information by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality.
B. Accessibility		
906	The MMP medical, behavioral, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the MMP alerts its enrollees of providers able to accommodate enrollees with disabilities.
C. Provider Training		
907	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 social model of disability, the independent living philosophy, and the recovery model;	P&P on provider training includes each of the listed elements.

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	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.	
908	The MMP provides training to all its network providers on the following topics: a. Linguistic and cultural competency; b. Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities; c. Accessibility to the office; d. Accessibility along public transportation routes, and/or providing enough parking; and e. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities. f. Coordinating with behavioral health and LTSS providers; g. Information about accessing behavioral health and LTSS; and h. Lists of community supports available.	P&P on provider training includes these topics.
909	The MMP has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	MMP's P&P addresses this requirement.
910	The training program for PCPs includes: a. How to identify behavioral health needs; and b. How to identify LTSS needs.	The MMP's P&P for PCP training includes these topics.
D. Provider Handbook		
911	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;	Each of the listed elements is included in the provider handbook.

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	h. Mandatory reporting; i. Enrollee Ombudsman services; j. Provider billing and reporting; k. Role of the Enrollment Counselor; l. Fraud, Waste and Abuse; and m. Marketing Guidelines.	
912	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).
E. Ongoing Assurance of Network Adequacy Standards		
913	The MMP ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, 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.	Network provider P&Ps and/or contract templates that include these provisions.
914	The MMP has a policy and procedure that states that it 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.
X. Monitoring of First-Tier, Downstream, and Related Entities		
1001	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 plan should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities, and 42 CFR §422.504 (i), the Medicare Advantage regulation governing contracts with first tier, downstream, and related entities.	Monitoring plan provides information on how the MMP monitors all first-tier, downstream, and related entities.

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XI. Systems		
A. Data Exchange		
1101	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 information; f. Provider data; and g. Prescription drug event (PDE) data.	Baseline documentation should illustrate that the required data types in a) – g) can and will be electronically exchanged along with the MMP's policies and procedures for securing, processing, and validating the exchange of these data elements.
1102	The MMP or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator.	Baseline documentation must include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator.
1103	The MMP reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website.	Baseline documentation must include the MMP's clinical care quality P&P for reviewing and acting upon the Part D monthly patient safety reports.
B. Data Security		
1104	The MMP has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation must illustrate that the MMP has a disaster recovery and business continuity plan in place.
1105	The MMP facilitates the secure, effective transmission of data.	Baseline documentation must include: 1. MMP's Data Security and Privacy P&P; and 2. MMP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. 3. Documentation of processes to document a breach in data integrity and any associated corrective actions.
1106	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.
1107	The MMP complies with all applicable standards, implementation specifications,	Baseline documentation must include:

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	and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	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 populated in provider system.
C. Claims Processing		
1108	The MMP systems and operational workflows have the capability to: a. Process accurate, timely, and HIPAA-compliant claims, adjustments and payments net of patient share; b. Adjudicate and track cross-over claims, (e.g., a SNF stay that exceeds maximum Medicare billable days with Medicaid benefits covering the remaining days); and c. Manage pended claims within timeframes that support prompt payment requirements.	Baseline documentation must include: 1. Claims systems description or screenshots that illustrate the claims system ability to process claims payments net of patient share and distinguish Medicare and Medicaid cross-over benefits. 2. Claims processing P&P that details claims processing steps and turnaround timeframes, including the management of pended claims. .
1109	The MMP processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and community-based or facility-based LTSS claims adjustment.	Baseline documentation must include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and community-based or facility-based long term services.
1110	The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation must include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation must also include metrics used to monitor and evaluate claims processing performance and capacity. 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.

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1111	The claims system benefit structure and associated fee schedule includes all medical, community-based or facility-based LTSS, HCBS waiver (or equivalent), Medicare, and Medicaid services.	Baseline documentation must illustrate the MMP's process and plan for loading and validating the Demonstration fee schedules and benefits.
1112	The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over the counter drugs.	Baseline documentation must 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 Medicare Part D and Medicaid prescription and Medicaid 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.
D. Claims Payment		
1113	The MMP pays 95% of "clean medical and LTSS claims" within 30 days of receipt.	Baseline documentation must include: 1. Claims P&P that describes clean claims payment standards. 2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims.
1114	The MMP or its PBM 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's PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	Baseline documentation must include: 1. PBM claims P&Ps that describe clean claims payment standards. 2. PBM P&Ps that define interest payments for clean claims that do not meet the processing timeframe standards.
1115	The MMP or its PBM assures 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 must include PBM pharmacy network provider P&Ps that detail the timeframe for submission of MMP sponsor claims from long term care facilities.
1116	The MMP's claims processing system checks claims payment and pricing logic to	Baseline documentation must include a description of

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	identify erroneous payments.	system edits and reports to identify claims processing trends and anomalies used to identify and correct erroneous claims payments
E. Provider Systems		
1117	The system generates and maintains records on 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. ADA-Accessibility of provider office; and k. Credentialing information.	Baseline documentation must include core provider system screen shots highlighting where each of these data elements are captured. Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications.
F. Pharmacy Systems		
1118	The MMP (or its PBM) generates and maintains or ensures that: a. Its PBM generates and maintains records on the pharmacy network information, including locations and operating hours. b. Its PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies in the MMP's pharmacy provider directories. c. The MMP or its PBM sends out notification to members of no longer participating pharmacies.	Baseline documentation must include: The MMP or its PBM's P&P for maintaining records on pharmacy networks including locations, operating hours and no longer participating pharmacies. This information should include the timeframes and method for ensuring that in-active pharmacy records are removed from provider directory listings. The pharmacy network website screenshots illustrating that operating hours are displayed for pharmacy locations. The PBM's P&P for sending notification to members of no longer participating pharmacies.
1119	The MMP audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a regular basis in those instances where the MMP subcontracts the maintenance of the pharmacy network.	Baseline documentation must 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

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		monitoring.
1120	The PBM can submit Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation must include: 1. The 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.
1121	The PBM ensures that pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and enrollee identifiers.	Baseline documentation must 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.
1122	The MMP ensures that the PBM's claims adjudication system and processes: a. Distinguishes between filling prescriptions for Part D drugs and non-Part D drugs; b. Appropriately meets the 90-day Part D and the non-Part D transitional fill requirements for drugs prescribed in an outpatient setting.	Baseline documentation must include: 1. The PBM's P&Ps for supporting the transitional fill requirements. 2. Evidence of systems capability to support both Part D and non-Part D formularies and transitional fill requirements. 3. The MMP's P&P for oversight of the PBM performance on transitional fills.
1123	The MMP's PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine drugs that are covered under the Demonstration and ensure continuity of care and access to medication for the Demonstration enrollees in the event the PBM systems are inaccessible.	Baseline document must include the PBM's disaster recovery and business continuity plan for confirming enrollee benefit coverage, ensuring that contracted pharmacies are able to determine what drugs are covered under the Demonstration, and that enrollees receive their required medications when pharmacies cannot access the PBM systems.
G. Enrollment Systems		
1124	The MMP receives, processes, and reconciles in an accurate and timely manner: a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and b. The benefit and enrollment maintenance file from the state.	Baseline documentation must include the MMP's P&P on processing and reconciling enrollment files. Documentation must also include the MMP's enrollment systems schematic that details the daily enrollment processing capacity.
1125	If the MMP receives a CMS DTRR with confirmation of a successfully processed	Baseline documentation must include the MMP's P&P for

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	enrollment transaction that is missing 4Rx data, the MMP submits a 4Rx transaction (TC 72) to RI EOHHS (or its vendor) within 72 hours of receipt of the DTRR. The 4Rx data elements are: a. RxBIN – Benefit Identification Number; b. RxPCN – Processor Control Number; c. RxID – Identification Number; and d. RxGRP – Group Number.	creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.
1126	The MMP's enrollment/enrollee system includes each of the following data elements: a. Name; b. Date of birth; c. Gender; d. Telephone #; e. Permanent residence address; f. Mailing address; g. Medicare #; h. ESRD status; i. Other insurance COB information; j. Language preference and alternative formats; k. Authorized representative contact information; l. Employer or union name and group number; m. Option to request materials in a language other than English or in alternate formats; and n. Medicaid #.	Documentation must include screenshots of the MMP's enrollment/enrollee system that confirms each data element listed is available in the system.
1127	For passive enrollments, the MMP sends the following to the enrollee 30 days prior to the effective date of coverage: a. A MMP-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the MMP; c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and	Baseline documentation must include the MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.

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	d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the enrollee may begin using MMP services as of the effective date of enrollment.	
1128	For passive enrollments, the MMP sends the following to the enrollee no later than the last calendar day of the month prior to the effective date of coverage: a. A single plan ID card for accessing all covered services under the MMP; and b. A Member Handbook (Evidence of Coverage).	Baseline documentation must include the MMP's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC). The MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.
1129	For opt-in enrollments, the MMP provides the following materials to the enrollee no later than ten days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later: a. A comprehensive integrated formulary; b. A combined provider and pharmacy directory; c. A single plan ID card; and d. A Member Handbook (Evidence of Coverage).	Baseline documentation must include the MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The MMP should also illustrate how they systematically track when these materials are sent.
H. Care coordination and Care Quality Management Systems		
1130	The MMP utilizes predictive modeling software that utilizes available claims data and evidence-based algorithms to stratify enrollees into low-, moderate-, and high-risk categories. With regard to predictive modeling data, the MMP can demonstrate that: a. The predictive modeling software stratifies enrollee's needs based on acuity as well as risk for hospitalization or nursing facility placement. b. Include a thorough analysis of claims, encounter and other data sources from 12 months of data. When 12 months of data doesn't exist for a particular enrollee, the MMP may determine alternate methods for stratifying risk for the enrollee. c. At least monthly the MMP will conduct an ongoing data sweep and subsequent review of claims data for all enrollees to identify at-risk enrollees who may benefit from care management. d. Use predictive modeling data and other resources (e.g. referrals) for each	Baseline documentation must include an overview of the MMP's tools and methodology for predictive modeling. Additional documentation should include policies and procedures for supporting the activities details in (a) – (d).

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	enrollee not eligible for a LTSS to determine if and when a CFNA is needed.	
1131	The system generates and maintains records necessary for care coordination, including: a. Enrollee data (from the enrollment system); b. Enrollee risk level as determined by the MMP's predictive modeling tools and resources; c. Integrated care team membership and preferred contact information; d. Enrollee assessments (with risk scoring where applicable) for IHS, CFNA, MDS, and the discharge opportunity assessment; e. Enrollee integrated care plan; f. The enrollee's ICP comprehensively documents the needs and interventions, goals, expected outcomes, barriers, and risk mitigation strategies; and g. Reporting and analyses capabilities to measure performance at the individual enrollee and population based level for improving care delivery.	Baseline documentation must include: 1. A process workflow including screenshots of the care coordination systems that confirms the ability to capture the required care coordination data elements and functionality as detailed. 2. Description of enhancements that will be made to customize systems to facilitate the requirements of this criterion and a projected delivery timeframe.
1132	The MMP maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include the MMP's help desk and application support P&Ps for managing issues related to the care coordination system.
1133	The MMP verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation must include the MMP's P&P for ensuring data quality in the care coordination system. The MMP should provide evidence such as a screenshot that illustrates the audit trail tracking of the date and person making the changes/corrections in the system.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
1134	The MMP will promote the sharing of care coordination data and information with providers through tools and solutions that include but are not limited to: a. Secure messaging, health information exchange and other technologies for supporting care integration. b. Access to enrollee assessments and ICPs for the enrollee's ICT and any of the enrollee's other providers if the enrollee has signed a consent to release form.	Documentation must include: 1. The MMP's P&P for securing and providing access to the enrollee care plan information. 2. The MMP's workflow processes and a description of solutions for meeting elements (a) and (b).
1135	The MMP has a mechanism to alert the LCM of an enrollee's ED use, inpatient admission, nursing facility admission, and any critical incidents to support the required follow-up activities upon discharge.	Baseline documentation must the MMP's P&P for tracking ED and inpatient admissions and notifying the LCM. Note: this should include the required notification timeframe for both admission types.
1136	The MMP complies with all requirements regarding reporting of critical incidents to the State and CMS.	Documentation must include the MMP's P&P for managing and reporting critical incidents to the State and CMS as required.
XII. Utilization Management		
A. The MMP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services		
1201	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.
1202	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: must be covered in accordance with clinical coverage guidelines specified in 1 T.A.C. Section 353.2., i.e. 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's guidelines, policies or procedures based on applicable standards of care and as approved by HHSC if necessary, for the diagnosis or treatment of a	The MMP's UM program description includes these definitions of medical necessity.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
	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 age-appropriate growth; and c. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the MMP will apply the definition of medical necessity that is the more generous to the enrollee of the applicable Medicare and Texas's Medicaid standards.	
1203	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 for the MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.
1204	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 for the MMP and the MMP's PBM.
1205	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.
1206	The MMP: a. Outlines its process for authorizing out-of-network services; and b. If specialties necessary for enrollees are not available within the network, the MMP will make such services available out-of-network.	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.
1207	The MMP describes its processes (e.g., periodic training, provider newsletters) for communicating to all providers which services require prior authorization and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization.	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures.
1208	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 member education and	The MMP's practice guidelines P&P includes these requirements.

1.Criteria Number	2. Readiness Review Criteria	3. Suggested Evidence
	service coverage.	
B. The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.		
1209	The MMP has a policy and procedure for appropriately informing enrollees of coverage decisions, including tailored strategies for communicating with 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.
1210	For the processing of requests for initial and continuing authorizations of covered services, the MMP: a. Has in place and follow written policies and procedures; b. Has in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consults with the requesting provider when appropriate.	The UM program descriptions for the MMP explains the process for obtaining initial and continuing authorizations for services.
1211	The MMP ensures that prior authorization requirements are not applied to: a. Emergency 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; and g. Out-of-area renal dialysis services.	The UM program descriptions for the MMP lists those services that are not subject to prior authorization.
1212	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. For overlap services, the MMP follows the three-way contract.	The UM program description for the MMP includes these requirements.
1213	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.