Financial Alignment Capitated Readiness Review
Washington Capitated Readiness Review Tool

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

CMS and the State of Washington have developed a state-specific readiness review tool based on stakeholder feedback received through letters and public meetings, the content of the Memorandum of Understanding signed on November 25, 2013 and applicable Medicare and Medicaid regulations.

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

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

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

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

Criteria #	Readiness Review Criteria	Suggested Evidence
I. Assessment		
A. Transition to New MMIP and Continuity of Care		
101	The Medicare-Medicaid Integration Plan (MMIP) ensures that: a. The enrollee may maintain his or her current providers as follows: i. For ESRD services, Nursing Facilities, Adult Family Homes and Assisted Living Facilities: 180 days from the effective date of enrollment, or until an ICP is completed, whichever is later. ii. For all other services, 90 days from the effective date of enrollment, or until an ICP is completed, whichever is later. iii. For enrollees with a HCBS service plan or a Medicaid Personal Care service plan, through HCBS authorization period (with the exception of Adult Family Homes and Assisted Living Facilities which follow the 180-day continuity of care period). b. During the transition period, the MMIP may change an enrollee's existing provider only under the following circumstances: i. The enrollee agrees to the change; ii. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid; or iii. The MMIP, CMS, or the state identifies provider performance issues that affect an enrollee's health and welfare.	Continuity of care plan includes these provisions.
102	After the applicable transition period, the MMIP will enter into Single Case Agreements with out-of-network providers: a. That are providing an ongoing course of treatment to continue to care for the enrollee; and b. If both the MMIP and the provider agree to the terms.	Continuity of care plan includes these provisions.
103	The MMIP reimburses an out-of-network provider of emergent or urgent care, as defined by 42 CFR §424.101 and 42 CFR §405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services.	Continuity of care plan should include these provisions**.**
104	The MMIP assures that, with the exception of Part D drugs, all prior approvals for drugs,	Continuity of care plan includes these provisions.

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	therapies, or other services existing in Medicare or Medicaid at the time of enrollment: a. Will be honored for the later of the applicable transition period or the completion of an ICP ; and b. Will not be terminated at the end of the applicable transition period without advance notice to the enrollee and transition to other services, if needed. c. Will not be terminated, suspended or reduced unless the Plan provides 10 days notice prior to the termination, suspension or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met.	
105	The MMIP assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug.	P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug.
106	The MMIP assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 30-day supply.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
107	The MMIP assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.
108	The MMIP 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.	Transition plan P&P defines a time period (within 3 business days) when it must provide Enrollees with notice about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary.
B. Assessment		
109	The MMIP stratifies enrollees into one of three risk levels, defined as follows: a. Tier One- Supported Self-Intervention, which includes enrollees who: i. Are not stratified into Tiers Two or Three; and ii. Are not receiving LTSS; b. Tier Two- Disease/Episodic Care Management, which includes enrollees who: i. Have chronic diseases that pose low to moderate risks for acute episodes	Risk stratification P&P includes these requirements.

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	ii. Have cognitive deficits; iii. Have traumatic brain injury; iv. Have no informal resources; v. Are homeless; vi. Have an anxiety diagnosis; vii. Frequently call 911 for assistance; viii. Have frequent hospitalizations/ER use; ix. Have had a psychological hospitalization in the past year; or x. Are receiving paid assistance with ADL's; and c. Tier Three- Intensive Care Management For Enrollees with Special Health Care Needs, which includes enrollees who: xi. Have a PRISM risk score of 1.5 or greater; and xii. Have at least one chronic condition.	
110	The MMIP will base the risk level assigned to an enrollee on the enrollee's: a. Initial and Secondary Screen; b. Health Risk Assessment; c. Predictive Modeling; d. PRISM risk score; and e. Utilization data.	Risk stratification P&P includes these requirements.
111	The MMIP has a policy and procedure that it will: a. Administer an Initial Health Screen to Tier One and Tier Two enrollees: i. Within 30 days of enrollment; and ii. That collects information about the enrollee's: 1. Medical, psychosocial, LTSS, functional, and cognitive needs; and 2. Medical and behavioral health (including substance abuse) history; and b. Document when it does not comply with these requirements for the Initial Health Screen for Tier One and Tier Two enrollees.	Health screen P&P includes these requirements.
112	The MMIP has a policy and procedure that it will: a. Administer a Secondary Health Screen to Tier One and Tier Two enrollees immediately, but no later than 10 days after the Initial Health Screen if warranted:	Health screen P&P includes these requirements.

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	i. By a positive result on the Initial Health Screen for chemical dependency, mental health, or long term services and supports; or ii. Based on clinical judgment; and b. Document when it does not comply with these requirements for the Secondary Health Screen for Tier One and Tier Two enrollees.	
113	The MMIP will administer a Health Risk Assessment (HRA): a. For Tier One enrollees, within 60 days of enrollment when the initial and secondary health screening indicate a need for the HRA; b. For Tier Two enrollees, when the initial and secondary health screens indicate a need for the HRA. The HRA must be conducted: i. Face-to-face in the enrollee's home or place of their choice; and ii. Within 60 days of enrollment; and c. For Enrollees With Special Health Care Needs, if the enrollee's PRISM score is 1.5 or more: i. Face-to-face in the enrollee's home or place of their choice; and ii. Within 30 days of enrollment.	Health Risk Assessment P&P includes these requirements.
114	The MMIP will administer an ongoing HRA: a. For Tier One enrollees: i. At least annually or whenever an enrollee experiences a major change in health; b. For Tier Two enrollees: i. At least once every six months or whenever an enrollee experiences a major change in health; and ii. Face-to-face on an annual basis in the enrollee's home or place of their choice; c. For Tier Three enrollees: i. At least once every four months or whenever an enrollee experiences a major change in health; and ii. Face-to-face on an annual basis in the enrollee's home or place of their choice; and d. Prior to these timeframes if warranted by a potential change in tier level as determined by PRISM and utilization data analysis.	Health Risk Assessment P&P includes these requirements.

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115	The MMIP has a policy and procedure that requires staff to coordinate screening and assessment visits as much as possible to minimize the burden on the enrollees.	P&P includes these requirements.
116	The MMIP will administer a Patient Activation Measure (PAM) for Tier Three enrollees, which will be used to work with the enrollee to develop a HAP, as follows: a. Within 30 days of enrollment; and b. After the initial PAM, update every 4 months while the enrollee is receiving intensive care management services.	P&P for PAM includes these provisions.
117	The MMIP ensures that it has the capacity to administer assessments and reassessments in a format suitable to the enrollee's preferences and abilities.	Assessment P&P explains how the MMIP will adapt its risk assessment tool, including format, language, and mode of communication, etc. to the specific needs of the target population. Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current enrollees.
118	The MMIP has policies for staff to follow up and to document when an enrollee refuses to participate in a comprehensive assessment.	Assessment P&P explains how staff from the MMPMMIP will respond to those enrollees who decline to participate in a comprehensive assessment. Assessment P&P describes how theMMIP staff will assist enrollees who require additional prompting/guidance about participating in the assessment (e.g., enrollees with co-morbidities such as mental health and substance abuse issues along with physical disabilities). Assessment P&P explains how the MMIP will monitor those enrollees who decline to participate in the risk assessment process.
II. Care Coordination		
A. Care Management and Interdisciplinary Care Team (ICT)		
201	The MMIP assures that every enrollee: a. Has a Care Manager or Intensive Care Coordinator; and	Care coordination P&P defines how an ICT is formed for each enrollee and how the enrollee and/or his or

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	b. Has access to an Interdisciplinary Care Team (ICT).	her caregiver are involved in determining the ICT.
202	The MMIP will ensure that Tier Level One enrollees are provided: a. A Care Manager; b. Access to an ICT; c. An ICP; d. Receive referral assistance when applicable; and e. Access to the full range of care coordination, including but not limited to: i. Connecting beneficiaries with local community services; and ii. Coordinating referrals for other non-Covered Services, such as supportive housing and other social services.	Care coordination P&P includes these requirements.
203	The MMIP will ensure that Tier Two enrollees are provided: a. Care Management services dedicated to problem-solving interventions; b. An ICP; c. Prevention and wellness messaging and condition-specific education materials; d. Access to an ICT; and e. The full range of care coordination to maximize opportunities for independence in the community, including but not limited to: i. HCBS waiver service planning when applicable; ii. Connecting beneficiaries with local community services; and iii. Coordinating referrals for other non-Covered Services, such as supportive housing and other social services.	Care coordination P&P includes these requirements.
204	The MMIP will ensure that Tier Three enrollees are provided: a. Intensive Care Management provided by an Intensive Care Coordinator; b. An ICP; and c. The full range of care coordination to maximize opportunities for independence in the community, including but not limited to: i. HCBS waiver service planning when applicable; ii. Connecting beneficiaries with local community services; and iii. Coordinating referrals for other non-Covered Services, such as supportive housing and other social services. d. Intensive Care Management, which is defined as “high touch” intensive care	Care coordination P&P includes these requirements.

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	management that uses face-to-face interactions to build essential trusting relationships that will help the enrollee to effectively communicate his/her needs, expectations, and strategies to meet their self-defined health goals. e. Access to an Interdisciplinary Care Team (ICT)	
205	The MMIP assures that the ICT: a. Has the following key competencies: i. Person-centered planning; ii. Cultural competence; iii. Disability; iv. Accessibility and reasonable accommodations; v. Independent living and recovery; and vi. Wellness principles; b. Assures appropriate and efficient care transitions, including discharge planning; c. Assesses the physical, cognitive, social, behavioral, and LTSS risks and needs of each Enrollee; d. Provides Enrollee health education on complex clinical conditions and wellness programs; e. Assures integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate; f. Maintains frequent contact with the Enrollee through various methods including face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and tier level; g. Assists in the development of a ICP within 90 days after enrollment; and h. Assists in the implementation and monitoring of the ICP.	ICT P&P requires each of these requirements.

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206	The MMIP: a. Conducts training for ICT members initially and on an annual basis on: i. The person-centered planning processes; ii. Cultural competence; iii. Accessibility and accommodations; iv. Independent living and recovery; v. ADA/Olmstead requirements; and vi. Wellness principles; b. Has a policy for documenting completion of training by all ICT members, including both employed and contracted personnel, and has specific policies to address non-completion.	P&P for ICT training includes these topic and protocols.
207	The MMIP has policy and procedures for engaging Enrollees who are: a. Difficult to locate; b. Do not respond to initial enrollment efforts; and c. Are at high risk due to treatment noncompliance.	The MMIP's P&P meets these requirements.
208	The MMIP ensures equitable access to care, including working with Enrollees to overcome barriers to access.	The MMIP's P&P meets these requirements.
B. ICP		
209	The MMIP will develop an Individualized Care Plan (ICP) that is: a. Person-centered, integrated, culturally competent, and individualized; b. Jointly created by: i. The enrollee, his/her legal representative, or an individual member of their choice; ii. His/her selected support system; iii. The enrollee's care management team; and iv. The enrollee's interdisciplinary team of care providers;	Care planning P&P outlines a process that describes how the MMIP will involve the enrollee in developing the ICP and will use the information gathered from the assessment(s) of the enrollee in developing the ICP. Care planning P&P states that the MMIP intends to provide person-centered care to all enrollees, and describes strategies for assuring this.

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	c. Incorporates the enrollee's medical, mental health, chemical dependency, LTSS, social, and functional needs; d. Includes the enrollee's identifiable goals; e. For Tier three enrollees, incorporates information from the enrollee's HAP; f. Includes a HCBS service plan, if appropriate; g. Incorporates a holistic, preventative, and recovery focus; and h. Addresses identified gaps in care and barriers to care.	
210	The MMIP has a policy and procedure that: a. For all enrollees, it will develop an Individualized Care Plan (ICP) within 90 days of enrollment; b. For all enrollees, it will update the ICP within 30 days of HCBS eligibility to include applicable services; c. For Tier One enrollees: i. It will contact the enrollee annually; and ii. It will update the ICP annually as part of an annual review for each enrollee; d. For Tier Two and Tier Three enrollees: i. It will contact the enrollee every four months; and ii. It will update the ICP every six months or more often if there are changes in health or functional status.	P&P for ICP includes these provisions.
211	For Tier Three enrollees, the MMIP develops a HAP that: a. Identifies what the enrollee plans to do to improve his or her health and/or self-management of health conditions; b. Contains at least one enrollee-developed and prioritized goal; c. Identifies what actions the enrollee is taking to achieve the goal(s); d. Includes the actions of the Intensive Care Coordinator, including use of health care or community resources and services that support the Enrollee's HAP; e. Includes transitional care planning; f. Is updated every four months; and g. Is incorporated into the ICP.	P&P for HAP includes these provisions.
212	For newly HCBS-eligible enrollees, the MMIP: a. Develops, implements, and monitors a HCBS waiver service plan ;	P&P for HCBS service plan includes these provisions.

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	b. Updates the service plan when an enrollee's needs change; and c. Assures that the MMIP Care Manager or Intensive Care Coordinator coordinates with the DDA case manager for services not included in the demonstration, including service planning with the enrollee.	
213	For existing HCBS-eligible enrollees, the MMIP: a. Maintains the existing HCBS service plan for at least a 90-day transition period unless changed with the consent and input of the enrollee following completion of the Health Risk Assessment; and b. Assures that the Care Manager or Intensive Care Coordinator coordinates the process for changing or updating the HCBS waiver service plan, as appropriate ICT.	P&P for HCBS service plan includes these provisions.
214	The MMIP will ensure that the enrollee receives: a. Any necessary assistance and accommodations to prepare for and fully participate in the care planning process; and b. Clear information about: i. The enrollee's health conditions and functional limitations; ii. How family members and social supports can be involved in the care planning as the enrollee chooses; iii. Opportunities for educational and vocational activities; and iv. Available treatment options, supports and/or alternative courses of care.	Care planning P&P describes how the MMIP will ensure that the enrollee receives necessary assistance and the types of information specified.
215	The MMIP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.	Care planning P&P states that the MMIP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.
C. Health Action Plan (HAP)		
216	The MMIP will develop with enrollees, their caregivers and their ICT a Health Action Plan (HAP) for Tier Three enrollees as follows: a. Within 30 days of enrollment; b. Face-to-face in enrollee's home or place of enrollee's choice; c. After the initial HAP, the HAP is updated every 6 months or if there is a change in circumstances that warrant an update; and d. A new HAP must be developed every 12 months.	P&P for HAP includes these requirements.

Criteria #	Readiness Review Criteria	Suggested Evidence
D. Coordination of Services		
217	The MMIP has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting and preserving evaluations and reports for the care coordination program; and b. Communicating these results and subsequent improvements to MMIP advisory boards and/or stakeholders.	Care coordination P&P explains how and when the MMIP will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to MMIP advisory boards and/or stakeholders.
E. Self-Direction of Services		
218	The MMIP has policies and procedures that ensures that the enrollee or his/her designated representative may: a. Decide how and what LTSS the enrollee will receive to maintain independence and quality of life, subject to coverage rules; b. Select his/her health care providers in the MMIP network (or as allowed for by continuity of care provisions); c. Control care planning and coordination with their health care providers; and d. Hire, fire, and supervise their personal care providers.	Self-direction P&P includes these provisions.
F. Transitions between Care Settings		
219	Intensive Care Coordinators are active participants in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays post hospital/institutional stay home visits and telephone calls.	Care setting transitions P&P includes these protocols.
220	When an enrollee is being discharged from a hospital or other inpatient facility, the MMIP ensures that a Care Manager or Intensive Care Coordinator: a. Works with the facility discharge planner to assure an enrollee has a follow-up medical appointment within seven days of release from the facility; b. Works with the enrollee to ensure that: i. All prescriptions and follow up instructions are followed by the enrollee; and ii. Any additional appointments are scheduled and attended; and c. Ensures that a clinical assessment is provided; and d. The ICP is updated after discharge.	Care setting transitions P&P includes these protocols.

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221	The MMIP 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 P&P explains how the MMIP and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the MMIP monitors transfers and hospital readmissions. Sample report(s) from the MMIP describe how it tracks enrollee transfers and admissions. Care coordination P&P describes the role of the Care Manager or Intensive Care Coordinator in monitoring care setting transitions. Draft Model Data Sharing Agreements
222	The MMIP has a draft model data sharing agreement with hospitals in its provider network.	Draft model data sharing agreement with hospitals
223	The MMIP's protocols for care setting transition planning ensure that: a. An assessment of whether an enrollee has a place to live is completed; b. All community supports are in place prior to the enrollee's move; and c. Providers are fully knowledgeable and prepared to support the enrollee, including interfacing and coordinating with and among clinical services and LTSS. d. A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage enrollees that do not receive post discharge care. e. Confirmation of services identified in the ICP have been implemented within 60 days of the care planning meeting.	Care setting transitions P&P explains how the MMIP ensures that community supports are available prior to an enrollee's move. Care setting transitions P&P explains how the MMIP assesses the qualifications of those providers charged with caring for an enrollee after his or her move. Sample care setting transition plan(s) detail the steps the MMIP takes to ensure continuity of care for an enrollee changing care settings.
224	The MMIP policies for LTSS provider transitions that at a minimum include: a. a schedule which ensure the change in provider does not create a lapse in service; b. A requirement with the LTSS provider which is no longer willing or able to provide services to an enrollee must cooperate with the Contractor to facilitate a seamless transition;	LTSS Transition P&P includes these requirements.

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	c. Process for which the Contractor will follow when an Assisted Living facility or AFH's license is revoked or is closed; d. A mechanism for assuring confidentiality; e. A Mechanism for allowing a member of request and be granted a change of provider; and f. An appropriate schedule for transitioning enrollees from one residential setting to another.	
225	The MMIP helps enrollees transition to another provider if their provider leaves the MMIP's network.	Care coordination P&P and/or provider handbook includes this policy.
226	The MMIP transitions enrollees to new providers, if needed, once the ICP is completed and signed and the continuity of care period is complete.	Care coordination P&P and/or provider handbook includes this policy.
G. **Compliance with HCBS Waiver Requirements**		
227	The MMIP has a process for ensuring that the enrollee's needs identified in the CARE functional assessment tool are addressed and incorporated in the ICP.	Care planning P&P describes how the MMIP will incorporate the HCBS waiver service plan, once available from the State, into the ICP.
228	The MMIP will provide the full range of care coordination including HCBS waiver service planning, connecting enrollees with local community services, and coordinating referrals for other non-Covered Services, such as supportive housing and other social services, to maximize opportunities for independence in the community. A directory of housing and meals resources will be compiled by each MMIP.	MMIP's P&P includes these requirements.
229	For enrollees on a HCBS waiver, the MMIP will provide the full range of services they are eligible to receive in compliance with the 1915(c) waiver including at minimum the number of personal care hours the state CARE tool determination.	Waiver services P&P that includes the authorization process of HCBS waiver services.
230	For enrollees determined newly eligible for HCBS waiver services following enrollment into the MMIP, the MMIP will develop, implement, and monitor the service plan in compliance with the 1915(c) waiver and in conjunction with the ICP.	Monitoring P&P describes how the MMIP will monitor the HCBS waiver services incorporated into the ICP.

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H. Coordination with Local Regional Support Networks, Crisis Lines, Emergency Departments and Counties		
231	The MMIP has written operational agreements, which include data sharing, with State and community physical and behavioral health hospitals, Regional Support Networks, long-term care facilities and inpatient and outpatient Drug and Alcohol Treatment programs for the purpose of facilitating transitions of care for enrollees.	Operational agreement
I. Coordination with DSHS or Its Designee for LTSS		
232	The MMIP has written agreements in place with DSHS or its designee (the Area Agencies on Aging) that define the processes used to communicate LTSS eligibility information.	MOU or business agreement
III. Confidentiality		
301	The MMIP 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 MMIP will safeguard PHI.
302	The MMIP 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 MMIP will safeguard PHI and the provider's role in safeguarding PHI.
IV. Enrollee and Provider Communications		
A. General Customer Service & Coverage Determination Hotline		
401	General Customer Service Hotline for Enrollees: The MMIP maintains and operates a toll-free call center that is available and staffed 24 hours a day, seven days a week that includesthe following services: a. Health and behavioral care advice; b. Triage concerning emergency, urgent or routine nature of health conditions; c. Service authorization; d. Emergency drug supply; and e. medically necessary mental health services.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS, and drugs.
402	The MMIP's customer service department representatives shall, upon request, make available to enrollees and potential enrollees information including, but not limited to, the following:	P&P includes these requirements.

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	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 Participating Plan to provide a covered service and to appeal any adverse actions (denials); d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. Process by which an enrollee can access the Demonstration's Ombudsman, the Washington Medical Assistance Customer Service Center (MACSC) and 1-800-Medicare; f. Information on all MMIP 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 Participating Plans or to opt out of the Demonstration.	
403	Coverage Determination Hotline: The MMIP operates a toll-free call center with live customer service representatives available to respond to providers or enrollees with information related to coverage determinations (including exceptions and prior authorizations), and appeals. The call center must meet all requirements in CMS Marketing Guidelines Appendix 5, including that it must operate during normal business hours and never less than from 8:00 A.M. to 6:00 P.M., Monday through Friday according to the time zones for the regions in which they operate.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times.
404	The MMIP maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency enrollees. In addition: a. The hours of operation for the MMIP's language line are the same for all enrollees, regardless of the language or other methods of communication they use to access the hotline. b. The language line is TDD/TTY accessible.	Contract with language line company includes these requirements, including mandatory hours of operation.
405	The MMIP must employ enrollee service representatives (ESR) who are: a. Trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees; b. Trained in the use of TTY, video relay services, remote interpreting services, and	ESR P&P includes these elements. Training materials for ESRs includes these elements.

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	how to provide accessible PDF materials, and other alternative formats; and c. Capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service.	
B. Pharmacy Technical Support Hotline		
406	The MMIP 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 MMIP (or PBM)'s documentation demonstrates that the PBM is prepared for increased call volume resulting from Demonstration enrollments.
407	The MMIP 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 MMIP has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
502	The MMIP policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.
503	The MMIP will cooperate with and assist the Ombudsman in the performance of Ombudsman functions.	Ombudsman services P&P to include access, providing information about services to enrollees, and training to staff.
504	The MMIP will have written P&Ps respecting the implementation of advance directives and will provide them to all enrollees.	P&P includes these requirements.
505	The MMIP does not discriminate against enrollees due to: a. Medical condition (including physical and mental illness); b. Claims experience;	Enrollee rights P&P addresses that the MMIP will not discriminate against enrollees based on the enumerated reasons.

Criteria #	Readiness Review Criteria	Suggested Evidence
	c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; or g. Disability.	Staff training includes discussion of enrollee rights.
506	The MMIP informs providers and the appropriate staff (i.e., claims processing, member services, and billing staff) on the prohibition on balancing 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 MMIP informs beneficiaries that they should not be balanced billed. Training materials for providers and staff cover this rule.
507	The MMIP has policies and procedures to inform enrollees of their right to reasonable accommodation.	Enrollee rights P&P states that the MMIP informs enrollees of their right to reasonable accommodation.
B. Appeals and Grievances		
508	The MMIP staff receives training on enrollee protections, including but not limited to: a. The MMIP's organization and coverage determination; and b. The MMIP's appeals and grievance processes. c. WA state administrative hearing processes. d. The role of the Ombudsman.	P&P on enrollee protections training includes these topics.
509	The MMIP provides enrollees with reasonable assistance in filing appeals and grievances and how to contact the Ombudsman.	Grievances and appeals P&P explains to the extent to which the MMIP will assist an enrollee in filing an appeal or grievance.
510	The MMIP must provide continuing benefits pending appeal as follows: a. For prior approved Medicare and Medicaid benefits other than Part D, pending the internal MMIP appeal; and b. For Medicaid benefits only, after the internal MMIP appeal, through the IRO or state fair hearing processes as long as the enrollee meet the Washington Medicaid requirements for continuation of benefits.	Appeals P&P meets these continuation of benefits requirements.
511	The MMIP maintains an established process to track and maintain records on all grievances, received both orally and in writing. Records must include, at a minimum, the date of receipt,	Screenshots of or reports from the tracking system in which enrollee grievances are kept that include these

Criteria #	Readiness Review Criteria	Suggested Evidence
	final disposition of the grievance, and the date that the MMIP notified the enrollee of the disposition.	elements. Data summaries or reports that detail the types of reporting and remediation steps that are taken to ensure grievances are correctly handled. Grievances P&P that define how staff from the MMIP should document grievances within the tracking system.
512	The MMIP maintains policies and procedures for addressing enrollee grievances, including following: a. Enrollees are entitled to file grievances directly with the MMIP; b. The MMIP resolves all grievances, or reroutes grievances to the coverage decision or appeals process as appropriate; and c. The MMIP has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals; and d. The MMIP has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.	Grievances P&P that includes these specifications.
513	The MMIP maintains policies and procedures for enrollee appeals other than Part D that include the following: a. The MMIP accepts appeals from enrollees for up to 90 calendar days from the date of the MMIP's notice of action; b. An enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action if the appeals relate to termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services. c. For Medicare services, if the MMP upholds the denial, the MMP will automatically forward the appeal to the IRE; d. For Medicaid-only services, if the MMP upholds the denial, the MMP will automatically forward the appeal to the state Independent Review Organization (IRO); and	Appeals P&P includes these requirements.

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	e. For services for which Medicare and Medicaid overlap, the MMP will automatically forward the appeal to the IRE.	
514	The MMIP resolves internal appeals: a. For standard resolution of appeals and for appeals for termination, suspension, or reduction of previously authorized services, , within 14 days calendar days of filing unless: i. The MMIP notifies the enrollee that an extension is necessary to complete the appeal; ii. For any extension beyond 30 calendar days: 1. The enrollee agrees to the extension; 2. The MMIP shows that the extension is in the enrollee's best interest; and 3. The appeal determination is made within 45 calendar days from the date the MMIP receives the appeal request; and b. For expedited appeals, within 72 hours after the MMIP receives the appeal or as expeditiously as the Enrollee's condition requires.	Appeals P&P that includes these specifications.
515	The MMIP'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		
516	The MMIP 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 ability to select a specialist who performs primary care functions as a PCP.	PCP selection and assignment P&P explains how and when an enrollee may elect a new PCP. PCP selection and assignment P&P explains how PCPs are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.
D. Emergency Services		
517	The MMIP has a back-up plan in place in case an LTSS provider does not arrive as scheduled to provide assistance with activities of daily living.	Emergency services P&P explains how the MMIP is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.
518	The MMIP can connect enrollees with emergency behavioral health services, when	Emergency services P&P addresses how the MMIP is

Criteria #	Readiness Review Criteria	Suggested Evidence
	applicable.	prepared to provide emergency behavioral health services to enrollees in crisis.
519	Appointment standards for urgent and emergent healthcare are as follows: a. Urgent, symptomatic office visits shall be available from the Enrollee's PCP or anther provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening. b. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week. c. Enrollees may access the following urgent and emergent medically necessary mental health services prior to the completion of an intake evaluation: Crisis Services; Freestanding Evaluation and Treatment; Stabilization; Rehabilitation Case Management; and Psychiatric Hospitalization.	Emergency Services P&P and/or provider handbook includes these appointment standards for urgent and emergent healthcare.
VI. Organizational Structure and Staffing		
A. Organizational Structure and Staffing		
601	The MMIP must establish at least one independent MMIP enrollee advisory committee and a process for that committee to provide input to the governing board. The MMIP must demonstrate the participation of consumers with disabilities, including enrollees, within the governance structure of the MMIP.	P&P for enrollee advisory committee meets these requirements. Bylaws governing the MMIP's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the MMIP), and that the committee has a process for providing input to the MMIP's governing board.
602	The MMIP's Quality Improvement (QI) committee includes physicians, behavioral health providers, 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 members are appropriate based on the target population described in the CMS-Washington MOU. Note: For MMIPs with current QI committees, review will focus on the change in composition to address the new services (e.g., LTSS and behavioral health).
603	The MMIP's medical director or other designated physician shall have direct responsibility	P&P, job description or other document demonstrates

Criteria #	Readiness Review Criteria	Suggested Evidence
	for and participation in the credential program.	the MMIP meets these requirements.
B. Sufficient Staff		
604	The MMIP demonstrates that it has sufficient employees and/or contractors to complete enrollee assessments, as required (including at least annually), for all enrollees within required timeframes through its staffing plan. The staffing plan must explain: a. The MMIP'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 MMIP believes will be needed to perform the function; d. How the MMIP derived that estimate; and e. In what timeframe the MMIP will staff to the level indicated.	The MMIP demonstrates that it meets the requirements of the criterion through the Readiness Review Staffing Worksheet and other documents as necessary.
605	The MMIP 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 include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description requirements.
606	The MMIP must: a. Establish caseload weights for Care Managers and Intensive Care Coordinators, including a blended overall caseload limit, taking into account the tier levels of the enrollees; and b. Provide its methodology for assigning weights to enrollees to CMS and the state during readiness review for prior approval.	P&P on care management staffing includes these provisions.
607	The MMIP demonstrates that it has sufficient employees and/or contractor staff to meet the care coordination needs of the target population through its staffing plan. The staffing plan must explain: a. The MMIP'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 MMIP believes will be needed to perform the function;	The MMIP demonstrates that it meets the requirements of the criterion through the Readiness Review Staffing Worksheet and other documents as necessary.

Criteria #	Readiness Review Criteria	Suggested Evidence
	d. How the MMIP derived that estimate; and e. In what timeframe the MMIP will staff to the level indicated.	
608	A Care Manager must have one of the following qualifications: a. Registered nurse; b. Master's degree in behavioral health sciences and one year of paid on-the-job social service experience; c. Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social service experience; or d. Bachelor's degree and four years of paid on-the-job social service experience.	Care Manager qualifications P&P includes those listed.
609	An Intensive Care Coordinator must have one of the following qualifications: a. Registered nurse; b. Licensed Practical Nurse; c. Physician Assistant; d. BDW or MSW-prepared Social Worker; e. Chemical Dependency Professional; f. Professional with significant experience working with applicable populations; or g. A clinical or non-clinical professional who has the written approval of HCA and DSHS before they can be an Intensive Care Coordinator.	Intensive Care Coordinator qualifications P&P includes those listed.
610	The MMIP demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight through its staffing plans. The staffing plan must explain: a. The MMIP'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 MMIP believes will be needed to perform the function; d. How the MMIP derived that estimate; and e. In what timeframe the MMIP will staff to the level indicated.	The MMIP demonstrates that it meets the requirements of the criterion through the Readiness Review Staffing Worksheet and other documents as necessary.
611	The MMIP 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. The MMIP's estimate of its enrollment over the enrollment period;	The MMIP demonstrates that it meets the requirements of the criterion through the Readiness Review Staffing Worksheet and other documents as necessary.

Criteria #	Readiness Review Criteria	Suggested Evidence
	b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMIP believes will be needed to perform the function; d. How the MMIP derived that estimate; and e. In what timeframe the MMIP will staff to the level indicated.	
612	The MMIP demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations, including care management hotline through its staffing plan. The staffing plan must explain: a. The MMIP'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 MMIP believes will be needed to perform the function; d. How the MMIP derived that estimate; and e. In what timeframe the MMIP will staff to the level indicated.	The MMIP demonstrates that it meets the requirements of the criterion through the Readiness Review Staffing Worksheet and other documents as necessary.
613	The MMIP Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that the medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. Job description for the medical director includes this responsibility.
C. Staff Training		
614	The MMIP has a cultural competency and disability training plan that comply with CLAS standards to ensure that staff delivers culturally-competent services, in both oral and written enrollee communications (e.g., person-first language, target population competencies).	The MMIP's P&P on cultural competency and disability training meets these requirements.
615	The MMIP staff is adequately trained to handle critical incident and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports	The MMIP's P&P describes training on critical incident and abuse reporting and include these topics.

Criteria #	Readiness Review Criteria	Suggested Evidence
	providers.	
616	The training program for Care Managers and Intensive Care Coordinators includes, but is not limited to: a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. LTSS and process; f. Self-direction of services (as authorized by the state); g. Behavioral health and processes; h. Care transitions; i. Skilled nursing needs/NF processes; j. Abuse and neglect reporting; k. Pharmacy and Part D services; l. Community resources; m. Enrollee rights and responsibilities; n. Independent living philosophy; o. Most integrated/least restrictive setting; p. How to identify behavioral health and LTSS needs; q. How to obtain services to meet behavioral and LTSS needs; and r. State role in enrollment processes.	The MMIP's P&P on training of Care Managers and Intensive Care Coordinators includes these elements.
617	The MMIP's staff is trained on HIPAA compliance obligations and the MMIP's confidentiality guidelines.	The MMIP's P&P addresses training on HIPAA compliance and confidentiality guidelines.
618	The MMIP or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment;	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See State specific MOU for details)

Criteria #	Readiness Review Criteria	Suggested Evidence
	f. Formulary information; g. Pharmacy information, including whether an enrollee's pharmacy is in the MMIP's network; h. Provider information, including whether an enrollee's physician is in the MMIP'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.	
619	The MMIP has protocols or staff training modules to train enrollee services telephone line staff in the following areas: a. Explaining the operation of the MMIP and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Knowledge of services available through the MMIP including HCBS waiver services, behavioral health and nursing facility services. d. Assisting enrollees to obtain services and make appointments; e. How to refer to emergency and crisis services; and f. Handling or directing enrollee inquiries or grievances.	P&P or training modules demonstrate that the MMIP trains its enrollee services telephone line staff personnel on these topics.
VII. Performance and Quality Improvement		
701	The MMIP collects and tracks reports of critical incidents and abuse of enrollees receiving LTSS in a home and community-based long-term care service delivery setting, including: adult day care centers; other HCBS provider sites; and a member's home, if the incident is related to the provision of covered HCBS. The MMIP must have a designated incident manager responsible for meeting the contractual requirements.	The MMIP has a P&P for both mandatory and serious and emergent incident reporting and referrals. The P&P must address the processes and timing of each type of incident.
702	The MMIP is prepared to report all Year 1 Quality Measures required under the Demonstration including all Medicare Advantage (Part C) required measures, HEDIS, HOS,	QI P&P details how the MMIP collects these measures for its enrollees.

Criteria #	Readiness Review Criteria	Suggested Evidence
	CAHPS as well as, measures related to behavioral health, care coordination/transitions, and LTSS, as required by the MOU.	
703	The MMIP provides a draft organizational structure for its Quality Improvement Committee and related quality committees, including reporting structure, responsibilities, and meeting frequency.	Organization charts, flow charts, draft meeting agendas and process for taking and distributing minutes, timeline for quality meetings, sample/example topics.
704	The MMIP provides an outline of its annual quality work plan.	Work plan should contain data elements for goals and objectives, including objectives for enrollee safety; timeframes to complete listed activities, roles and responsibilities, monitoring to assure completion of work plan elements, inclusion of MOC elements that represent under-performance.
705	The MMIP provides a written description of their process for Performance Improvement Projects.	Format of PIPs, description of data analysis that supports PIP, quality indicators, barrier identification, targeted interventions, and evaluation of effectiveness of PIP
VIII. Provider Credentialing		
801	The MMIP: a. Adheres to standards for provider credentialing under 42 CFR § 438.214 and 42 CFR § 422.204; b. Credentials and re-credentials providers in accordance with NCQA credentialing standards; and c. Ensure that all providers and facilities who deliver LTSS meet licensing, certification and qualifications required by: i. The HCBS waiver; ii. DSHS Residential Care Services Administration; iii. ALTSA; and iv. The Department of Health.	Provider credentialing P&P includes these requirements.
802	For enrollees who choose an individual provider (IP), the MMIP will collect, process and	Individual Provider P&Ps related to the contracting

Criteria #	Readiness Review Criteria	Suggested Evidence
	maintain employment related forms to comply with RCW 43.20A.710 and WAC 388-71.	process, verification of the individual right to work, background processing including FBI fingerprinting; collection/review of timesheets; training, termination of payment/contract.
803	Prior to contracting with a new provider, the MMIP considers and/or verifies the following information for 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 MMIP will review these documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.
804	The MMIP requires that all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The MMIP 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 MMIP has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including LTSS providers; d. Whether providers are accepting new enrollees.	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.
902	The MMIP has a policy and procedure and training materials that demonstrate that the	Provider network P&P explains how its primary care,

Criteria #	Readiness Review Criteria	Suggested Evidence
	medical, behavioral, LTSS, and pharmacy provider networks are trained in cultural competency (including language) for delivering services target populations in the Demonstration.	specialty, behavioral health, and LTSS, providers are prepared to meet the additional competencies necessary to serve enrollees within the target population. Provider training materials for all of these groups include modules on cultural competency when serving target populations.
903	The MMIP has a policy and procedure that states that it establishes a panel of primary care providers (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.
904	The MMIP has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.
905	The MMIP provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.
906	The MMIP 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 (for online provider directories).
B. Accessibility		
907	The MMIP medical, behavioral, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the MMIP alerts its enrollees of providers able to accommodate enrollees with disabilities (e.g., MMIPs in provider directory, information available upon request).
908	Medical, behavioral, and LTSS, network providers provide linguistically- and culturally-competent services.	P&P on provider training includes training on cultural competency.
909	Providers receive training in the following areas: a. Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities;	P&P on provider training details special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees.

Criteria #	Readiness Review Criteria	Suggested Evidence
	b. Accessibility to the office; c. Accessibility along public transportation routes, and/or providing enough parking; and d. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities.	
910	For Enrollees with Special Health Care Needs that indicate the need for frequent utilization of a treatment or regular monitoring by a specialist, the MMIP must allow Enrollees to retain specialists as a PCP or allow direct access to a specialist for needed care.	P&P
C. Provider Training		
911	The MMIP 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; 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.	P&P on provider training includes each of the listed elements.
912	The MMIP's training for all providers includes: a. Coordinating with behavioral health and LTSS providers; b. Information about accessing behavioral health and LTSS; and c. Lists of community supports available.	P&P on provider training includes coordination of care, behavioral health services, LTSS, and community supports
913	The MMIP provides training to providers, explaining that their contracts require there be no balance billing under the Financial Alignment Demonstration.	P&P on provider training includes this topic.
914	The MMIP has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	MMIP's P&P addresses this requirement.
915	The training program for primary care providers includes:	The MMIP's P&P for PCP training includes these topics.

Criteria #	Readiness Review Criteria	Suggested Evidence
	a. How to identify behavioral health needs; and b. How to identify LTSS needs.	
D. Provider Handbook		
916	The MMIP 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. MMIP contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; h. Mandatory reporting; i. Ombudsman services; j. Provider billing and reporting; k. Role of the Enrollment Broker; l. Fraud, Waste and Abuse; and m. Marketing Guidelines.	Each of the listed elements is included in the provider handbook.
917	The MMIP 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 MMIP website, information about local organizations serving specific subpopulations of the target population).
E. Ongoing Assurance of Network Adequacy Standards		
918	The MMIP 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 MMIP 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	Network provider P&Ps and/or contract templates that include these provisions.

Criteria #	Readiness Review Criteria	Suggested Evidence
	hours a day, 7 days a week, when medically necessary.	
919	The MMIP 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.
E. Appointment Standards		
920	Behavioral Health: The MMIP ensures that: a. An appointment for the initial mental health intake assessment by a Mental Health Professional shall be offered within ten (10) working days of the request for mental health services by an Enrollee or referral from a provider or Care Coordinator. b. After an initial assessment has been completed, routine mental health services must be offered to occur within 14 days of the determination to initiate mental health services. The time from request for mental health services to first routine appointment must not exceed 28 days, unless the MMIP documents a reason for the delay. c. Comprehensive chemical dependency assessment and treatment services must be provided no later than 14 days after the services have been requested by the enrollee and if the enrollee cannot be placed in treatment within 14 days, interim services must be made available.	P&P includes these requirements.
921	The MMIP ensures that a referral is made to DSHS or its designee within 5 calendar days upon identification through the care coordination process, referral, or by the enrollee that the enrollee has unmet LTSS needs.	P&P includes these requirements.
X. Monitoring of First-Tier, Downstream, and Related Entities		
1001	The MMIP 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 MMIP. 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 MMIP monitors all first-tier, downstream, and related entities.

Criteria #	Readiness Review Criteria	Suggested Evidence
XI. Systems		
A. Data Exchange		
1101	The MMIP is able to electronically exchange the following types of data: a. ICP and HAP; b. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data; c. Claims data (including paid, denied, and adjustment transactions); d. Financial transaction data (including Medicare C, D, and Medicaid payments); e. Third-party coverage data; f. Enrollee demographic information; g. Provider data; and h. Prescription drug event (PDE) data	Baseline documentation should illustrate the types of data that can and will be electronically exchanged along with policies and procedures for securing, processing, and validating the exchange of data including EDI system specifications for transmitting ANSI compliant file formats—e.g., 834, 835, 837 transactions. Supporting documentation should include: 1) Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports. 2) Documentation of rejection thresholds and data reconciliation processes. 3) File layouts for transmitted data illustrating compliance with transmission of required data elements (e.g., Items 2a-2i). 4) Documentation of MMIPs transaction sets with CMS, the State, and other third party vendors, including where transaction are compliant with HIPAA versioning standards—e.g., HIPAA Version 5010.
1102	The MMIP or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator.	Baseline documentation should include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. Supporting documentation should include transaction facilitator certification documentation for its FIR.
1103	The MMIP reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website.	Baseline documentation should include the MMIP's quality of care policies and procedures for reviewing and acting upon the Part D monthly patient safety

Criteria #	Readiness Review Criteria	Suggested Evidence
		reports.
B. Data Security		
1104	The MMIP has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation should include a copy of the MMIP's disaster recovery and business continuity plan and an inventory of the core systems specifically used to operate this Demonstration. 1. Supplemental documentation may include proof of disaster recovery plan validation and testing.
1105	The MMIP facilitates the secure, effective transmission of data.	Baseline documentation should include: 2. MMIP's Data Security and Privacy P&P; and 3. MMIP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. 4. Documentation of processes to document a breach in data integrity and any associated corrective actions.
1106	The MMIP 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 MMIP complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	Baseline documentation should include: 1. MMIP 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 MMIP processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates. This includes a process and timeframe for managing pended claims.	Baseline documentation should include: 1. Claims processing P&P that details claims processing turnaround timeframes, steps for

Criteria #	Readiness Review Criteria	Suggested Evidence
		managing pended claims, including turnaround times, and methods for ensuring claims processing accuracy. 2. Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.).
1109	The MMIP 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 should 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 should include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation should highlight the basis for MMIP estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by MMIP staff without affecting performance standards. Supplemental documentation may include statistics on average claims processed per processor, annual average of claims per enrollee (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity.
1111	The claims system fee schedule includes all medical, community-based or facility-based LTSS, home and community-based services (HCBS), Medicare and Medicaid services.	Baseline documentation should illustrate the following: 1. MMIP's process and plan for loading and validating the Demonstration fee schedules. 2. Screen shots of the modules where the fee

Criteria #	Readiness Review Criteria	Suggested Evidence
		schedules will be configured and identify how medical, community-based or facility-based LTSS and HCBS Medicare, and Medicaid services are captured within the system.
1112	The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over the counter drugs.	Baseline documentation should include: 1. The MMIP'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. 3. Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs.
D. Claims Payment		
1113	The MMIP pays 95% of "clean medical and LTSS claims" within 30 days of receipt.	Baseline documentation should 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 MMIP 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	Baseline documentation should include: 1. PBM claims P&Ps that describe clean claims

Criteria #	Readiness Review Criteria	Suggested Evidence
	days of receipt all other claims. The MMIP's PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	payment standards. 2. PBM P&Ps that define interest payments for clean claims that do not meet the processing timeframe standards.
1115	The MMIP 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 should include PBM pharmacy network provider P&Ps that detail the timeframe for submission of MMIP sponsor claims from long term care facilities.
1116	The MMIP's claims processing system checks claims payment logic to identify erroneous payments.	Baseline documentation should include a description of system edits as well as proscriptive and retrospective reporting to identify claims processing trends and anomalies used to identify erroneous claims. Note: If this validation is performed outside of the MMIP, please provide evidence of the contract with the external vendor, as well as oversight P&Ps, and any performance standards.
1117	The MMIP's claims processing system checks for pricing errors to identify erroneous payments.	Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous payments. MMIPs should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits. Note: If this validation is performed outside of the MMIP, please provide evidence of the contract with the external vendor, as well as oversight P&P.
E. Provider Systems		

Criteria #	Readiness Review Criteria	Suggested Evidence
1118	The system generates and maintains records on medical provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. ADA-Accessibility of provider office; and k. Credentialing information; and	Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots illustrating where 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		
1119	The MMIP or its PBM generates and maintains or ensures that its PBM generates and maintains records on the pharmacy networks, including locations and operating hours where the MMIP subcontracts the maintenance of the pharmacy network.	Baseline documentation should include: 1. The MMIP or its PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours. 2. A screenshot or sample of how this information is collected, maintained, and made accessible to enrollees.
1120	The MMIP or its PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies. The MMIP ensures that the PBM performs this function in those instances where the MMIP subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the PBM's P&P for updating/maintaining pharmacy provider network information.
1121	The MMIP 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 MMIP subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the MMIP's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring.
1122	The PBM can submit Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation should include: 1. The PBM P&P that defines the processes and data

Criteria #	Readiness Review Criteria	Suggested Evidence
		submission requirements for Part D PDE reporting. 2. MMIP's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.
1123	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 should include the PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers.
1124	The MMIP 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. c. Ensures that all prior approvals for drugs, therapies will be honored 90 days after enrollment and will not be terminated at the end of the 90 days without advance notice to the enrollee and transition to other drugs or therapies, if needed.	Baseline documentation should 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 PBM's P&Ps for supporting the advance notification and transition to other drugs or therapies prior to the end of the 90 day transition period. 4. The MMIP's P&P for oversight of the PBM performance on transitional fills.
1125	The MMIP'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 should 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.
G. Enrollment Systems		

Criteria #	Readiness Review Criteria	Suggested Evidence
1126	The MMIP 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 should include the MMIP's P&P on processing and reconciling enrollment files. Documentation should also include the MMIP's enrollment systems schematic that details the daily enrollment processing capacity.
1127	If the MMIP receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the MMIP submits a 4Rx transaction (TC 72) to CMS' enrollment 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.	Baseline documentation should include the MMIP's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.
1128	The MMIP's enrollment/member 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. Which plan the enrollee is currently a member of and to which MMIP the enrollee is changing; n. Option to request materials in a language other than English or in alternate formats; and o. Medicaid #.	Documentation should include screenshots of the MMIP's enrollment/member system that confirms each data element listed is available in the system.
1129	For passive enrollments, the MMIP sends the following to the enrollee 30 days prior to the	Baseline documentation should include the MMIP's

Criteria #	Readiness Review Criteria	Suggested Evidence
	effective date of coverage: a. A MMIP-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the MMIP; c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the enrollee may begin using MMIP services as of the effective date of enrollment.	P&P detailing the processes and timeframes for sending the enrollee materials. The MMIP should also illustrate how it systematically tracks when these materials are sent, if applicable.
1130	For passive enrollments, the MMIP 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 MMIP; and b. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the MMIP's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC). The MMIP should also illustrate how it systematically tracks when these materials are sent, if applicable.
1131	For voluntary enrollments, the MMIP 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 should include the MMIP's P&P detailing the processes and timeframes for sending the enrollee materials. The MMIP should also illustrate how they systematically track when these materials are sent.
H. Care Coordination and Care Quality Management Systems		
1132	The system generates and maintains records necessary for care coordination, including: a. Enrollee data (from the enrollment system); b. Enrollee Tier assignment (One, Two, or Three) c. Enrollee HCBS Waiver status (if applicable); d. Provider network; e. Interdisciplinary care team membership for specific enrollees; f. Enrollee assessments; g. Enrollee individual care plan (ICP);	Baseline documentation should include: 1) An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements. 2) Description of software solutions (e.g., care management solutions) that will be used to support the systems infrastructure of the care

Criteria #	Readiness Review Criteria	Suggested Evidence
	h. Health action plan (HAP); i. Patient activation measure (PAM); j. Interdisciplinary care team case notes; k. Pharmacy data and l. Claims information.	coordination process. This includes documentation of enhancements made to customize systems to facilitate management of the Demonstration population. 3) Screen shots of the application(s) / modules(s) that support these requirements. 4) Description of processes used to profile, measure and monitor enrollee profiles. An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements.
1133	The MMIP maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include the MMIP's help desk and application support P&Ps for managing issues related to the care coordination system.
1134	The MMIP verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include the MMIP's P&P for ensuring data quality in the care coordination system.
1135	The enrollee assessments and plans of care are available to enrollee interdisciplinary care teams and any of the enrollee's other providers if the enrollee has signed a consent to release form.	Documentation should include: m. The MMIP's P&P for securing and providing access to the care coordination system. n. The MMIP's workflow processes for making enrollee assessment and plans of care information available to the enrollee's providers.
1136	The MMIP has a mechanism to alert the Care Manager/Intensive Care Coordinator of an enrollee's ED use, inpatient admission, nursing home admission and any critical incidents to support the required follow-up activities upon discharge.	Baseline documentation should the MMIP's P&P for tracking ED and inpatient admissions and notifying the Care Manager/Intensive Care Coordinator. Note: this should include the required notification timeframe for

Criteria #	Readiness Review Criteria	Suggested Evidence
		both admission types.
1137	The MMIP complies with all requirements regarding reporting of critical incidents to the State and CMS.	
XII. Utilization Management		
A. The MMIP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services		
1201	The MMIP specifies procedures under which the enrollee may self-refer services.	The UM program descriptions for the MMIP explains for which services an enrollee can self-refer.
1202	The MMIP 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, "Medically Necessary" is a term for describing service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all. c. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the MMIP will apply the definition of medical necessity that is the more generous to the enrollee of the applicable Medicare and Washington's Medicaid standards.	The MMIP's UM program description includes these definitions of medical necessity.
1203	The MMIP 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 MMIP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.

Criteria #	Readiness Review Criteria	Suggested Evidence
1204	The MMIP has policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description for the MMIP includes these elements for the MMIP and the MMIP's PBM.
1205	The MMIP 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 MMIP explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines).
1206	The MMIP: a. Outlines its process for authorizing out-of-network services; and b. If specialties necessary for enrollees are not available within the network, the MMIP 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 MMIP's network.
1207	The MMIP describes its processes for communicating to all providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The MMIP's provider materials describe prior authorization requirements and procedures.
1208	The MMIP 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 MMIP's members; 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 service coverage.	The MMIP's practice guidelines P&P includes these requirements.
B. The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.		
1209	The MMIP has a policy and procedure for appropriately informing enrollees of coverage decisions, including tailored strategies for enrollees with communication barriers.	Plan management guidelines or the MMIP's UM program describes the type of communications sent to enrollees, regarding their receipt or denial of referrals

Criteria #	Readiness Review Criteria	Suggested Evidence
		of service authorizations.
1210	For the processing of requests for initial and continuing authorizations of covered services, the MMIP shall: a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consult with the requesting provider when appropriate.	The UM program descriptions for the MMIP explains the process for obtaining initial and continuing authorizations for services.
1211	The MMIP 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; g. Out-of-area renal dialysis services.	The UM program descriptions for the MMIP lists those services that are not subject to prior authorization and this list is consistent with the required elements.
1212	The MMIP 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 MMIP follows the three-way contract.	The UM program description for the MMIP 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 MMIP includes this requirement. Resumes for staff who review coverage decisions show that these staff have appropriate competencies to apply MMIP policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.
1214	The MMIP ensures that a physician and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees out of the emergency department, if necessary.	The UM program description for the MMIP states that a physician and behavioral health provider are available 24 hours a day, seven days a week for timely authorization of medically necessary services and to

Criteria #	Readiness Review Criteria	Suggested Evidence
		coordinate transfer of stabilized enrollees in emergencies.