Financial Alignment Capitated Readiness Review Virginia 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 Virginia 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 May 21, 2013, and applicable Medicare and Medicaid regulations.

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

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

All State readiness review tools 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. This readiness review structure is designed to ensure that the participating 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 an MMP has the appropriate beneficiary protections in place including, but not limited to, whether the MMP has policies that adhere to the Americans with Disabilities Act, uses person-centered language and reinforces beneficiary roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models of behavioral health services. Enrollment functions and systems will be reviewed at a later date.

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

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I. Assessment

A. Transition to New MMP and Continuity of Care

Readiness Review Criteria	Suggested Evidence
1. The Medicare-Medicaid Plan (MMP) ensures that, for enrollees other than those who reside in nursing facilities: a. The enrollees maintain his or her current providers for 180 days from the effective date of enrollment. b. During the 180-day transition period, the MMP may change an enrollee's existing provider only under the following circumstances: i. The enrollee requests a change; ii. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid; or iii. The MMP, CMS, or DMAS identifies provider performance issues that affect an enrollee's health and welfare.	Continuity of care plan includes these provisions.
2. The MMP must allow an enrollee who resides in a nursing facility at the time of enrollment to remain in the facility as long as he or she continues to meet DMAS criteria for nursing home care (including beyond the 180-day transition period), unless the enrollee or his or her family agrees to move the enrollee to a different nursing facility.	Continuity of care plan should include these provisions.
3. During the 180-day transition period, the MMP: a. Reimburses any of the enrollee's current providers who are out of the MMP's network at the current Medicare and Medicaid FFS rates; and b. Honors prior authorizations issued by DMAS as provided through DMAS transition reports, DMAS' contracted managed care entities, and Medicare.	Continuity of care plan should include these provisions**.**
4. The MMP assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug.	P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug.
5. The MMP assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 30-day supply.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
6. The MMP assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.
7. The MMP provides written notice to each Enrollee, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary.	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

Readiness Review Criteria	Suggested Evidence
1. The MMP has an identification strategy to prioritize the timeframe by which Enrollees will receive the health risk assessments. The strategy must: a. Use a combination of predictive-modeling software, assessment tools, referrals, administrative claims data, and other sources of information as appropriate; and b. Consider medical, behavioral health, substance use, and LTSS needs.	MMP's Assessment P&Ps or other documentation must include the criteria and thresholds indicating how to prioritize completion of the HRAs.

Readiness Review Criteria	Suggested Evidence
2. The MMP's health risk assessment: a. Includes the following domains: i. Medical; ii. Psychosocial; iii. Functional; iv. Cognitive; and v. Behavioral health; b. Is approved by DMAS and CMS; and ***c.*** Takes into account information from the enrollee, providers, and the enrollee's family/caregivers.	As part of the RFP process, Virginia's RFP review team reviewed the draft HRA submitted with the RFP. For readiness reviews, the MMP must submit its final version of their health risk assessment as part of the readiness review process. DMAS and CMS will use the readiness review process to collect and approve the health risk assessment.
3. The MMP adheres to the following timeframes for administering a comprehensive health risk assessment (HRA) in the first demonstration year: a. Enrollees identified as being within a "vulnerable subpopulation" must receive an HRA no later than 60 days after the individual's enrollment date (for EDCD and Nursing facility this must be face- to face); i. The following enrollees are considered members of a "vulnerable subpopulation:" 1. Individuals enrolled in the EDCD Waiver; 2. Individuals with intellectual/developmental disabilities; 3. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury); 4. Individuals with physical or sensory disabilities; 5. Individuals residing in nursing facilities; 6. Individuals with serious and persistent mental illnesses; 7. Individuals with end stage renal disease; and, 8. Individuals with complex or multiple chronic conditions. b. For enrollees who are not a member of a "vulnerable subpopulation," the MMP must complete the HRA within 90 days of enrollment.	Assessment P&P outlines the process by which the MMP will administer the initial assessment. At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment within 90 days.
4. The MMP adheres to the following timeframes in administering a comprehensive HRA to individuals who are enrolled for the first time in the second and subsequent years of the Demonstration: a. Individuals enrolled in the EDCD Waiver must receive an HRA within 30 days of enrollment; and b. All other enrollees must receive an HRA within 60 days of enrollment.	Assessment P&P explains how the timeframes for administration of the initial comprehensive HRA and subsequent HRAs.
5. The HRAs for individuals residing in nursing facilities must also incorporate the MDS requirements.	Assessment P&P includes this requirement.
6. The MMP must have a process to determine whether it will provide a face-to-face assessment for enrollees who are neither residents of nursing facilities nor participants in the EDCD waiver. This MMP's process should include a determination of the enrollee's history and level of service need.	Assessment P&P includes this requirement.

Readiness Review Criteria	Suggested Evidence
7. The MMP's process for the annual level of care (LOC) reassessments for EDCD waiver participants and nursing facility residents includes the following requirements: a. For EDCD participants, the reassessment must: i. Be conducted when an enrollee experiences a triggering event such as a hospitalization or significant change in health or functional status, but no later than within 365 days after the last annual reassessment; ii. Be face-to-face for the functional part of the reassessment (for continued eligibility for the EDCD Waiver); and iii. Include all the elements on the DMAS 99-C LOC Review Instrument for individuals who have had a change in status. b. For nursing facility participants, the MMP: i. Works with the facility on annual assessment (functional) for continued nursing facility placement; and ii. Follows MDS guidelines/timeframes for quarterly and annual POC development. c. For EDCD participants and nursing facility residents, the MMP communicates the reassessment results and annual LOC reassessment data to DMAS within 30 days of the reassessment.	Assessment P&P includes these timeframe requirement pertaining to annual level of care reassessments for EDCD waiver participants and nursing facility residents.
8. The MMP assures that the LOC annual reassessments for EDCD Waiver participants are performed by providers with the following qualifications: a. A registered nurse licensed in Virginia with at least one year of experience as an RN; or b. An individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly and/or have disabilities.	Assessment P&P includes these timeframe requirements pertaining to annual level of care reassessments for EDCD waiver participants and nursing facility residents.
9. The 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 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.
10. For all enrollees, the MMP conducts re-assessments when an enrollee experiences a triggering event such as a hospitalization or significant change in health or functional status.	Assessment P&P explains that re-assessments should be conducted under these circumstances.
11. The 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 MMP will respond to those enrollees who decline to participate in a comprehensive assessment. Assessment P&P describes how the MMP 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 MMP will monitor those enrollees who decline to participate in the risk assessment process.

II. Care Coordination

A. Care Management and Interdisciplinary Care Team (ICT)

Readiness Review Criteria	Suggested Evidence
1. The MMP has a process to ensure that every enrollee has an Interdisciplinary Care Team (ICT).	Care coordination P&P defines how an ICT is formed for each enrollee and how the enrollee and/or his or her caregiver are involved in determining the ICT.
2. The ICT should: a. Be person-centered; b. Be built on the enrollee's specific preferences and needs; and c. Deliver services with transparency, respect, linguistic and cultural competence, and dignity.	ICT P&P requires each of these requirements.
3. The MMP's process for developing ICTs includes the following requirements: a. The MMP has a mechanism to include the "targeted case manager" as a member of the ICT where the enrollee is receiving Medicaid State Plan Targeted Case Management Services. b. Community Services Board (CSB) case managers are assigned to ICTs for the following individuals, assuming they choose to continue receiving case management services: i. Individuals with mental illness; ii. Individuals with substance abuse; and iii. Individuals with intellectual disabilities.	Care coordination or ICT P&P includes a description of how the MMP will ensure that the targeted case manager is a member of the ICT.
4. The MMP provides person-centered care management functions to all enrollees that include the following supports depending on the enrollee's needs and preferences: a. A single, toll-free point of contact for all of the enrollee's questions; b. Ability to develop, maintain and monitor the plan of care (POC); c. Assurance that referrals result in timely appointments; d. Communication and education regarding available services and community resources; and e. Assistance developing self-management skills to effectively access and use services.	Care coordination P&P defines the role and responsibilities of the ICT and either this P&P or other P&Ps include the ICT's specified functions.

Readiness Review Criteria	Suggested Evidence
5. The MMP provides the following additional person-centered care management functions to enrollees who are members of a "vulnerable population" (as defined in I.B.3.a.i.): a. Assurance that enrollees receive needed medical and behavioral health services, preventive services, medications, LTSS, social services and enhanced benefits that includes: i. Assistance in setting up appointments, ii. In-person contacts as appropriate, iii. Strong working relationships between care managers and physicians, iv. Providing enrollees with evidence-based education programs, and v. Arranging transportation as needed; b. Continuous monitoring of functional and health status; c. Seamless transitions of care across specialties and settings; d. Assurances that individuals with disabilities have effective communication with health care providers and participate in making decisions with respect to treatment options; e. Connections for individuals to services that promote community living and help avoid premature or unnecessary nursing facility placements; f. Coordination with social service agencies (e.g. local departments of health, social services, and Community Services Boards) and referral of enrollees to state, local, and other community resources; and, g. Coordination with nursing facilities to: i. Promote adoption of evidence-based interventions to reduce avoidable hospitalizations; ii. Manage chronic conditions, medication optimization, and prevention of falls and pressure ulcers; iii. Coordinate services beyond the scope of the NF benefit.	Care coordination P&P includes the explanation of additional person-centered care management function requirements for members who are "vulnerable" as described in the criterion.
6. The MMP develops or enters into contractual arrangements or partnerships such as sub-capitation arrangements, health home arrangements, or performance incentives to improve care management or offer support services to individuals eligible for the Demonstration. Entities can include, but are not limited to Community Services Boards (CSBs), adult day care centers, and nursing facilities.	The MMP must submit any contracts or MOUs with such entities describing the care coordination functions to be performed.
7. The MMP has a process for assigning a care coordinator with the appropriate experience and qualifications based on an enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers) to each enrollee.	Care coordination P&P requires each enrollee to be assigned a care coordinator based on his or her risk level and/or individual needs and outlines the process for assigning such care coordinators. MMP describes reasonable measures taken to ensure that staff and enrollees are matched based on their expertise and special needs.

Readiness Review Criteria	Suggested Evidence
8. The MMP: 1. Conducts training for ICT members initially and on an annual basis on: a. The person-centered planning processes; b. Cultural competence; c. Accessibility and accommodations; d. Independent living and recovery; e. ADA/Olmstead requirements; and f. Wellness principles; 2. 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.	Sample training materials for ICT members and potential ICT members include the required topics. Care coordination P&P states that completion of training of ICT members will be documented and defines the consequences associated with non-completion of ICT trainings.
9. The MMP has: a. A process to address the care management needs of enrollees that are covered by the DOJ Olmstead agreement; and b. A mechanism for the ICT to work with the Community Services Boards and the Department of Behavioral Health and Developmental Services to successfully transition the enrollees identified as eligible to transition into the community, through the DOJ Olmstead Settlement Agreement, into the community.	Care coordination P & P describes the process for providing care management services to individuals who are eligible for the demonstration and covered by the DOJ Olmstead agreement.

B. Plan of Care / Service Plan

Readiness Review Criteria	Suggested Evidence
1. The MMP will: a. Implement a person-centered and culturally competent plan of care development process; b. Work with the enrollee to develop the plan of care that is tailored to the enrollee's individual needs; c. Use the information gathered from the assessments of the enrollee in developing the plan of care; and d. Explain how its plan of care development process incorporates, but does not duplicate, Targeted Case Management for enrollees receiving Targeted Case Management.	Care planning P&P outlines a process that describes how the MMP will involve the enrollee in developing the plan of care and will use the information gathered from the assessment(s) of the enrollee in developing the plan of care. Care planning P&P states that the MMP intends to provide person-centered care to all enrollees, and describes strategies for assuring this.
2. The MMP will: a. Implement a person-centered and culturally competent plan of care development process; b. Work with the enrollee to develop the plan of care that is tailored to the enrollee's individual needs; c. Use the information gathered from the assessments of the enrollee in developing the plan of care; and d. Explain how its plan of care development process incorporates, but does not duplicate, Targeted Case Management for enrollees receiving Targeted Case Management.	Care planning P&P outlines a process that describes how the MMP will involve the enrollee in developing the plan of care and will use the information gathered from the assessment(s) of the enrollee in developing the plan of care. Care planning P&P states that the MMP intends to provide person-centered care to all enrollees, and describes strategies for assuring this.
3. The MMP's process ensures that plans of care for all individuals are completed within 90 days of enrollment.	Care planning P&P includes these timeframes and describes the process for meeting the timeframes.
4. After Year 1 of the Demonstration, the MMP must ensure that plans of care are conducted within the following timeframes: a. For EDCD Waiver participants, within 30 days of enrollment; b. For enrollees who are not EDCD Waiver participants, but are members of a "Vulnerable Subpopulation," (as defined in I.B.3.a.i.) within 60 days of enrollment; and c. For all other enrollees, within 90 days of enrollment.	Care planning P&P describes the timeframe for care planning after Year 1 of the Demonstration as described.

Readiness Review Criteria	Suggested Evidence
5. The MMP 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. Self-directed care options and assistance available to self-direct care; iv. Opportunities for educational and vocational activities; and v. Available treatment options, supports and/or alternative courses of care.	Care planning P&P describes how the MMP will ensure that the enrollee receives necessary assistance and the types of information specified.
6. The MMP describes its process for addressing health, safety (including minimizing risk), and welfare of the enrollee in the POC. The POC will contain the following: a. Prioritized list of enrollee's concerns, needs, and strengths; b. Attainable goals, outcome measures, and target dates selected by the enrollee and/or caregiver; c. Strategies and actions, including interventions and services to be implemented, the person(s)/providers responsible for specific interventions/services, and their frequency; d. Progress noting success, barriers or obstacles; e. Enrollee's informal support network and services; f. Back up plans as appropriate (for EDCD Waiver participants using personal care and respite services) in the event that the scheduled provider(s) is unable to provide services; g. Determined need and plan to access community resources and non-covered services; h. Enrollee choice of services (including consumer-direction) and service providers; and, i. Elements included in the DMAS-97AB form, (which can be downloaded from https://www.virginiamedicaid.dmas.virginia.gov/wps/portal) for individuals enrolled in the EDCD Waiver.	Care planning P&P states that the MMP assures that these elements are incorporated into the plan of care.
7. The MMP ensures that reassessments and plan of care reviews are conducted: a. No later than the plan of care anniversary for "Vulnerable Subpopulations" (as defined in I.B.3.a.i.) and all other enrollees; b. No later than plan of care anniversary, not to exceed 365 days for EDCD Waiver participants (must be face-to-face); and, c. In accordance with MDS guidelines/timeframes for quarterly and annual plan of care development for nursing facility residents.	Care planning P&P include the required timeframes for reviews of the POC.
8. The MMP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the plan of care.	Care planning P&P states that the MMP accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the plan of care.

C. Self-Directed Services: Consumer Direction

Readiness Review Criteria	Suggested Evidence
1. The MMP has policies to provide enrollees the following information: a. An explanation that only EDCD waiver enrollees will participate in self-direction of services; b. That self-direction is voluntary, and the extent to which enrollees would like to self-direct is the enrollee's choice; c. An explanation of the options to select self-directed personal and/or respite services; and d. An overview of the supports and resources available to assist enrollees to participate to the extent desired in self-direction including, but not limited to, FEA services, facilitator services.	Sample enrollee communications demonstrating that the MMP has provided the information contained within this criterion to enrollees eligible for self-direction.
2. The MMP's policies regarding self-direction conform to the state requirements.	Personal care service P&Ps includes state self-direction requirements.
3. The MMP provides enrollees participating in self-direction with assistance in managing their self-directed services. The MMP may contract with a service facilitator to perform this function or it may perform this task internally. If the MMP is contracting out the function, it must provide the contract, any relevant policies and procedures from the subcontractor, and any contractor oversight policies. If the MMP is performing this task internally, it must provide policies or procedures or other documentation outlining how it will provide assistance to Enrollees in self-directing services.	If the MMP is contracting out the function, it must provide the contract, any relevant policies and procedures from the subcontractor, and any contractor oversight policies. If the MMP is performing this task internally, it must provide policies or procedures or other documentation outlining how it will provide assistance to Enrollees in self-directing services

D. Coordination of Services

Readiness Review Criteria	Suggested Evidence
1. The MMP has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting and preserving evaluations and reports for the care coordination program; and b. Communicating these results and subsequent improvements to MMP advisory boards and/or stakeholders.	Care coordination P&P explains how and when the MMP will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to MMP advisory boards and/or stakeholders.
2. The MMP facilitates timely and thorough coordination among the MMP, the primary care provider, and other providers as necessary and appropriate	Care coordination P&P outlines how coordination between the parties will occur; including the mechanism by which information will be shared and how the MMP will facilitate the coordination.

E. Transitions between Care Settings

Readiness Review Criteria	Suggested Evidence
1. For individuals in a nursing facility who wish to move to the community, the MMP will refer them to preadmission screening teams or the Money Follows the Person (MFP) Program.	Sample communications the MMP plans to send to enrollees living in institutional settings contain information related to accessing community supports.

Readiness Review Criteria	Suggested Evidence
2. The MMP has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning.	Care setting transitions P&P explains how the MMP and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the MMP monitors transfers and hospital readmissions. Evidence of relationship of data sharing agreements between hospitals and the MMP. Sample report(s) from the MMP describe how it tracks enrollee transfers and admissions. Care coordination P&P describes the role of the Care Coordinator in monitoring care setting transitions.
3. The 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; and c. Providers are fully knowledgeable and prepared to support the enrollee, including interfacing and coordinating with and among clinical services and LTSS.	Care setting transitions P&P explains how the MMP ensures that community supports are available prior to an enrollee's move. Care setting transitions P&P explains how the MMP 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 MMP takes to ensure continuity of care for an enrollee changing care settings.
4. The MMP helps enrollees transition to another provider if their provider leaves the MMP's network.	Care coordination P&P and/or provider handbook includes this policy.
5. The MMP transitions enrollees to new providers, if needed, once the plan of care is completed and signed.	Care coordination P&P and/or provider handbook includes this policy.

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

IV. Enrollee and Provider Communications	
A. General Customer Service & Coverage Determination Hotlines	
Readiness Review Criteria	**Suggested Evidence**
1. **General Customer Service Hotline:** The MMP maintains and operates a toll-free call center that operates seven days a week at least from 8:00 A.M. to 8:00 P.M. according to the time zones for the regions in which they operate. The MMP is permitted to use alternative technologies to meet the customer service call center requirements for Saturdays, Sundays, and holidays.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS, and drugs. An automated voice response system would meet the definition of an "alternative technology" to meet customer call center requirements on the weekends.
2. The MMP's customer service department 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 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. Information on all MMP covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and f. The procedures for an enrollee to change Participating Plans or to opt out of the Demonstration.	P&P includes these requirements.
3. **Coverage Determination Hotline:** The 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.
4. The 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 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.
5. The MMP 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 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	ESR P&P includes these elements. Training materials for ESRs includes these elements.

Readiness Review Criteria	Suggested Evidence
their primary language, including American Sign Language, or through an alternative language device or telephone translation service.	

B. Pharmacy Technical Support Hotline

Readiness Review Criteria	Suggested Evidence
1. The MMP or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume resulting from Demonstration enrollments.	The MMP (or PBM) has a staffing plan that shows how it has arrived at an estimated staffing ratio for the pharmacy technical help desk call center and how and in what timeframe it intends to staff to that ratio.
2. The MMP ensures that pharmacy technical support is available at any time that any of the network's pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.

C. Care Management Hotline

Readiness Review Criteria	Suggested Evidence
1. The MMP operates a twenty-four hour, seven days a week, toll free Care Management call-in system available statewide that: a. Is staffed by appropriately trained and qualified health professionals who are able to: i. Access the enrollee's records; ii. Assess the enrollee's issues; and iii. Provide an appropriate course of action, including, but not limited to, medical advice, directing the enrollee to an appropriate care setting, and referral to a member of the care management team, including a physician if necessary. b. Obtains information from the enrollee sufficient to ascertain what services the enrollee needs such as symptoms and desired outcome of the call; c. Ensures that if care management needs are identified for an enrollee, the staff person facilitating the enrollee's issue has access to, and is familiar with, the enrollee's Plan of Care; d. Ensures that follow-up is timely and appropriate to assure the enrollee's health and welfare; and e. Includes a mechanism for non-English speaking members to access the hotline.	Care management hotline P&P confirms that the hotline is toll-free and available 24 hours per day 7 days per week.

D. Nurse Hotline

Readiness Review Criteria	Suggested Evidence
1. **Nurse Advice Line**: MMP maintains a Nurse Advice Line accessible by enrollees 24 hours a day 7 days a week. The nurse advice line shall: a. Be staffed by a registered nurse who shall be available to respond to enrollee questions about health or medical concerns which includes access to a physician on call, a primary care physician, or a member of a physician group for the purpose of rendering medical advice, determining the need for emergency and other after-hours services, authorizing care, and verifying enrollee enrollment with the Contractor; b. Be accessible through a dedicated toll-free telephone number; c. Provide direct access through a RN for medical triage and health questions to assist enrollees in determining the most appropriate level of care for their condition; d. Provide general health information to enrollees and answer general health and wellness related questions; e. Provide a direct transfer to the customer service center for non-clinical administrative questions during the customer service center hours of operation; f. Provide coordination with the enrollees care coordinator (or LTSS case manager) and PCP when appropriate based on protocols established by the MMP.	Policies and procedures describe how these services are operated either through the MMP or through a contractual agreement in compliance with these terms.

V. Enrollee Protections

A. Enrollee Rights

Readiness Review Criteria	Suggested Evidence
1. The MMP has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
2. The MMP policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.
3. The MMP does not discriminate against enrollees due to: a. Medical condition (including physical and mental illness); b. Claims experience; c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; or g. Disability.	Enrollee rights P&P addresses that the MMP will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.

Readiness Review Criteria	Suggested Evidence
4. The MMP 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 MMP informs beneficiaries that they should not be balanced billed. Training materials for providers and staff cover this rule.
5. The MMP has policies and procedures to inform enrollees of their right to reasonable accommodation.	Enrollee rights P&P states that the MMP informs enrollees of their right to reasonable accommodation.

B. Appeals and Grievances

Readiness Review Criteria	Suggested Evidence
1. The MMP staff receives training on enrollee protections, including but not limited to: a. The MMP's organization and coverage determination; and b. The MMP's appeals and grievance processes.	Training materials contain information about the MMP's organization and coverage determination processes and the appeals and grievance processes.
2. The MMP provides enrollees with reasonable assistance in filing appeals and grievances.	Grievances and appeals P&P explains to the extent to which the MMP will assist an enrollee in filing an appeal or grievance.
3. The MMP must: a. Continue to pay providers for all prior-approved, non-Part D benefits that are terminated or modified, pending internal MMP appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that MMPs must continue to pay providers for providing such services, pending an internal MMP appeal. b. Inform Enrollees that they may request continuation of benefits previously authorized for all appeals filed through the State fair hearing process.	Grievances and appeals P&P confirm that any benefits or services being appealed through the internal appeals process are continued for the length of the appeal.
4. The 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 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 MMP should document grievances within the tracking system.
5. The MMP maintains policies and procedures for addressing enrollee grievances, including following: a. Enrollees are entitled to file grievances directly with the MMP; b. The MMP tracks and resolves all grievances, or reroutes grievances to the coverage decision or appeals process as appropriate; and c. The MMP has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals; and d. The 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.

Readiness Review Criteria	Suggested Evidence
6. The MMP maintains policies and procedures for enrollee appeals (other than Part D appeals): a. The MMP resolves internal appeals: i. For standard appeals, within 30 days of filing; and ii. For expedited appeals, within 72 hours of filing or as expeditiously as the Enrollee's condition requires. b. For all non-Part D benefits that the MMP terminates or modifies, the MMP provides continuing Medicare and Medicaid benefits pending an internal MMP appeal. This means that such benefits will continue to be provided by providers to beneficiaries, and that the MMP continues to pay providers for providing such services pending an internal MMP appeal.	Appeals P&P that includes these specifications.
7. The MMP's Part D appeals process under the Demonstration is consistent with the requirements under 42 CFR § 423 Subpart M.	Part D appeals P&P that include these requirements for processing appeals.

C. Enrollee Choice of PCP

Readiness Review Criteria	Suggested Evidence
1. The MMP notifies enrollees about the process for choosing their primary care provider (PCP), including the enrollee's right to select his or her PCP and the 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

Readiness Review Criteria	Suggested Evidence
1. The 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 MMP is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.
2. The MMP can connect enrollees with emergency behavioral health services, when applicable.	Emergency services P&P addresses how the MMP is prepared to provide emergency behavioral health services to enrollees in crisis.

VI. Organizational Structure and Staffing

A. Organizational Structure and Staffing

Readiness Review Criteria	Suggested Evidence
1. The MMP identifies a: a. Behavioral Health Clinical Director; b. Director of Long-Term Services and Supports; c. President of Commonwealth Business; and d. Medical Management Director.	Staff resumes indicate that qualified and experienced staff with appropriate expertise fills these positions.
2. The MMP must establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The MMP must demonstrate the participation of consumers with disabilities, including enrollees, within the governance structure of the MMP.	Bylaws governing the MMP's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the MMP), and that the committee has a process for providing input to the MMP's governing board.

Readiness Review Criteria	Suggested Evidence
3. The MMP's Quality Improvement (QI) committee includes physicians, behavioral health providers, providers with expertise in LTSS, 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-Virginia MOU. Note: For MMPs with current QI committees, review will focus on the change in composition to address the new services (e.g., LTSS and behavioral health).
4. The MMP has an individual or committee responsible for provider credentialing who is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, LTSS, behavioral health, and pharmacy).	A provider credentialing point of contact or committee is reflected in an organizational chart. The provider credentialing point of contact is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, LTSS, behavioral health, and pharmacy).

B. Sufficient Staff

Readiness Review Criteria	Suggested Evidence
1. The MMP demonstrates that it has sufficient employees and/or contractors to complete enrollee assessments, including the LOC annual reassessments for EDCD Waiver participants, as required (including at least annually), for all enrollees within required timeframes through its staffing plan. The staffing plan must explain: a. The MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
2. The MMP staff, contractors, and providers performing enrollee-assessments have the appropriate education and experience for the subpopulations (e.g., experience in LTSS or behavioral health). Staff performing the LOC annual reassessments for EDCD Waiver must have the following qualifications: a. A registered nurse licensed in Virginia with at least one year of experience as an RN; or b. An individual who holds at least a bachelor's degree in a health or human services field and has at least two years of experience working with individuals who are elderly and/or have disabilities.	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description requirements.
3. The MMP 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 MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
4. The qualifications for a care coordinator meet the requirements of the state Demonstration. These requirements include the following: a. Must have a bachelor's degree with demonstrated ability to communicate with members who have medical needs and may have communication barriers; and b. Experience navigating resources and computer systems to access information.	Care coordinator qualifications P&P includes those listed.

Readiness Review Criteria	Suggested Evidence
5. The MMP 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 MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
6. The MMP demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan. The staffing plan must explain: a. The MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
7. The MMP 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 MMP's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the MMP believes will be needed to perform the function; d. How the MMP derived that estimate; and e. In what timeframe the MMP will staff to the level indicated.	The MMP demonstrates that it meets the requirements of the criterion.
8. The MMP Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that 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

Readiness Review Criteria	Suggested Evidence
1. The MMP has a cultural competency and disability training plan to ensure that staff delivers culturally-competent services, in both oral and written enrollee communications (e.g., person-first language, target population competencies).	The MMP's cultural competency and disability training plan (or P&P) identifies which staff receive this training and how often, and includes a schedule of training activities for new staff. The MMP's training materials include training on cultural competency and disability.
2. The MMP staff is adequately trained to handle critical incident and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports providers.	The MMP's training materials include training on critical incident and abuse reporting and include these topics.

Readiness Review Criteria	Suggested Evidence
3. The training program for 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; r. Role of FEA and processes; and s. Role of enrollment broker.	The MMP's training materials for care coordinators include modules or sections on each of these elements.
4. The MMP's staff is trained on HIPAA compliance obligations and the MMP's confidentiality guidelines.	The MMP's training materials include training on HIPAA compliance and confidentiality guidelines.
5. The MMP or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment; f. Formulary information; g. Pharmacy information, including whether an enrollee's pharmacy is in the MMP's network; h. Provider information, including whether an enrollee's physician is in the MMP's network; i. Out-of-network coverage; j. Claims submission, processing, and payment; k. Formulary transition process; l. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); m. Information on how to obtain needed forms; n. Information on replacing an identification card; and o. Service area information.	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See State specific MOU for details)

Readiness Review Criteria	Suggested Evidence
6. The MMP has protocols or staff training modules to train enrollee services telephone line staff in the following areas: a. Explaining the operation of the MMP and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Knowledge of services available through the MMP including EDCD Waiver, consumer-directed options, behavioral health and nursing facility services. d. Assisting enrollees to obtain services and make appointments; and e. Handling or directing enrollee inquiries or grievances.	Content from training programs or orientation modules demonstrate staff from the MMP trains its enrollee services telephone line staff personnel on these topics. Step-by-step procedures or a flow chart showing how staff from the MMP would walk through assisting enrollees in explaining or selecting services.

D. Performance and Quality Improvement

Readiness Review Criteria	Suggested Evidence
1. The 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 a member's home, if the incident is related to the provision of covered HCBS. Critical incidents shall include but not be limited to the following incidents when they occur in a home and community-based long-term care service delivery setting: a. Unexpected death of an EDCD enrollee; b. Suspected physical or mental abuse of an EDCD enrollee; c. Theft against an EDCD enrollee; d. Financial exploitation of an EDCD enrollee; e. Severe injury sustained by an EDCD enrollee; f. Medication error involving an EDCD enrollee; g. Sexual abuse and/or suspected sexual abuse of an EDCD enrollee; and h. Abuse and neglect and/or suspected abuse and neglect of an EDCD enrollee.	QI program description explains how the MMP tracks incidents and cases of abuse for enrollees receiving LTSS. Sample annual performance report includes the MMP's method of tracking and reporting cases of incidents and abuse.
2. The MMP is prepared to report all Year 1 Quality Measures required under the Demonstration including all Medicare Advantage (Part C) required measures, HEDIS, HOS, CAHPS as well as, measures related to behavioral health, care coordination/transitions, LTSS as required by the MOU.	QI Program Description details how the MMP collects these measures for its enrollees. Sample annual performance report includes the MMP's method of reporting these measures.

VII. Provider Credentialing	
Readiness Review Criteria	**Suggested Evidence**
1. The MMP shall: a. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the MMP's provider network that are consistent with recognized NCQA standards, State (MCHIP, and Bureau of Insurance) Standards and Federal regulatory standards particularly with respect to disclosure of ownership and control and assurances of verification against Federal and State excluded entities data bases. b. Ensure that all providers are credentialed prior to becoming network providers; c. Ensure that a site visit is conducted, following recognized NCQA standards and relevant Federal and State regulations and d. Maintain a documented re-credentialing process that: i. Occurs regularly; ii. Includes the consideration of performance indicators obtained through the Quality Improvement Program, utilization management program, grievance and appeals system, and member satisfaction surveys; and iii. Requires physician providers and other licensed and certified professional providers, including behavioral health providers, to maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform to recognized standards by the appropriate licensure/certification entity (health professions, board of medicine, Department of Behavioral Health, etc.), health care industry standards and any other state and DMAS MCO Contract requirements.	Provider credentialing P&P includes these requirements.
2. Prior to contracting with a new provider, the MMP 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 MMP will review these documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.
3. The MMP requires that all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The MMP submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.

VIII. Provider Network	
A. Establishment and Maintenance of Network, including Capacity and Services Offered	
Readiness Review Criteria	**Suggested Evidence**

Readiness Review Criteria	Suggested Evidence
1. The MMP has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including 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.
2. The MMP has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS, and pharmacy provider networks are trained in cultural competency (including language,) for delivering services 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.
3. The MMP 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.
4. The MMP has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.
5. The MMP provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.
6. The MMP ensures that enrollees have access to the most current and accurate information by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).
7. For nursing facilities, the MMP's policy is to contract with any nursing facility that is eligible to participate in Medicare and Medicaid and is willing to accept the MMP payment rates and contract requirements.	P&P for contracting with nursing facility that reflects this requirement.
8. The MMP has secured a contract with the FEA appointed by the State.	The State requires the MMP to contract with the same FEA as is currently used by the State; MMPs must provide an executed contract.

B. Accessibility

Readiness Review Criteria	Suggested Evidence
1. The MMP medical, behavioral, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the MMP alerts its enrollees of providers able to accommodate enrollees with disabilities (e.g., MMPs in provider directory, information available upon request).
2. Medical, behavioral, and LTSS, network providers provide linguistically- and culturally-competent services.	Provider training includes training on cultural competency.
3. 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;	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees.

Readiness Review Criteria	Suggested Evidence
b. Accessibility along public transportation routes, and/or providing enough parking; and c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities.	Templates require providers to take these actions as a condition for participation.

C. Provider Training

Readiness Review Criteria	Suggested Evidence
1. The MMP requires disability literacy training for its medical, behavioral, and LTSS providers, including information about the following: a. Various types of chronic conditions prevalent within the target population; b. Awareness of personal prejudices; c. Legal obligations to comply with the ADA requirements; d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; e. Types of barriers encountered by the target population; f. Training on person-centered planning and self-determination, the 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.	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.
2. The MMP's training for all providers and ICT members includes coordinating with behavioral health and LTSS providers, information about accessing behavioral health and LTSS, and lists of community supports available.	Provider training materials include modules on coordination of care, behavioral health services, LTSS, and community supports (see also care coordinator training in the care coordination section).
3. The MMP provides training to providers, explaining that their contracts require there be no balance billing under the Financial Alignment Demonstration.	Provider training materials and provider handbook include information informing providers of no balance billing.
4. The MMP has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	Data systems management guidelines for LTSS providers address LTSS providers who are not required to have National Provider Identifiers (NPIs).
5. The training program for primary care providers includes: a. How to identify behavioral health needs; and b. How to identify LTSS needs.	The MMP's training materials for PCPs include modules or sections on behavioral health needs and services.

D. Provider Handbook

Readiness Review Criteria	Suggested Evidence
1. The MMP prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. MMP contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; h. Provider billing and reporting; i. Role of the Enrollment Broker; j. Fraud, Waste and Abuse; and k. Marketing Guidelines	Each of the listed elements is included in the provider handbook.
2. The MMP makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers who work with enrollees that require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on MMP website, information about local organizations serving specific subpopulations of the target population).

E. Ongoing Assurance of Network Adequacy Standards

Readiness Review Criteria	Suggested Evidence
1. The MMP ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, are convenient to the population served and do not discriminate against MMP enrollees (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that plan services are available 24 hours a day, 7 days a week, when medically necessary.	Network provider P&Ps that include these provisions.
2. The MMP has a policy and procedure that states that the provider network arranges for necessary specialty care, LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care. List of network providers includes specialties in all geographic regions.

IX. Monitoring of First-Tier, Downstream, and Related Entities

Readiness Review Criteria	Suggested Evidence
1. The MMP has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the MMP. The plan should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities, and 42 CFR §422.504 (i), the Medicare Advantage regulation governing contracts with first tier, downstream, and related entities.	Monitoring plan provides information on how the MMP monitors all first-tier, downstream, and related entities.

X. Systems

A. Data Exchange

Readiness Review Criteria	Suggested Evidence
1. The MMP is able to electronically exchange the following types of data: a. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data; b. Claims data (including paid, denied, and adjustment transactions); c. Financial transaction data (including Medicare C, D, and Medicaid payments); d. Third-party coverage data; e. Enrollee demographic information; f. Provider data; and g. Prescription drug event (PDE) data.	Baseline documentation should include examples of the listed data transmission types and the policies and procedures for securing, processing and validating the data exchange.
2. The MMP 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.
3. The MMP reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website.	Baseline documentation should include the MMP's quality of care policies and procedures for reviewing and acting upon the Part D monthly patient safety reports.
4. The MMP ensures that health information technologies and related processes support national, state, and regional standards for health information exchange and interoperability.	Baseline documentation should include policies and procedures for monitoring the standards for health information exchange and interoperability. The MMP should highlight any HIEs networks in which they currently or are preparing to participate.

B. Data Security

Readiness Review Criteria	Suggested Evidence
1. The MMP has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation should include a copy of the MMP's disaster recovery and business continuity plan and an inventory of the core systems specifically used to operate this Demonstration. Supplemental documentation may include: 1. Proof of disaster recovery plan validation and testing
2. The MMP facilitates the secure, effective transmission of data.	Baseline documentation should include: 2. MMP's Data Security and Privacy P&P; and 3. MMP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives.
3. The MMP maintains a history of changes, adjustments, and audit trails for current and past data systems.	Baseline documentation should include Change Management P&Ps.

Readiness Review Criteria	Suggested Evidence
4. The MMP complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	Baseline documentation should include: 1. MMP P&P noting compliance with NPI standards, specifications, and requirements. 2. Screenshot of provider data/records illustrating that the NPI data field is populated in provider system.

C. Claims Processing

Readiness Review Criteria	Suggested Evidence
1. The MMP processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates.	Baseline documentation should include: 1. Claims processing P&P that details claims processing turnaround timeframes, steps for managing pended claims, and methods for ensuring claims processing accuracy. 2. Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.).
2. The MMP processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and 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 long term services.
3. The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation should include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation should highlight the basis for MMP estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by MMP staff without affecting performance standards. Supplemental documentation may include statistics on average claims processed per processor, annual average of claims per enrollee (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity.
4. The claims system fee schedule includes all medical, LTSS, HCBS, Medicare and Medicaid services.	Baseline documentation should illustrate the following: 1. MMP's process and plan for loading and validating the Demonstration fee schedules. 2. Screen shots of the modules where the fee schedules will be configured and identify how medical, LTSS and HCBS Medicare, and Medicaid services are captured within the system.
5. 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 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.

D. Claims Payment

Readiness Review Criteria	Suggested Evidence
1. The MMP pays 90% 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.
2. The PBM pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims. The MMP pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	Baseline documentation should include: 1. PBM claims P&Ps that describe clean claims payment standards. 2. PBM P&Ps that define interest payments for clean claims that do not meet the processing timeframe standards.
3. The 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 MMP sponsor claims from long term care facilities.
4. The MMP'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 MMP, please provide evidence of the contract with the external vendor, as well as oversight P&Ps, and any performance standards.
5. The MMP's claims processing system checks for pricing errors to identify erroneous payments.	Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous payments. MMPs should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits. Note: If this validation is performed outside of the MMP, please provide evidence of the contract with the external vendor, as well as oversight P&P To include monitoring of timeliness of authorizations for consumer-directed services to ensure that payments to attendants are timely.

E. Provider Systems

Readiness Review Criteria	Suggested Evidence
1. The system generates and maintains records on medical provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. Accessibility of provider office; k. Credentialing information; and l. Proximity to public transportation.	Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots 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

Readiness Review Criteria	Suggested Evidence
1. The PBM generates and maintains records on the pharmacy networks, including locations and operating hours where the MMP subcontracts the maintenance of the pharmacy network.	Baseline documentation should include: 1. The PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours. 2. A screenshot or sample of how this information is collected, maintained, and made accessible to enrollees.
2. The PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies. The MMP ensures that the PBM performs this function.	Baseline documentation should include the PBM's P&P for updating/maintaining pharmacy provider network information and the MMP's P&P for oversight of the PBM for this function.
3. The MMP audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a regular basis in those instances where the MMP subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the MMP's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring.
4. 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 submission requirements for Part D PDE reporting. 2. MMP's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.
5. The 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.

Readiness Review Criteria	Suggested Evidence
6. The MMP ensures that the PBM's claims adjudication system: 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.	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 MMP's P&P for oversight of the PBM performance on transitional fills.
7. The PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine Part D and Medicaid covered drugs and can coordinate benefits properly in the event of systems downtime.	Baseline document should include the PBM's disaster recovery and business continuity plan for ensuring the proper identification of benefit coverage and continued coordination of benefits with secondary payers in the event of downtime or the pharmacy's inability to connect to the PBM's systems.

G. Enrollment Systems

	Suggested Evidence
1. The MMP receives, processes, and reconciles in an accurate and timely manner: a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and b. The benefit and enrollment maintenance file from the state.	Baseline documentation should include the MMP's P&P on processing and reconciling enrollment files. Documentation should also include the MMP's enrollment systems schematic that details the daily enrollment processing capacity.
2. If the MMP receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the 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 should include the MMP's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.
3. The MMP'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. Enrollee signature and/or authorized representative signature; l. Date of signature; m. Authorized representative contact information; n. Employer or union name and group number; o. Which plan the enrollee is currently a member of and to which MMP the enrollee is changing; p. Information provided under "please read and sign below" q. Release of information; r. Option to request materials in a language other than English or in alternate formats; and s. Medicaid #.	Documentation should include screenshots of the MMP's enrollment/member system that confirms each data element listed is available in the system.

	Suggested Evidence
4. For passive enrollments, the MMP sends the following to the enrollee 30 days prior to the effective date of coverage: a. A MMP-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the MMP; c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the enrollee may begin using MMP services as of the effective date of enrollment.	Baseline documentation should include the MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.
5. For passive enrollments, the MMP sends the following to the enrollee no later than the last calendar day of the month prior to the effective date of coverage: a. A single ID card for accessing all covered services under the MMP; and b. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the MMP's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC). The MMP should also illustrate how it systematically tracks when these materials are sent, if applicable.
6. For voluntary enrollments, the MMP provides the following materials to the enrollee no later than ten days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later: a. A comprehensive integrated formulary; b. A combined provider and pharmacy directory; c. A single ID card; and d. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the MMP's P&P detailing the processes and timeframes for sending the enrollee materials. The MMP should also illustrate how they systematically track when these materials are sent.

H. Care Coordination and Care Quality Management Systems

Readiness Review Criteria	Suggested Evidence
1. The system generates and maintains records necessary for care coordination, including: a. Enrollee data (from the enrollment system); b. Enrollee EDCD Waiver status (if applicable); c. Provider network; d. Interdisciplinary care team membership for specific enrollees; e. Enrollee assessments; f. Enrollee plans of care; g. Interdisciplinary care team case notes; and h. Claims information.	Baseline documentation should illustrate where each of these items are captured in the care coordination system. If screenshots are provided, note where each item is captured. If the system requires modifications to support new data fields, provide information that details the requirements and timeline for these system modifications.
2. The MMP maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include the MMP's help desk and application support P&Ps for managing issues related to the care coordination system.
3. The MMP verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include the MMP's P&P for ensuring data quality in the care coordination system.
4. The enrollee assessments and plans of care are available to enrollee interdisciplinary care teams and any of the enrollee's other providers.	Documentation should include: a. The MMP's P&P for securing and providing access to the care coordination system. b. The MMP's workflow processes for making enrollee assessment and plans of care information available to the enrollee's providers.

Readiness Review Criteria	Suggested Evidence
5. The care coordination system includes a mechanism to alert interdisciplinary care team members of ED use or inpatient admissions.	Baseline documentation should the MMP's P&P for tracking ED and inpatient admissions and notifying the interdisciplinary care team. Note: this should include the required notification timeframe for both admission types.

XI. Utilization Management

A. The MMP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services

Readiness Review Criteria	Suggested Evidence
1. The MMP specifies procedures under which the enrollee may self-refer services.	The UM program descriptions for the MMP explains for which services an enrollee can self-refer.
2. The MMP defines medically necessary services as services that are: a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the MMP will apply the definition of medical necessity that is the more generous to the enrollee of the applicable Medicare and Virginia's Medicaid standards.	The MMP's UM program description includes these definitions of medical necessity.
3. The MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.	The UM program description for the MMP defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.
4. The MMP has policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description for the MMP includes these elements for the MMP and the MMP's PBM.
5. The MMP has a methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The UM program descriptions for the MMP explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines).
6. The MMP: a. Outlines its process for authorizing out-of-network services; and b. If specialties necessary for enrollees are not available within the network, the MMP will make such services available out-of-network.	Out-of-network service authorization P&P explains how an enrollee or provider may obtain authorization for a service being provided by a provider outside of the MMP's network.
7. The MMP describes its processes for communicating to all providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The MMP's provider materials describe prior authorization requirements and procedures.

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