Medicare-Medicaid Capitated Financial Alignment Demonstration
MMP Readiness Review

December 17, 2012

Agenda

- Introduction
  - Overview of monitoring strategy
  - Description of readiness review and goals
- Overview of readiness review
  - Steps in readiness review process
  - Timeline
- Discussion of key areas and criteria in readiness review plan
- Questions

Introduction: Oversight Strategy

The readiness review is one aspect of the multi-pronged oversight strategy for preserving and strengthening Medicare-Medicaid enrollees' access to and quality of care under the Financial Alignment Demonstration.

Introduction: Oversight Strategy

- Base requirements:
  - MMPs must meet core Medicare and Medicaid requirements, State procurement requirements, and State insurance rules (as applicable).
- Readiness review:
  - Prior to enrollment, CMS and the State will perform an assessment of each MMP's operational capacity and ability to offer high quality, coordinated care while adhering to all federal and State laws and regulations.
  - CMS has contracted with NORC, at the University of Chicago (NORC) to assist in developing and conducting the readiness review process.
  - CMS and the State will make the final determination of MMP readiness.

Introduction: Oversight Strategy

- Implementation monitoring:
  - At regular intervals throughout the implementation process, MMPs must meet implementation milestones as a condition for receiving future enrollments.
  - Failure to meet key implementation measures will stop passive enrollment or trigger other corrective actions.

Introduction: Oversight Strategy

- Ongoing monitoring:
  - Over the course of the demonstration, a contract management team composed of CMS and the State representatives will ensure that MMPs continue to adhere to program requirements and provide comprehensive, high-quality services in all aspects of the beneficiary experience.

Introduction: Readiness Review

A State-specific readiness review protocol represents the expected universe of criteria CMS and the State will consider.

- All MMPs will be measured according to a core set of readiness criteria.
  - CMS and the State will take an MMP's experience and past performance into account in developing the MMP-specific readiness review plan. An MMP may be exempt from certain criteria.
- Regardless of an MMP's experience, every readiness review will assess a MMP's capacity and ability to provide person-centered services to enrollees.
- The readiness review will not duplicate the extensive reviews that took place during the MMP selection phases.

Introduction: Readiness Review

- **Staffing capacity:** Each readiness review will review staffing to assess whether the organization is hiring or contracting with a sufficient number of qualified staff to serve the diversity and complexity of the targeted population.
- **Provider and pharmacy networks:** The readiness review will confirm that the plan has an appropriate provider network with the capacity to serve the population. Part of the assessment will include surveying a sample of an MMP's network providers to assure compliance with the Americans with Disabilities Act.
- **Systems capacity:** We will perform systems testing to assess whether the MMP's enrollment, payment, and claims processing systems can accommodate the anticipated enrollment volume.

Introduction: Readiness Review

- **Person-first services:** Ensure that the MMPs are prepared to provide coordinated, integrated care in a person-centered manner to enrollees. This includes having policies in place that:
  - Require the use of person-first language;
  - Reinforce beneficiary roles and empowerment;
  - Adhere to the Americans with Disabilities Act;
  - Develop a culturally competent provider network that meets the diversity of the target population;
  - Reflects independent living philosophies; and
  - Promotes recovery-oriented models of behavioral health services.

Steps in the Readiness Review Process

1. Documentation request
2. Desk review
3. Systems testing
4. Provider network validation review
5. Site review (including provider ADA compliance survey and/or site visit)
6. Notification to MMPs of deficiencies
7. Correction of deficiencies by MMPs
8. Joint determination of readiness by CMS and the State

Step 1: Document Request

- Before desk review begins, CMS, the State and the CMS contractor (NORC) will:
  - Customize readiness review criteria based on MMP experience and past performance;
  - Identify outstanding MMP deficiencies from Medicare Financial Alignment Demonstration applications; and
  - Generate and send documentation request (desk review letter) to MMPs to submit materials, including evidence of MMP systems testing.

Step 1: Document Request (cont'd)

- MMPs will upload all documents for the desk review to a secure website maintained by NORC.
- For each criterion, MMPs must identify the document(s) that meet the criterion and the relevant page number(s) in the documents.
- All documents must be identified by name and date.

Step 2: Desk Review

- Once the documents have been submitted, NORC, in consultation with CMS and the State, will:
  - Determine whether the MMP has corrected application deficiencies;
  - Assess whether review criteria are “met” or “not met” and document reason;
  - Determine whether a site review is recommended;
  - Generate site review scope; and
  - Identify areas where additional pre-implementation or implementation/on-going monitoring is needed.

Step 3: Systems Testing

- Ensures MMP's systems meet the business requirements of the State's demonstration.
- MMPs are required to provide documentation of systems testing output that shows compliance with scenarios.
  - Example of scenario: An enrollee is authorized by Medicaid FFS to receive 8 hours of assistance by a home health aide five days a week. The home health agency that provides the aide is out-of-network. During the first week of the enrollee's enrollment she receives the services.
- If MMP provides documentation of system functionality from a test environment, it must also provide documentation showing when the functionality will be migrated and operational in the live environment.

Step 4: Network Validation

- Will occur subsequent to the desk review and no sooner than 3 weeks after rates have been released.
- Includes review of HSD tables of executed provider network.
- For Medicare provider types not found deficient, review of sample of signature pages.
- For Medicaid providers (LTSS and BH), review of signature pages for selected contracts.

Step 5: Site Reviews/Provider ADA Compliance

- On-site with the MMP and claims processing vendor (if applicable) or over the phone.
- Each site review will include some questions that are based on the MMP's desk review.
- Includes:
  - Interviews with key staff of the MMP and claims processing vendor (if applicable);
  - Tests of selected systems; and
  - On-site visits of selected provider facilities to determine ADA-compliance.

Step 6: Notification to MMPs of deficiencies

- NORC will:
  - Compile deficiencies found during each phase of the readiness review (desk review, site review, network validation review, systems testing, and provider ADA compliance survey);
  - Analyze the deficiencies and make an overall assessment of the MMP's performance on the readiness review; and
  - Submit a readiness review report to CMS and the State.
- CMS and the State will make a joint determination about an MMP's deficiencies.
- The MMP will be notified of its deficiencies, including the reasons why criteria were found "not met."

Step 7: Correction of deficiencies by MMPs

- MMP will have 14 days from the deficiency notification letter to correct deficiencies.
- To correct a deficiency, MMP will submit the specific document(s) listed in the notification letter for that deficiency (e.g., an updated P&P or a signed P&P).
- MMPs will upload documents to NORC's website.

Step 8: Joint determination of readiness by CMS and the State

- NORC will:
  - Review and assess the documents submitted by the MMP; and
  - Make a recommendation to CMS and the State on whether the documents are sufficient to cure the deficiencies and the MMP has passed readiness review
- CMS and the State will reach a joint determination of MMP readiness.
- The MMP will be notified of the joint readiness determination.

Readiness Review Preliminary Timeframes

Readiness Review Step	Timeframe*
MMPs receive desk review letter, including system testing scenarios	[Depends on the State]
MMPs respond to document request in the desk review letter and complete systems testing	14 – 28 calendar days following receipt of the desk review letter
MMPs submit HSD tables for fully contracted network and sample of Medicaid and Medicare contract pages	At least 21 calendar days following publication of rates
MMPs receive letter informing them of the specific plan for on-site visit	14 calendar days prior to site visit
NORC/CMS/State conduct site visit	2 days on site at MMP; may also be site visits of subcontractors and provider practices for ADA compliance
MMPs are notified of any deficiencies	Following CMS/State review of readiness report and supporting documentation (a minimum of 3 weeks after site visit)
MMPs address deficiencies	14 calendar days after MMPs receive deficiency notices
CMS and State make final determination of readiness	7 days following MMP's submission of responses

** Timeframes subject to change and depend on the State-specific timeline*

Major Content Areas in General Readiness Review

1. Assessment processes
2. Care Coordination
3. Enrollment
4. Provider network
5. Systems
6. Confidentiality
7. Enrollee and provider communications
8. Enrollee protections
9. Organizational structure and staffing
10. Performance and quality improvement
11. Program integrity
12. Provider credentialing
13. Qualifications of first tier, downstream and related entities
14. Utilization management
15. Financial soundness

Assessment Processes

Key Review Areas:

- Continuity of care during transition to the MMP (e.g., first 90 or 180 days of enrollment). Reviewers will assess if the MMP:
  - Evaluates enrollees' needs on a timely basis;
  - Has policies and procedures for assuring continuity of care; and
  - Provides temporary coverage of out-of-network services, drugs, and providers.
- MMP is prepared to conduct in-person assessments of enrollees' needs within the required timeframe using appropriate assessment tools.

Care Coordination

Key Review Areas:

- MMP is prepared to coordinate care through care coordinators as specified in the State's MOU with CMS (MOU).

- Reviewers will assess whether:
  - MMP is prepared to implement the Model of Care (as modified by the State)
  - Enrollees have access to an Interdisciplinary Care Team (ICT) to coordinate care that is built on the enrollee's specific preferences and needs and delivers services with linguistic and cultural competence;
  - MMP has person-specific plan of care policies and procedures;
  - MMP has policies for care coordination monitoring and auditing and procedures for improvement; and
  - MMP has processes in place to ensure care is consistently provided during transitions between care settings.

Enrollment

Key Review Areas:

- MMP has processes to assure that enrollees receive required new enrollee materials in the appropriate timeframes;
- MMP has policies to address non-response to initial contact;
- Enrollees receive sufficient information and assistance in response to inquiries made of the MMP during enrollment process;
- MMP has sufficient capacity to handle expected enrollment; and
- Care disruption is minimized for those who transition out of the demonstration.

Provider Network

Key Review Areas:

- Determine whether the MMP provider network:
  - Is large and diverse enough to ensure enrollee access to all medically necessary demonstration benefits; and
  - Meets the State's geographic access standards for LTSS and behavioral health providers;
- Disability literacy and competency training;
- Provider handbook content adequacy;
- Continuous monitoring of network adequacy; and
- Network compliance with Americans with Disabilities Act.

Systems

Key Review Areas:

- Data Exchange;
- Data Security;
- Enrollment Systems;
- Claims Processing;
- Claims Payment;
- Provider Systems;
- Pharmacy Systems;
- Encounter Data Systems; and
- Care Coordination Systems.

Systems (cont'd)

- Review team will assess whether the MMP's systems can accommodate the anticipated volume of enrollment and claims processing.
- Two phases of systems review
  - Review of documentation submitted by the MMP to demonstrate compliance with the criteria in the MMP-specific readiness review plan; and
  - For specified systems testing scenarios to be run by the MMP, review of dummy remittance advices submitted by the MMP as documentation of adjudication of claims.

Enrollee and Provider Communications

Key Review Areas:

- MMP's enrollee services telephone line operates during the hours required by CMS and the State;
- MMP provides training to enrollee services telephone line representatives as necessary to meet the needs of the enrollees under the demonstration;
- MMP has a compliant website or webpage; and
- MMP operates a provider services line and a pharmacy technical help desk during the required hours.

Enrollee Protections

Key Review Areas:

- All enrollees are made aware of their rights and receive notification of those rights; and
- MMP has appeals and grievances policies and procedures that meet the requirements of the demonstration.

Organizational Structure & Staffing

Key Review Areas:

- MMP has sufficient and qualified leadership and staff (both employed and contractual) to meet the demo requirements.
- Reviewers will assess:
  - Staffing adequacy and hiring plans for key positions and key functions such as assessments, call center operations, care coordination, coverage determinations, and grievances and appeals;
  - Qualifications and competencies for key positions and certain other staff (such as care coordinators);
  - Key committees and boards reflect the needs of the target population; and
  - Sufficient training resources for all required competencies.

Performance and Quality Improvement

Key Review Areas:

- MMP is prepared to report the required quality measures; and
- MMP has a plan to monitors the performance of all first-tier, downstream, and related entities.

Program Integrity

Key Review Areas:

- MMP has a program integrity plan to minimize fraud and abuse; and
- MMP continuously monitors for fraud and abuse.

Provider Credentialing

Key Review Areas:

- The MMP's provider credentialing process meets the State's requirements; and
- The MMP's polices and procedures cover licensure, certification, training, history, sanctions.

Utilization Management

Key Review Areas:

- MMP utilizes the definitions of “medical necessity” required under the State-CMS MOU;
- MMP’s policies and procedures for coverage determinations, including timelines and qualifications of staff involved, are consistent with demonstration requirements;
- MMP has a process for approving out-of-network services in accordance with the demonstration; and
- MMP has a process for adoption and dissemination of practice guidelines.

Questions?

Contact Information

Medicare-Medicaid Coordination Office
Centers for Medicare & Medicaid Services
7500 Security Boulevard, S3-12-28
Baltimore, MD 21244
Email:
MMCOCAPsmodel@cms.hhs.gov