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1. Criteria Number	2. Readiness Review Criteria	3. Example Evidence	4. File/Document Name and Page Numbers/Sections
I. Assessment			
A. Transition to New STAR+PLUS MMP and Continuity of Care			
101.	The STAR+PLUS MMP must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for up to 90 days. Exception shall be made for an enrollee who, at the time of enrollment in the STAR+PLUS MMP, has been diagnosed with and is receiving treatment for a terminal illness and remains enrolled in the Demonstration, in which case the STAR+PLUS MMP shall ensure continued access to covered services for nine months from the time of enrollment.	Continuity of care plan includes these provisions.	*Example of naming convention and page number identification:* *201_506_[plan acronym]_Privacy Notice_20130911 (pg.3)*
102.	The STAR+PLUS MMP's transition requirements ensure that all enrollees who are receiving LTSS, including nursing facility services, at the time of enrollment into the Demonstration receive continued authorization of those services for up to six months after initial enrollment into the Demonstration.	Continuity of care plan includes these provisions.	
103.	If, as a result of the comprehensive health risk assessment, the STAR+PLUS MMP proposes modifications to the services outlined in an enrollee's preexisting Plan of Care and/or Individual Service Plan (ISP) the STAR+PLUS MMP must provide, no less than ten days prior to implementation of the enrollee's updated Plan of Care, written notification of: a. The proposed modifications; and b. The opportunity to appeal the proposed modifications, including the right to a continuation of benefits pending appeal, if applicable.	Continuity of care plan includes these provisions.	
104.	During the applicable transition period, the STAR+PLUS MMP is required to provide	Continuity of care plan includes	

	or arrange for all medically necessary covered services, whether by sub-contract or by single-case agreement, in order to meet the needs of the enrollee.	these provisions.	
105.	The STAR+PLUS MMP must reimburse an out-of-network provider of emergent or urgent care at the prevailing Medicare or Medicaid FFS rate applicable for that service. For services for which Medicaid is the primary payer, the STAR+PLUS MMP must comply with the state's out-of-network provider reimbursement rules.	Continuity of care plan should include these provisions**.**	
106.	The STAR+PLUS MMP assures that, with the exception of Part D drugs, all prior approvals for drugs, therapies, or other services existing in Medicare or Medicaid at the time of enrollment: a. Will be honored for the applicable transition period; and b. Will not be terminated at the end of the applicable transition period without advance notice to the enrollee and, if needed, transition to other services. c. Will not be terminated, suspended or reduced unless the STAR+PLUS MMP 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.	Continuity of care plan includes these provisions.	
107.	The STAR+PLUS MMP assures that, in outpatient settings, within the first 90 days of coverage, it will provide a temporary supply of drugs, when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug. Consistent with the requirements of Chapter 6 of the Prescription Drug Benefit Manual, the temporary supply must be for at least 30 days of medication, unless the prescription is written by a prescriber for less than 30 days	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.	
108.	The STAR+PLUS MMP assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.	
109.	The STAR+PLUS MMP provides written notice to each Enrollee, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary.	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			
110.	The STAR+PLUS MMP stratifies enrollees into one of two risk levels as follows: a. Level 1 for the highest risk enrollees; and b. Level 2 for moderate and lower risk enrollees.	Risk stratification P&P includes these requirements.	
111.	The STAR+PLUS MMPs has a risk stratification process that: a. Uses a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information, as appropriate; and b. Considers enrollees' physical and behavioral health, substance use, and LTSS needs.	Risk stratification P&P includes these requirements. Plans must submit their risk stratification algorithm for HHSC and CMS review.	
112.	The STAR+PLUS MMP conducts an assessment to determine eligibility for HCBS waiver services if: a. The enrollee has an unmet need for at least one waiver service; or b. If requested by the enrollee as part of the comprehensive health risk assessment for all enrollees.	Health risk assessment P&P includes these requirements.	
113.	The STAR+PLUS MMP: a. Administers an initial comprehensive risk health assessment to enrollees within 90 days of enrollment; and b. Uses the results of the assessment to confirm the appropriate risk stratification level for the enrollee and as the basis for developing the Plan of Care.	Health Risk Assessment P&P includes these requirements.	
114.	In administering the health risk assessment, the MMP shall use relevant and comprehensive data sources, including the enrollee, providers, and family/caregivers, as appropriate.	Health Risk Assessment P&P includes these requirements.	
115.	The STAR+PLUS assessment tool will include, at a minimum, the following domains: a. Physical and behavioral health; b. Social needs; c. Functional status; d. Wellness and prevention domains; e. Caregiver status and capabilities; and	Health Risk Assessment P&P includes these requirements	

	f. The enrollees' preferences, strengths, and goals.		
116.	The STAR+PLUS MMP assures that all assessments are conducted by qualified health professionals who possess an appropriate professional scope of practice, licensure, and/or credentials and are appropriate for responding to or helping enrollees manage their service needs, including, but not limited to: a. a registered nurse (RN); b. A nurse practitioner (NP); c. A licensed vocational nurse (LVN); d. A physician's assistant (PA); or e. A person with an undergraduate or graduate degree in social work or a related field).	Health Risk Assessment P&P includes these requirements	
117.	The STAR+PLUS MMP completes a reassessment: a. At least once every 12 months after the initial assessment completion date; b. When there is a change in the enrollee's health status or needs; c. Following a significant health care event; or d. As requested by the enrollee, his/her caregiver, or his/her provider.	Health Risk Assessment P&P includes these requirements.	
118.	The STAR+PLUS MMP updates the Plan of Care when any of the following triggering events occur: a. A hospital admission; b. Transition between care settings; c. A change in functional status; d. Loss of a caregiver; e. A change in diagnosis; or f. As requested by a member of the Service Coordination Team who observes a change that requires further investigation.	Health Risk Assessment P&P includes these requirements	
119.	The STAR+PLUS MMP completes the initial comprehensive assessments and annual reassessments: a. In person for those enrollees stratified to Level 1; b. Telephonically for enrollees stratified to Level 2, unless an in-person assessment is requested by the enrollee, caregiver, or provider.	Health Risk Assessment P&P includes these requirements	

120.	The STAR+PLUS MMP 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 STAR+PLUS MMP 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.	
121.	The STAR+PLUS MMP 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 MMPSTAR+PLUS MMP will respond to those enrollees who decline to participate in a comprehensive assessment, including documenting when an enrollee refuses to participate in a comprehensive assessment.	
II. Service Coordination			
A. Service Coordination and Service Coordination Team			
201.	The STAR+PLUS MMP assures that: a. For each enrollee, the STAR+PLUS MMP supports a Service Coordination Team ("the team"), led by a Service Coordinator. b. In addition to the Service Coordinator, other required members of the team include: a. The enrollee; and b. The enrollee's PCP. c. The team may also include other providers and individuals, including the enrollee's caregiver, as appropriate or by request of the enrollee. d. The Service Coordinator actively collaborates with the enrollee's specialty care providers, including behavioral health and LTSS service providers, as	Service Coordination Team P&P requires each of these requirements.	

	appropriate.		
202.	The STAR+PLUS MMP ensures that: a. All enrollees stratified to Level 1 receive a minimum of two in-person service coordination contacts annually; b. All enrollees stratified to Level 2 receive a minimum of one in-person and one telephonic service coordination contact annually.	P&P for Service Coordination includes these requirements.	
203.	The Service Coordination Team: a. Is person-centered; b. Is built on the enrollee's specific preferences and needs, as identified in the comprehensive risk assessment and outlined in the Plan of Care; and c. Delivers services with transparency, individualization, respect, linguistic and cultural competence, and dignity.	P&P for Service Coordination includes these requirements.	
204.	The STAR+PLUS MMP: a. Conducts training for Service Coordination Team members initially and on an annual basis on: i. The person-centered planning processes; ii. Health Risk Assessments, to include the medical, behavioral, and social needs of enrollees; iii. Cultural competence; iv. Accessibility and accommodations; v. Independent living and recovery; vi. Wellness principles; and vii. ADA/*Olmstead* requirements; b. Has a policy for documenting completion of training by all Service Coordination Team members, including both employed and contracted personnel, as well as timeframes for completion and training methods; and c. Has specific policies to address non-completion of trainings.	P&P for Service Coordination Team training includes these topic and protocols.	
B. Plan of Care			

205.	The STAR+PLUS MMP has a policy and procedure that the Plan of Care: a. Is developed by the STAR+PLUS MMP Service Coordinator, with the enrollee, his/her caregiver and/or family supports, PCP, and other members of the Service Coordination Team; b. Addresses all the health and social needs of the enrollee, as identified in the comprehensive health risk assessment; c. Contains: i. The enrollee's health history; ii. A summary of current, short-term, and long-term health and social needs, concerns, and goals; and iii. A list of required services, their frequency, and a description of who will provide such services.	Care planning P&P includes these requirements.	
206.	The STAR+PLUS MMP ensures that the Plan of Care is in place at the later of: a. 90 days after enrollment; or b. Upon receipt of all necessary eligibility information from the State.	P&P for Plan of Care includes these provisions.	
207.	The STAR+PLUS MMP: a. Continuously monitors the Plan of Care; b. Addresses any gaps in services in an integrated manner, including by making any necessary revisions to the Plan of Care; and c. Updates the Plan of Care annually regardless of any mid-year revisions.	P&P for Plan of Care includes these provisions.	
208.	The STAR+PLUS MMP is required to: a. Conduct an annual reassessment; b. Update the Plan of Care prior to its expiration date; and c. If the Plan of Care has not been updated by the expiration date, continue all services under the Plan of Care until updating occurs.	P&P for Plan of Care includes these provisions.	
209.	The STAR+PLUS MMP has a policy and procedure that states that the Plan of Care: a. Includes, as applicable and consistent with enrollee preferences:, coordination with the enrollee's family and community support systems, including Independent Living Centers, Area Agencies on Aging (AAAs), and Mental Retardation Authorities, as applicable;	P&P for Plan of Care includes these provisions.	

	b. Is agreed to and signed by the enrollee or the enrollee's legally authorized representative (LAR) to indicate agreement with the plan; c. Allows for financial management services and promotes self-determination; and d. May include information about accessing services outside of Demonstration-covered services, such as affordable, integrated housing.		
210.	The STAR+PLUS MMP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the Plan of Care.	Care planning P&P states that the STAR+PLUS MMP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the Plan of Care.	
D. Coordination of Services			
211.	The STAR+PLUS MMP has a process to monitor and audit service coordination that includes, at a minimum: a. Documenting evaluations and reports for the service coordination program; and b. Communicating these results and subsequent improvements to STAR+PLUS MMP advisory boards and/or stakeholders.	Care coordination P&P explains how and when the STAR+PLUS MMP will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to STAR+PLUS MMP advisory boards and/or stakeholders.	
E. Self-Direction of Services			
212.	The STAR+PLUS MMP ensures that enrollees may have the opportunity to direct their own services for certain LTSS services, including both employer and budget authority. Enrollees will choose a financial management service agency (FMSA) to assist with these activities.	Self-direction P&P includes these provisions.	
F. Transitions between Care Settings			
213.	When an enrollee is being discharged from a hospital or other inpatient facility, the STAR+PLUS MMP ensures that a member of the Service Coordination Team:	Care setting transitions P&P includes these protocols.	

	a. Works with the facility discharge planner to assure an enrollee has a follow-up medical appointment ; 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. Updates the Plan of Care after discharge.		
214.	The STAR+PLUS MMP has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning.	Care setting transitions P&P explains how the STAR+PLUS MMP and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the STAR+PLUS MMP monitors transfers and hospital readmissions.	
215.	The STAR+PLUS MMP'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; 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 is implemented; and e. Services identified in the Plan of Care have been implemented within 60 days of the transition.	Care setting transitions P&P includes these provisions.	
216.	The STAR+PLUS MMP helps enrollees transition to another provider if their provider leaves the STAR+PLUS MMP's network.	Service coordination P&P and/or provider handbook includes this policy.	
217.	The STAR+PLUS MMP transitions enrollees to new providers, if needed, once the Plan of Care is completed and signed and the continuity of care period is complete.	Service coordination P&P and/or provider handbook includes this policy.	
G. **Compliance with HCBS Waiver Requirements**			

218.	For HCBS waiver-eligible enrollees: a. The Service Coordinator will work with the enrollee to develop an Individual Service Plan (ISP). b. HCBS waiver service planning includes: i. Determining the individual's needs; goals, and preferences; ii. Determining service levels; iii. Maintaining costs and cost ceilings; iv. Reviewing services; and v. Obtaining approval for planned services. c. The ISP will be incorporated into the enrollee's overall Plan of Care.	P&P for HCBS ISP includes these provisions.	
219.	The STAR+PLUS MMP has a process for ensuring that the enrollee's STAR+PLUS HCBS Waiver service needs identified in the MN/LOC assessment tool and documented in the ISP are addressed and incorporated into the Plan of Care.	Care planning P&P describes how the STAR+PLUS MMP will incorporate the STAR+PLUS HCBS waiver ISP, once available from the State, into the Plan of Care.	
220.	For enrollees eligible for STAR+PLUS HCBS Waiver services, the STAR+PLUS MMP will provide the full range of services they are eligible to receive.	Waiver services P&P that includes the authorization process of HCBS waiver services.	
221.	For enrollees determined newly eligible for STAR+PLUS HCBS Waiver services following enrollment into the STAR+PLUS MMP, the STAR+PLUS MMP will develop, implement, and monitor the ISP in conjunction with the Plan of Care.	Monitoring P&P describes how the STAR+PLUS MMP will monitor the STAR+PLUS HCBS waiver services incorporated into the Plan of Care.	

III. Confidentiality			
301.	The STAR+PLUS MMP provides a privacy notice to enrollees, which explains the policies and procedures for the use and protection of protected health information (PHI).	Sample privacy notice to be sent to enrollees explains how the STAR+PLUS MMP will safeguard PHI.	
302.	The STAR+PLUS MMP provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers explains how the STAR+PLUS MMP will safeguard PHI and the provider's role in safeguarding PHI.	
IV. Enrollee and Provider Communications			
A. General Customer Service & Coverage Determination Hotline			
401.	STAR+PLUS MMPs shall operate a toll-free enrollee services telephone line that meets the following requirements: a. The line must be available statewide a minimum of 8 a.m. to 8 p.m. Central Time, and be staffed by customer service representatives seven days a week, except for weekends and federal and state holidays; b. After hours, on weekends, and on holidays, the toll-free enrollee services telephone line is answered by an automated system that: a. Has the capability to provide callers with operating hours and instructions on what to do in cases of emergency; b. Provides recordings in English, Spanish, and the languages of the other major population groups in the service area; c. Assures that a voice mailbox is available after hours for callers to leave messages; and d. Returns calls received by the automated system on the next business day; c. Has customer service representatives available in sufficient numbers to support current and prospective enrollees and meet CMS and State-specified standards; d. Makes oral interpreter services available in all non-English languages	Enrollee services telephone line P&P includes these provisions.	

	spoken by enrollees free-of-charge; and e. Makes TTY services or comparable services available for people who are deaf or hard of hearing.		
402.	Coverage Determination Hotline: The STAR+PLUS MMP 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.	
403.	The STAR+PLUS MMP's customer service representatives shall, upon request, make available to enrollees and potential enrollees information including, but not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Enrollees' rights and responsibilities; c. The procedures available to an enrollee and/or provider(s) to challenge or appeal the failure of the STAR+PLUS MMP to provide a requested benefit 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. The process by which an enrollee can access the Ombudsman, the HHSC enrollment broker, and 1-800-Medicare; f. Information on all STAR+PLUS MMP covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and g. The procedures for an enrollee to change MMPs or to opt out of the Demonstration.	P&P includes these requirements.	
404.	The STAR+PLUS MMP 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 STAR+PLUS MMP'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 STAR+PLUS MMP must employ customer service representatives (CSRs) who are: a. Trained to answer inquiries and concerns from enrollees and prospective enrollees; b. Trained in the use of TTY, video relay services, remote interpreting services, and 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.	CSR P&P includes these elements. Training materials for CSRs includes these elements.	
B. Pharmacy Technical Support Hotline			
406.	The STAR+PLUS MMP or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume resulting from Demonstration enrollments.	The STAR+PLUS MMP (or PBM)'s documentation demonstrates that the PBM is prepared for increased call volume resulting from Demonstration enrollments.	
407.	The STAR+PLUS MMP ensures that pharmacy technical support is available at any time that any of the network's pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.	
V. Enrollee Protections			
A. Enrollee Rights			
501.	The STAR+PLUS MMP has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.	
502.	The STAR+PLUS MMP policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections.	

		Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.	
503.	The STAR+PLUS MMP will cooperate with and assist the HHSC or Long-Term Care 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 STAR+PLUS MMP has written P&Ps respecting the implementation of advance directives and will provide them to all enrollees.	P&P includes these requirements.	
505.	The STAR+PLUS MMP does not discriminate against enrollees due to: a. Medical condition (including physical and mental illness); b. Claims experience; c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; or g. Disability.	Enrollee rights P&P addresses that the STAR+PLUS MMP will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.	
506.	The STAR+PLUS MMP informs providers and the appropriate staff (i.e., claims processing, member services, and billing staff) on the prohibition against balance billing. This is articulated through: a. Policies and procedures; b. Staff training modules; and c. Provider training modules.	Enrollee rights P&P explains that the STAR+PLUS MMP informs beneficiaries that they should not be balanced billed. Training materials for providers and staff cover this rule.	
507.	The STAR+PLUS MMP has P&Ps to inform enrollees of their right to reasonable accommodation.	Enrollee rights P&P states that the STAR+PLUS MMP informs enrollees of their right to reasonable accommodation.	
B. Enrollee Appeals and Grievances			
508.	The STAR+PLUS MMP staff receives training on enrollee protections, including but not limited to: a. The STAR+PLUS MMP's organization and coverage determination; b. The STAR+PLUS MMP's appeals and grievance processes; c. The HHSC Appeals Division Fair Hearing processes; and d. The role of the Ombudsman.	P&P on enrollee protections training includes these topics.	

509.	The STAR+PLUS MMP provides enrollees with reasonable assistance with: a. Filing appeals and grievances; and b. Contacting the Ombudsman.	Grievances and appeals P&P explains to the extent to which the STAR+PLUS MMP will assist an enrollee in filing an appeal or grievance.	
510.	The STAR+PLUS MMP must provide continuing benefits pending appeal for a previously authorized service if the enrollee files an appeal and requests continuation of benefits within 10 days of the notice of Action.	Appeals P&P meets these continuation of benefits requirements.	
511.	The STAR+PLUS MMP 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, final disposition of the grievance, and the date that the STAR+PLUS MMP notified the enrollee of the disposition.	Screenshots of or reports from the tracking system in which enrollee grievances are kept that include these 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 STAR+PLUS MMP should document grievances within the tracking system.	
512.	The STAR+PLUS MMP has a P&P for addressing enrollee grievances that includes the following: a. Enrollees are entitled to file grievances directly with the STAR+PLUS MMP; b. The STAR+PLUS MMP resolves all grievances, or reroutes grievances to the coverage decision or appeals process as appropriate; and c. The STAR+PLUS MMP has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals; and d. The STAR+PLUS MMP 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 STAR+PLUS MMP maintains P&Ps for enrollee appeals, other than for Part D services, that include the following: a. The STAR+PLUS MMP accepts appeals from enrollees for up to 60 calendar	Appeals P&P that includes these requirements.	

	days from the date of the STAR+PLUS MMP's notice of Action; b. For Medicare services, if the STAR+PLUS MMP upholds the denial, the MMP will automatically forward the appeal to the IRE; c. For Medicaid services, if the STAR+PLUS MMP upholds the denial, the enrollee may appeal to the HHSC Appeals Division d. Enrollees may appeal directly to the HHSC Appeals Division at any time.		
514.	The STAR+PLUS MMP has policies and procedures for resolution of internal appeals as follows: a. For standard service denials, as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date the appeal is filed. b. For expedited appeals, as expeditiously as the enrollee's condition requires, but no later than 72 hours after the STAR+PLUS MMP receives the appeal. c. The STAR+PLUS MMP may extend the timeframes for resolution of internal appeals by up to 14 calendar days if: i. The enrollee requests the extension; or ii. The STAR+PLUS MMP shows (to the satisfaction of the State and/or CMS, upon request) that there is need for additional information and how the delay is in the enrollee's interest.	Appeals P&P that includes these specifications.	
515.	The STAR+PLUS MMP's Part D appeals process under the Demonstration is consistent with the requirements under 42 CFR § 423 Subpart M.	Part D appeals P&P that include these requirements for processing appeals.	
C. Enrollee Choice of PCP			
516.	The STAR+PLUS MMP notifies enrollees about the process for choosing their primary care provider (PCP), including the enrollee's right to select his or her PCP and the 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 select a new PCP. PCP selection and assignment P&P explains how PCPs are assigned to enrollees who do not select a provider and/or who are not capable of selecting a provider.	
D. Emergency Services			

517.	The STAR+PLUS MMP 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 STAR+PLUS MMP is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.	
518.	The STAR+PLUS MMP can connect enrollees with emergency behavioral health services, when applicable.	Emergency services P&P addresses how the STAR+PLUS MMP is prepared to provide emergency behavioral health services to enrollees in crisis.	
VI. Organizational Structure and Staffing			
A. Organizational Structure and Staffing			
601.	Each STAR+PLUS MMP must establish at least one enrollee advisory committee per service area: a. For which there is a process for the committee to provide input to the STAR+PLUS MMP's governing board; b. The membership of which reflects the diversity of the Demonstration enrollee population, including enrollees with disabilities.	P&P for enrollee advisory committee meets these requirements. Bylaws governing the STAR+PLUS MMP's enrollee advisory committee state that individuals with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the STAR+PLUS MMP), and that the committee has a process for providing input to the STAR+PLUS MMP's governing board.	
602.	The STAR+PLUS MMP'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-Texas MOU. Note: For STAR+PLUS MMPs with current QI committees, review will focus on the change in composition to address the	

		new services (e.g., LTSS and behavioral health).	
B. Sufficient Staff			
603.	The STAR+PLUS MMP demonstrates that it has sufficient employees and/or contractors to complete enrollee health risk assessments, as required (including at least annually), for all enrollees within required timeframes through its staffing plan. The staffing plan must explain: a. The STAR+PLUS MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the STAR+PLUS MMP believes will be needed to perform the function; d. How the STAR+PLUS MMP derived that estimate; and e. In what timeframe the STAR+PLUS MMP will staff to the level indicated.	A STAR+PLUS MMP staffing plan, with any other documents as necessary.	
604.	The STAR+PLUS MMP staff, contractors, and providers performing enrollee assessments have the appropriate education and experience for the subpopulations (e.g., experience in LTSS or behavioral health).	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description requirements.	
605.	The STAR+PLUS MMP must: a. Establish caseload weights for Service Coordinators, including a blended overall caseload limit, taking into account the risk 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 service coordination staffing includes these provisions.	
606.	The STAR+PLUS MMP demonstrates that it has sufficient employees and/or contractor staff to meet the service coordination needs of the target population through its staffing plan. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the STAR+PLUS MMP believes will be needed to perform the function; c. How the STAR+PLUS MMP derived that estimate; and d. In what timeframe the STAR+PLUS MMP will staff to the level indicated.	STAR+PLUS MMP staffing plan, with any other documents as necessary.	

607.	A Service Coordinator must either: a. Have an undergraduate and/or graduate degree in social work or a related field; or b. Be a registered nurse, a nurse practitioner, or a physician's assistant, except in the following circumstances: • Licensed vocational nurses (LVNs) employed as Service Coordinators for Level 1 enrollees before March 1, 2013, will be allowed to continue in that role, consistent with the STAR+PLUS contract. Service coordinators for Level 1 enrollees employed on or after March 1, 2013 must be either an RN or nurse practitioner. LVNs can be Service Coordinators for Level 2 enrollees.	Service Coordinator qualifications P&P includes those listed.	
608.	The STAR+PLUS MMP demonstrates that it has sufficient employees and/or contractor staff to handle service coordination oversight through its staffing plans. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the STAR+PLUS MMP believes will be needed to perform the function; c. How the STAR+PLUS MMP derived that estimate; and d. In what timeframe the STAR+PLUS MMP will staff to the level indicated.	STAR+PLUS MMP staffing plan, with any other documents as necessary.	
609.	The STAR+PLUS MMP demonstrates that it has sufficient internal and/or contracted staff to handle organization and coverage determinations and appeals and grievances. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the STAR+PLUS MMP believes will be needed to perform the function; c. How the STAR+PLUS MMP derived that estimate; and d. In what timeframe the STAR+PLUS MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.	
610.	The STAR+PLUS MMP demonstrates that it has sufficient employees and/or contractor staff to handle its enrollee services phone line through its staffing plan. The staffing plan must explain: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the STAR+PLUS MMP believes will be needed to perform the function; c. How the STAR+PLUS MMP derived that estimate; and d. In what timeframe the STAR+PLUS MMP will staff to the level	The MMP demonstrates that it meets the requirements of the criterion.	

	indicated.		
611.	The STAR+PLUS MMP Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that 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			
612.	The STAR+PLUS MMP has a cultural competency and disability training plan to ensure that staff delivers culturally-competent services, in both oral and written enrollee communications (e.g., person-first language, target population competencies).	The STAR+PLUS MMP's P&P on cultural competency and disability training meets these requirements.	
613.	The STAR+PLUS MMP staff is trained to handle critical incident and abuse reporting. Training includes, ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports providers.	The STAR+PLUS MMP's P&P describes training on critical incident and abuse reporting and includes these topics.	
614.	The training program for Service Coordinators includes, but is not limited to, information detailing: a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. LTSS; f. Self-direction of services (as authorized by the state); g. Behavioral health; h. Care transitions; i. Skilled nursing needs/NF processes; j. Abuse and neglect reporting;	The STAR+PLUS MMP's P&P on training of Service Coordinators includes these elements.	

	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; r. The state's role in enrollment processes; s. Information related to the population served; t. How to assess Member's medical, behavioral health, and social needs and concerns; u. PASRR requirements; v. Available local and statewide resources; and w. Respect for cultural, spiritual, racial, and ethnic beliefs of others.		
615.	The STAR+PLUS MMP's staff is trained on HIPAA compliance obligations and the STAR+PLUS MMP's confidentiality guidelines.	The STAR+PLUS MMP's P&P addresses training on HIPAA compliance and confidentiality guidelines.	
616.	The STAR+PLUS MMP or PBM has scripts for its customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment; f. Formulary information; g. Pharmacy information, including whether an enrollee's pharmacy is in the STAR+PLUS MMP's network; h. Provider information, including whether an enrollee's physician is in the STAR+PLUS MMP's network; i. Out-of-network coverage; j. Claims submission, processing, and payment; k. Formulary transition process; l. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); m. Information on how to obtain needed forms; n. Information on replacing an identification card; and	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See State specific MOU for details)	

	o. Service area information.		
617.	The STAR+PLUS MMP has protocols or staff training modules to train enrollee services telephone line staff in the following areas: a. Explaining the operation of the STAR+PLUS MMP and the roles of participating providers; b. Assisting enrollees in the selection of a PCP; c. Knowledge of services available through the STAR+PLUS MMP 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, grievances, and appeals.	P&P or training modules demonstrate that the STAR+PLUS MMP trains its enrollee services telephone line staff personnel on these topics.	
VII. Performance and Quality Improvement			
701.	The STAR+PLUS MMP 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 the enrollee's home, if the incident is related to the provision of covered HCBS. The STAR+PLUS MMP must have a designated incident manager responsible for meeting the contractual requirements.	The STAR+PLUS MMP 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 STAR+PLUS MMP is prepared to report all Year 1 Quality Measures required under the Demonstration including all Medicare Advantage (Part C) required measures, HEDIS, HOS, CAHPS, as well as measures related to behavioral health, service coordination/transitions, and LTSS, as required by the MOU.	QI P&P details how the STAR+PLUS MMP collects these measures for its enrollees.	
VIII. Provider Credentialing			
801.	The STAR+PLUS MMP credentialing standards must be consistent with recognized MCO industry standards, such as those provided by NCQA or URAC, and relevant state and federal regulations, including 28 TAC §11.1902 and §11.1402(c), relating to provider credentialing and notice. Under this Demonstration, STAR+PLUS MMPs must also adhere to managed care standards at 42 CFR §438.12, 42 CFR §422.204, and 42 CFR §438.214.	Provider credentialing P&P includes these requirements.	
802.	Prior to contracting with a new provider, the STAR+PLUS MMP considers and/or verifies the following information about the provider: a. The provider has a valid license to practice medicine, when applicable;	Provider credentialing P&P states that the STAR+PLUS MMP will review these	

	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.	documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.	
803.	The STAR+PLUS MMP requires that all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The STAR+PLUS MMP submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.	
IX. Provider Network			
A. Establishment and Maintenance of Network, including Capacity and Services Offered			
901.	The STAR+PLUS MMP has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including LTSS providers; and 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 STAR+PLUS MMP has a P&P and training materials that demonstrate it will make training on cultural competency (including language) available to medical, behavioral, LTSS, and pharmacy provider networks for delivering services to target populations in the Demonstration.	Provider network P&P explains how its primary care, 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 STAR+PLUS MMP has a P&P 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 STAR+PLUS MMP has a P&P that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.	
905.	The STAR+PLUS MMP provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.	
906.	The STAR+PLUS MMP ensures that enrollees have access to the most current and accurate information by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).	
B. Accessibility			
907.	The STAR+PLUS MMP medical, behavioral, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the STAR+PLUS MMP alerts its enrollees of providers able to accommodate enrollees with disabilities (e.g., STAR+PLUS MMPs 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; 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.	P&P on provider training details special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees.	
910.	For enrollees with special health care needs who indicate the need for frequent utilization of a treatment or regular monitoring by a specialist, the STAR+PLUS MMP must allow enrollees to retain a specialist as a PCP or allow direct access to a specialist for needed care.	Provider Network P&P describes the process for and circumstances under which specialist can be selected as a PCP	
C. Provider Training			
911.	The STAR+PLUS MMP requires disability literacy training for its medical, behavioral, and LTSS providers, including information about the following: a. Various types of chronic conditions prevalent within the target population; b. Awareness of personal prejudices; c. Legal obligations to comply with the ADA requirements; d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; e. Types of barriers encountered by the target population; f. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model; 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 STAR+PLUS MMP'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 STAR+PLUS MMP has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	STAR+PLUS MMP's P&P addresses this requirement.	

914.	The training program for PCPs includes: a. How to identify behavioral health needs; and b. How to identify LTSS needs.	The STAR+PLUS MMP's P&P for PCP training includes these topics.	
D. Provider Handbook			
915.	The STAR+PLUS MMP prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. STAR+PLUS MMP 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.	
916.	The STAR+PLUS MMP makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers who work with enrollees that require culturally-, linguistically-, or disability-competent care.	Provider handbook 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 STAR+PLUS MMP website, information about local organizations serving specific subpopulations of the target population).	
E. Ongoing Assurance of Network Adequacy Standards			
917.	The STAR+PLUS MMP ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, are convenient to the population served and do not discriminate against STAR+PLUS MMP enrollees (e.g. hours of	Network provider P&Ps and/or contract templates that include these provisions.	

	operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that plan services are available 24 hours a day, 7 days a week, when medically necessary.		
918.	The STAR+PLUS MMP has a policy and procedure that states that it arranges for necessary specialty care, LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care. List of network providers includes specialties in all geographic regions.	
E. Appointment Standards			
919.	The STAR+PLUS MMP ensures that the following standards are met. In all cases below, "day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first. a. Emergency Services must be provided upon the enrollee's presentation at the service delivery site, including at non-network and out-of-area facilities; b. Urgent care, including urgent specialty care, must be provided within 24 hours; c. Routine primary care must be provided within 14 days; d. Initial outpatient behavioral health visits must be provided within 14 days; e. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the enrollee's medical condition, but no later than 30 days; f. Pre-natal care must be provided within 14 days, except for high-risk pregnancies or new enrollees in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists; and g. Preventive health services for adults must be offered within 90 days.		
X. Monitoring of First-Tier, Downstream, and Related Entities			
1001	The STAR+PLUS MMP has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the STAR+PLUS MMP. The plan should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation	Monitoring plan provides information on how the STAR+PLUS MMP monitors all first-tier, downstream, and	

	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.	related entities.	
XI. Systems			
A. Data Exchange			
1101.	The STAR+PLUS MMP is able to electronically exchange the following types of data: a. Plan of Care and ISP, as appropriate; 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 must illustrate that these types of data can and will be electronically exchanged. Additionally, submit P&Ps for securing, processing, and validating the exchange of data. Supporting documentation must include: 1. Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports as it relates to enrollment and claims data. 2. File layouts for transmitted data illustrating compliance with transmission of each of these required data types.	
1102.	The STAR+PLUS MMP or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator.	Baseline documentation must include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator.	
1103.	The STAR+PLUS MMPs will include revenue, cost, and other data in the financial reporting system (FSR) reports broken out for financial alignment demonstration enrollees and separate from individuals served by other Texas Medicaid programs.	Financial Statistical Report for MMP-specific costs and revenue	

	The FSR and the data reported in it will be subject to HHSC's Cost Principles (which governs allowable costs), and will be subject to annual audit. MMP FSRs will be submitted to HHSC quarterly and annually, as directed by HHSC. Standard FSR misreporting repercussions will apply if warranted, such as potential assessed interest expenses and Liquidated Damages (LDs).		
1104.	The STAR+PLUS MMP reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website.	Baseline documentation must include the MMP's clinical care quality P&P for reviewing and acting upon the Part D monthly patient safety reports.	
B. Data Security			
1105.	The STAR+PLUS MMP has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation must illustrate that the STAR+PLUS MMP has a disaster recovery and a business continuity plan in place.	
1106.	The STAR+PLUS MMP facilitates the secure, effective transmission of data.	Baseline documentation must include: 1. STAR+PLUS MMP's Data Security and Privacy P&P; and 2. STAR+PLUS MMP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. 3. Documentation of processes to document a breach in data integrity and any associated corrective actions.	
1107.	The STAR+PLUS MMP maintains a history of changes, adjustments, and audit trails for current and past data systems.	Baseline documentation must include Change Management P&Ps.	
1108.	The STAR+PLUS MMP complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier	Baseline documentation must	

	(standard unique health identifier for health care providers).	include: 1. STAR+PLUS MMP P&P noting compliance with NPI standards, specifications, and requirements. 2. Screenshot of provider data/records illustrating that the NPI data field is populated in provider system.	
C. Claims Processing			
1109.	The STAR+PLUS MMP 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 must include: 1. Claims processing P&P that details clean claims processing steps and turnaround timeframes. 2. Claims processing P&P that details claims processing steps and turnaround timeframes for pended claims. 3. Claims processing P&P that details methods for ensuring claims processing accuracy.	
1110.	The STAR+PLUS MMP processes adjustments and issues refunds or recovery notices within the contractually required timeframe of receipt for complete information regarding a retroactive medical and community-based or facility-based LTSS claims adjustment.	Baseline documentation must include P&Ps on claims adjustments, refunds and recoveries that specify a time required for processing retroactive medical and community-based or facility-based long term services.	
1111.	The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation must	

		include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation must also include metrics used to monitor and evaluate claims processing performance and capacity. Documentation should highlight the basis for STAR+PLUS MMP estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by STAR+PLUS MMP staff without affecting performance standards.	
1112.	The claims system benefit structure and associated fee schedules include all medical, community-based or facility-based LTSS, HCBS waiver, Medicare, and Medicaid services.	Baseline documentation must illustrate the STAR+PLUS MMP's process and plan for loading and validating the Demonstration fee schedules.	
1113.	The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over the counter drugs.	Baseline documentation must include: 1. The STAR+PLUS MMP's oversight procedures for monitoring pharmacy claims processing including the PBM's plan to configure, test, and	

		implement the benefits and adjudication rules to properly process Medicare Part D and Medicaid prescription and Medicaid over-the-counter drugs for the Demonstration. 2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs.	
D. Claims Payment			
1114.	The STAR+PLUS MMP pays 95% of clean medical, behavioral, and LTSS claims within 30 days of receipt. The STAR+PLUS MMP pays 95% of clean Nursing Facility claims within 10 days of receipt.	Baseline documentation must include: 1. Claims P&P that describes clean claims payment standards. 2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims.	
1115.	The STAR+PLUS MMP or its PBM pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 21 days of receipt all other claims. The STAR+PLUS MMP's PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 21 days (all other claims).	Baseline documentation must include: 1. PBM claims P&Ps that describe clean claims payment standards. 2. PBM P&Ps that define interest payments for clean claims that do not meet	

		the processing timeframe standards.	
1116.	The STAR+PLUS MMP or its PBM assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement.	Baseline documentation must include PBM pharmacy network provider P&Ps that detail the timeframe for submission of STAR+PLUS MMP sponsor claims from long term care facilities.	
1117.	The STAR+PLUS MMP's claims processing system checks claims pricing and payment logic to identify erroneous payments.	Baseline documentation must include a description of system edits and reports to identify claims processing trends and anomalies used to identify and correct erroneous claims payments.	
E. Provider Systems			
1118.	The system generates and maintains records on provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. ADA-accessibility of provider office; and k. Credentialing information.	Baseline documentation must include core provider system screen shots highlighting where each of these data elements are captured. Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications.	
F. Pharmacy Systems			
1119.	The STAR+PLUS MMP generates and maintains or ensures that: a. Its PBM generates and maintains records on the pharmacy network information, including locations and operating hours.	Baseline documentation must include:	

	b. Its PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies. c. The STAR+PLUS MMP its PBM sends out notification to members of no longer participating pharmacies.	The STAR+PLUS MMP or its PBM's P&Ps for maintaining records on pharmacy networks including locations, operating hours and no longer participating pharmacies.. The pharmacy network website screenshots illustrating that operating hours are displayed for pharmacy locations. The STAR+PLUS MMP its PBM's P&Ps for notification of members of no longer participating pharmacies.	
1120.	The STAR+PLUS MMP audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a regular basis in those instances where the STAR+PLUS MMP subcontracts the maintenance of the pharmacy network.	Baseline documentation must include the STAR+PLUS MMP's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring.	
1121.	The PBM can submit Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation must include: 1. The PBM P&P that defines the processes and data submission requirements for Part D PDE reporting. 2. STAR+PLUS MMP's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.	
1122.	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.	
1123.	The STAR+PLUS MMP ensures that the PBM's claims adjudication system and processes: 1. Distinguishes between filling prescriptions for Part D drugs and non-Part D drugs; 2. Appropriately meets the 90-day Part D and the non-Part D transitional fill requirements; and 3. 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 STAR+PLUS MMP's P&P for oversight of the PBM performance on transitional fills.	
1124.	The STAR+PLUS MMP's PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine drugs that are covered under the Demonstration and ensure continuity of care and access to medication for the Demonstration enrollees in the event the PBM systems are inaccessible.	Baseline document 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 when pharmacies cannot access the PBM systems.	
G. Enrollment Systems			
1125.	The STAR+PLUS MMP receives, processes, and reconciles in an accurate and timely manner: a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and b. The benefit and enrollment maintenance file from the state.	Baseline documentation must include the STAR+PLUS MMP's P&P on processing and reconciling enrollment files. Documentation should also include the STAR+PLUS MMP's enrollment systems schematic that details the daily enrollment processing capacity.	
1126.	If the STAR+PLUS MMP receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the STAR+PLUS MMP 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 must include the STAR+PLUS MMP's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.	
1127.	The STAR+PLUS MMP's enrollment/enrollee system includes each of the following data elements: a. Name; b. Date of birth; c. Gender; d. Telephone number; e. Permanent residence address; f. Mailing address; g. Medicare and Medicaid numbers; h. ESRD status; i. Other insurance COB information; j. Language and alternative formats preferences; k. Authorized representative contact information; l. Which plan the enrollee is currently a member of and to which STAR+PLUS	Documentation must include screenshots of the STAR+PLUS MMP's enrollment/enrollee system that confirms each data element listed is available in the system.	

	MMP the enrollee is enrolling.		
1128.	For passive enrollments, the STAR+PLUS MMP sends the following to the enrollee 30 days prior to the effective date of coverage: a. A STAR+PLUS MMP-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the STAR+PLUS MMP; 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 STAR+PLUS MMP services as of the effective date of enrollment.	Baseline documentation must include the STAR+PLUS MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The STAR+PLUS MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.	
1129.	For passive enrollments, the STAR+PLUS MMP sends the following to the enrollee no later than the last calendar day of the month prior to the effective date of coverage: a. A single plan ID card for accessing all covered services under the STAR+PLUS MMP; and b. A Member Handbook (Evidence of Coverage).	Baseline documentation must include the STAR+PLUS MMP's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC). The STAR+PLUS MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.	
1130.	For opt-in enrollments, the STAR+PLUS MMP provides the following materials to the enrollee no later than ten days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later: a. A comprehensive integrated formulary; b. A combined provider and pharmacy directory; c. A single plan ID card; and d. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the STAR+PLUS MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The STAR+PLUS MMP should also illustrate how they systematically track when these materials are sent.	

H. Service Coordination and Care Quality Management Systems			
1131.	The system generates and maintains records necessary for service coordination, including: a. Enrollee data (from the enrollment system); b. Enrollee risk level assignment (1 or 2) c. Enrollee HCBS Waiver eligibility status (if applicable); d. Provider network; e. Service Coordination Team membership; f. Enrollee health risk assessments; g. Enrollee Plan of Care; h. Enrollee Individual Service Plan (ISP) for enrollees that are eligible for HCBS Waiver services; i. Service Coordination Team case notes; j. Pharmacy data; and k. Claims information.	Baseline documentation must include: 1. A process workflow including screenshots of the care coordination system that confirms the ability to capture the required care coordination data elements and functionality as detailed. 2. Description of enhancements that will be made to customize systems to facilitate the requirements of this criterion and a projected delivery timeframe.	
1132.	The STAR+PLUS MMP maintains the service coordination system and addresses technological issues as they arise.	Baseline documentation must include the STAR+PLUS MMP's help desk and application support P&Ps for managing issues related to the service coordination system.	
1133.	The STAR+PLUS MMP verifies the accuracy of service coordination data and amends or corrects inaccuracies.	Baseline documentation must include the STAR+PLUS MMP's P&P for ensuring data quality in the service coordination system. The STAR+PLUS MMP should provide evidence such as a screenshot that illustrates the audit trail tracking of the date	

		and person making the changes/corrections in the system.	
1134.	The enrollee health risk assessments and Plans of Care are available to enrollee service coordination teams and any of the enrollee's other providers if the enrollee has signed a consent to release form.	Documentation should include: The STAR+PLUS MMP's P&P for securing and providing access to the service coordination system. The STAR+PLUS MMP's workflow processes for making enrollee health risk assessment and plans of care information available to the enrollee's providers.	
1135.	The STAR+PLUS MMP has a mechanism to alert the Service 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 STAR+PLUS MMP's P&P for tracking ED and inpatient admissions and notifying the Service Coordinator. Note: this should include the required notification timeframe for both admission types.	
1136.	The STAR+PLUS MMP complies with all requirements regarding reporting of critical incidents to the State and CMS.	Documentation must include the STAR+PLUS MMP's P&P for managing and reporting critical incidents as required by the State and CMS.	
XII. Utilization Management			
A. The STAR+PLUS MMP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services			
1201.	The STAR+PLUS MMP specifies procedures under which the enrollee may self-refer services.	The UM program descriptions for the STAR+PLUS MMP explains for which services an enrollee can self-refer.	

1202.	The STAR+PLUS MMP defines medically necessary services as services that are: a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y; b. For Medicaid services: must be covered in accordance with clinical coverage guidelines specified in 1 T.A.C. Section 353.2., i.e. a service, supply, or medicine that is appropriate, covered by the State, and meets the standards of good medical practice in the medical community, as determined by the provider in accordance with the STAR+PLUS MMP's guidelines, policies or procedures based on applicable standards of care and as approved by HHSC if necessary, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the enrollee's ability to attain, maintain, or regain functional capacity, or to achieve age-appropriate growth; and c. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the STAR+PLUS MMP will apply the definition of medical necessity that is the more generous to the enrollee of the applicable Medicare and Texas's Medicaid standards.	The STAR+PLUS MMP's UM program description includes these definitions of medical necessity.	
1203.	The STAR+PLUS MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.	The UM program description for the STAR+PLUS MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.	
1204.	The STAR+PLUS MMP has policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description for the STAR+PLUS MMP includes these elements for the STAR+PLUS MMP and the STAR+PLUS MMP's PBM.	
1205.	The STAR+PLUS MMP has a methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The UM program descriptions for the STAR+PLUS MMP explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to	

		integrate new treatments or services into the review criteria, make updates based on clinical guidelines).	
1206.	The STAR+PLUS MMP: a. Outlines its process for authorizing out-of-network services; and b. If specialties necessary for enrollees are not available within the network, the STAR+PLUS MMP will make such services available out-of-network.	Out-of-network service authorization P&P explains how an enrollee or provider may obtain authorization for a service being provided by a provider outside of the STAR+PLUS MMP's network.	
1207.	The STAR+PLUS MMP describes its processes (e.g., periodic training, provider newsletters) for communicating to all providers which services require prior authorization and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization.	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The STAR+PLUS MMP's provider materials describe prior authorization requirements and procedures.	
1208.	The STAR+PLUS MMP policies for adoption and dissemination of practice guidelines require that the guidelines: a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the STAR+PLUS MMP's enrollees; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and member education and service coverage.	The STAR+PLUS MMP's practice guidelines P&P includes these requirements.	
B. The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.			
1209.	The STAR+PLUS MMP has a policy and procedure for appropriately informing enrollees of coverage decisions, including tailored strategies for enrollees with communication barriers.	Plan management guidelines or the STAR+PLUS MMP's UM program describes the type of communications sent to enrollees, regarding their receipt or denial of referrals of	

		service authorizations.	
1210.	For the processing of requests for initial and continuing authorizations of covered services, the STAR+PLUS MMP: a. Has in place and follows written policies and procedures; b. Has in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consults with the requesting provider when appropriate.	The UM program descriptions for the STAR+PLUS MMP explains the process for obtaining initial and continuing authorizations for services.	
1211.	The STAR+PLUS MMP ensures that prior authorization requirements are not applied to: a. Emergency services, including emergency behavioral health care; b. Urgent care; c. Crisis stabilization, including mental health; d. Family planning services; e. Preventive services; f. Communicable disease services, including STI and HIV testing; and g. Out-of-area renal dialysis services.	The UM program descriptions for the STAR+PLUS MMP lists those services that are not subject to prior authorization and this list is consistent with the required elements.	
1212.	The STAR+PLUS MMP follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §422.568, 422.570 and 422.572. For overlap services, the STAR+PLUS MMP follows the three-way contract.	The UM program description for the STAR+PLUS MMP includes these requirements.	
1213.	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment.	The UM program description for the STAR+PLUS MMP includes this requirement. Resumes for staff who review coverage decisions show that the staff have appropriate competencies to apply STAR+PLUS MMP policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.	

1214.	The STAR+PLUS MMP 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 STAR+PLUS MMP 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 coordinate transfer of stabilized enrollees in emergencies.	