Plan Readiness Report

Coordinated Care Initiative

April 2014

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Executive Summary

Governor Brown signed Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012) and SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), as part of the Budget Act of 2012, which established the Coordinated Care Initiative (CCI). Further updates and clarifications to this initiative were enacted in June 2013 through SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). This legislation requires the California Department of Health Care Services (DHCS) to submit a readiness report describing the process used to assure that health plans are prepared to participate in California's Duals Demonstration Project, referred to as Cal MediConnect, pursuant to Welfare and Institutions (W&I) Code Section (§) 14182.17(e)(4)(D).

CCI will become effective in the counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara according to the implementation schedule titled, "CCI Enrollment Timeline by Population and County," that can be found on the calduals website under the heading Enrollment Chart at the following link: http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/.

As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, CMS and California developed a multi-step process to ensure that every selected Cal MediConnect plan is fully ready to accept enrollment.

In February 2014, DHCS announced a revised enrollment strategy for Los Angeles County. For Cal MediConnect only, there will be five Cal MediConnect plans, instead of two (LA Care and Health Net) as previously scheduled, in Los Angeles County. This means beneficiaries will have more options when selecting a Cal MediConnect plan in this county. The three additional plans, CareMore, Care 1st, and Molina are in the process of readiness reviews for Los Angeles County; however, these three plans have undergone extensive readiness reviews in other counties.

There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

The Cal MediConnect Readiness Review Tool, a 58-page document, contains wide-ranging areas and criteria within each functional area that cover the broad range of plan requirements related to Cal MediConnect. To ensure a complete review, CMS engaged an external contractor, National Opinion Research Center (NORC) at the University of Chicago, to assist in the readiness review process. The readiness review was conducted in addition to other review steps (e.g., Medicare application, National Committee for Quality Assurance (NCQA) review of each Cal MediConnect plan model of care). The readiness review consists of four main components:

- Desk Review;
- Site Visit and Systems Testing;

- Network Validation; and
- Pre-Enrollment Validation.

For a plan to participate in Cal MediConnect, it must have successfully completed all components of the readiness review, including other important reviews, such as Medicare's application process and an NCQA review of each Cal MediConnect plan's Medicare model of care.

Introduction

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), including dual-eligibles (individuals eligible for Medicaid and Medicare), while achieving savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI through SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). This legislation requires the California Department of Health Care Services (DHCS) to submit a readiness report describing the process used to assure that health plans are prepared to participate in California's Duals Demonstration Project, referred to as Cal MediConnect, pursuant to Welfare and Institutions (W&I) Code Section (§) 14182.17(e)(4)(D).

The three major components of the CCI to be implemented in 2014 are:[1]

1. A three-year Demonstration Project (Cal MediConnect) for dual-eligibles that combines the full continuum of acute, primary, institutional, and home- and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for dual-eligibles; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD dual-eligibles.

This report explains the process used to assure plan readiness, as required by W&I Code §14182.17(e)(4)(D). As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, Centers for Medicare and Medicaid Services (CMS) and DHCS developed a multi-step process to ensure that every selected Cal MediConnect plan is fully ready to accept enrollment. This document explains the comprehensive joint CMS/State readiness review that every selected Cal MediConnect plan must pass in order to participate in Cal MediConnect.

[1] SB 1036 also authorizes the creation of a Statewide Public Authority for In Home Supportive Services (IHSS) collective bargaining and a county Maintenance of Effort for funding IHSS. However, statute does not require that these provisions be included in the scope of this report.

I. Readiness Review: Overview

The Cal MediConnect Readiness Review Tool was posted on the CMS website March 29, 2013.[2] This readiness review tool developed by CMS and DHCS for Cal MediConnect, California's Duals Demonstration Project, is the product of:

- Key requirements outlined in the CMS/California Memorandum of Understanding signed on March 27, 2013;
- The California Request for Solutions;
- Duals Plan Letters, which articulate key policy for the Cal MediConnect program;
- Key Medicaid and Medicare regulations; and,
- Stakeholder input received through letters and public meetings.

Systems-related criteria included in the readiness review tool reflect standard health care Information Technology practices. Particular attention was also paid to criteria for pharmacy and claims processing and payment that align with Medicare and Medicaid requirements. The readiness review tool contains functional areas and criteria within each functional area that cover the broad range of plan requirements related to Cal MediConnect. The functional areas reviewed that plans were required to meet are:

- Assessment;
- Care Coordination;
- Confidentiality;
- Enrollee and Provider Communications;
- Enrollee Protections;
- Monitoring of First-Tier, Downstream, and Related Entities;
- Organizational Structure and Staffing;
- Performance and Quality Improvement;
- Provider Credentialing;
- Provider Network;
- Systems; and,
- Utilization Management.

To ensure a complete review, CMS engaged an external contractor, National Opinion Research Center (NORC) at the University of Chicago, to assist in the readiness review process. The readiness review was conducted in addition to other review steps (e.g., Medicare application, National Committee for Quality Assurance (NCQA) review of each Cal MediConnect plan model of care). The readiness review consists of four main components:

- Desk Review;
- Site Visit and Systems Testing;
- Network Validation; and,
- Pre-Enrollment Validation.

[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf

Desk Reviews

On March 28, 2013, NORC sent a letter to each prospective plan (including subcontracted plans in Los Angeles County) to initiate the readiness review process, notify them of the documents they would be required to submit as part of the desk review, and inform them of the other phases of the readiness review process (e.g., site review, network validation, systems testing). Each plan was provided a list of the functional areas and related criteria, and was required to submit documents to demonstrate compliance with all criteria. Additionally, each plan was required to submit documents to rectify outstanding deficiencies. Plans were also required to submit a detailed project plan for the enhancement, development, and implementation of the information systems architecture required by Cal MediConnect. Between April and June 2013, the NORC team conducted extensive analysis of all the materials received from each plan.

Site Visit and System Testing

In July and August 2013, NORC, accompanied by CMS and DHCS staff, visited each plan, including subcontracted plans in Los Angeles County, at its place of business to further assess its understanding of Cal MediConnect requirements. During each site visit, the team reviewed all key areas of the readiness review tool.

Two teams participated in each site visit: one team interviewed plan staff about key operational areas; the other reviewed the plan's systems and systems-related functions. Additionally, each plan was provided with comprehensive care coordination systems testing scenarios that required the plan to simulate a "day in the life" of an enrollee and care manager within its systems. The functional areas evaluated included:

- Enrollment Processing;
- New Enrollee Intake and Outreach;
- Conducting the Health Risk Assessment (HRA);
- Enrollee Stratification;
- Care Manager Assignment;
- Creation of an Interdisciplinary Care Team (ICT);
- Development of a Care Plan;
- Documentation of the ICT Team Meeting Outcomes;
- Acute and Ambulatory Care Transitions; and,
- Process for Securing Long Term Care Support and Behavioral Health Services.

Pharmacy and non-pharmacy claims system testing was also conducted using a series of claims scenarios designed to address Medicare and Medicaid benefits along with continuity of care requirements. NORC developed 25 – 35 pharmacy and non-pharmacy test claim scenarios that each plan had to run through its claims processing system to test whether the system was configured properly for Cal MediConnect (i.e., testing if continuity of care requirements are programmed correctly). NORC conducted additional systems testing remotely in mid-October, as necessary, on a plan-specific basis.

Network Validation

On May 17, 2013, each plan received a letter from NORC asking them to submit Medicare facility and provider health services delivery tables, and DHCS Medi-Cal provider network tables. Based on a sample of providers, facilities and pharmacy networks pulled by NORC from the Health Plan Management System (HPMS), CMS and DHCS conducted a network validation review to confirm that each Cal MediConnect plan has fully contracted provider, facility, and pharmacy networks that meet Medicare and Medi-Cal network adequacy standards. On July 3, 2013 NORC sent each plan the sample of providers, facilities and pharmacies, and asked the plan to submit contract signature pages for this sample. Plans were also asked to provide contact information for each provider/facility/pharmacy by July 11, 2013. NORC then checked that all signature pages were submitted and signed. NORC pulled an additional sample of providers, facilities and pharmacies from each table and placed calls to verify that the provider/facility/pharmacy had a current contract with the plan for the Cal MediConnect.

Pre-Enrollment Validation

CMS conducted a pre-enrollment validation process to confirm that the policies and procedures reviewed during the desk review or discussed as part of the site visit are being operationalized prior to the start of Cal MediConnect plan marketing. This includes making sure that staff are being hired in accordance with staffing plans, staff are being trained on the topics required by Cal MediConnect prior to marketing, and key call center and customer service center scripts contain accurate and sufficient information.

Cal MediConnect plans received the request for information on November 7, 2013 and were required to submit the requested information the week of November 18, 2013. The request for information included five parts (beyond the items already submitted in the readiness review process):

- Call Center Information: Telephone numbers for each call line (e.g., language line, customer service line, coverage determination line, nurse advice line, behavioral health line, provider hotline, accompanying TTA/TTY lines).
- Staffing Information: Number of staff expected for key functions, including assessment, care coordination, member services, Minimum Data Set-Home Care assessments, and coverage line determinations; staff trainings to date and planned for future.
- Scripts: Five key scripts (benefits, formulary, continuity of care, formulary transition, and grievances and appeals) to ensure the unique requirements of Cal MediConnect, are explained correctly.
- Attestations: Attestations were obtained to the following statements:
  - The consumer governance board will be established by or on the effective date of Cal MediConnect and will comply with all contractual requirements, including composition and frequency of meetings;
  - The CMS HPMS is current and all plan points of contact are up to date; and
  - All call center scripts required through the Medicare marketing guidelines that were not collected as part of the pre-enrollment validation appropriately incorporate Cal MediConnect.

II. Readiness Review: Specific Analyses

This section lists the specific standard, process or tools that were used to analyze the readiness of the 17 separate items enumerated in W&I Code §14182.17(e)(4)(D). This section is intended to be read in conjunction with the California Readiness Review Tool[3] which was used to evaluate the readiness of plans for certain items listed below.

There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

1. Data Sharing:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(1) utilizing the California Readiness Review Tool. The California Readiness Review Tool sections relevant to Data Sharing include Table 11. Systems, Points A-F: Pages 42-50.

2. Provider Networks and Access:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(2) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Provider Networks and Access:

- Table 7. Organizational Structure and Staffing, Point A, Bullet 5: Page 24.
- Table 9. Provider Credentialing: Page 35.
- Table 10. Provider Network, Point A: Page 36-38.
- Table 10. Provider Network, Point F, Bullets 1-4: Pages 40-41.

3. Monitoring and Quality Improvements:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(3) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Monitoring and Quality Improvements:

- Table 7. Organizational Structure and Staffing, Point A, Bullet 4: Page 24.
- Table 7. Organizational Structure and Staffing, Point B, Bullet 6: Page 26.
- Table 11. Systems, Point G: Pages 50-52.
- Table 12. Utilization Management, Points A-B: Pages 53-55.

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf

4. Accessibility:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(4) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Accessibility:

- Table 10. Provider Network, Point E: Page 39.
- Table 10. Provider Network, Point H: Page 41.

5. Readiness Standards:

Per the requirements of W&I Code §14087.48(b)(5), DHCS is to report on, "The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees."

DHCS will only allow plans to implement Cal MediConnect if all readiness standards have been met. There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

6. Contract Deliverables:

Per the requirements of W&I Code §14087.48(b)(6), DHCS is to report on, "The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments."

DHCS will only allow plans to implement Cal MediConnect if all needed contract deliverables have been provided. DHCS will continue to work with all plans to ensure that materials are received timely.

7. Health Plans Informational Materials:

Per the requirements of W&I Code §14087.48(b)(7), DHCS is to report on, "The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood."

Medicare sets strict marketing rules and marketing materials can only be used in Cal MediConnect once approved through that process. Medi-Cal notices are drafted by DHCS, who then oversees the work done by the plans. Taken together, this process ensures that Cal MediConnect plans have accurate and easily understood documents for beneficiaries.

8. Facility Site Reviews:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(8). The Facility Site Review was completed separately from the California Readiness Tool. The review procedures are provided in Duals Plan Letter 13-003 "Facility Site Review/Physical Accessibility Reviews" released July 17, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-003.pdf)

9. Enrollee Communications:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(1) to ensure timely and appropriate communications with beneficiaries through the following:

- Outreach Plan: DHCS released for comment an outreach and communications plan in 2013. That outreach plan has been revised per stakeholder comment and will be re-released in the near future. The document is part of an iterative process where the outreach plan is improved and reformed over the enrollment period.
- Plan Communications: As part of existing Medicare and Medi-Cal requirements, plans have met requirements on communicating in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations. This includes information on grievance and appeals. This also includes ensuring that plan policies and procedures address the effective transition of beneficiaries from Medicare Part D plans not participating in Cal MediConnect; as Medicare plans, Medicare ensures that Cal MediConnect plans are in compliance with all Medicare Managed Care Manual provisions.
- Contracting with Community-Based Groups: DHCS will contract with one community based organization in each county. SCAN Foundation is facilitating the selection of that individual who will then be supported by DHCS for 25 of the percent time.
- Enrollment Notice Development: DHCS continues to develop notices in compliance with all relevant statutory provisions and with stakeholder input. Each notice is made available publicly for stakeholder comment, and typically results in 20 or so letters being received. Notices are available in all threshold languages and alternative formats. Each notice includes information on how to obtain assistance on enrollment from both the Health Insurance Counseling & Advocacy Program and Medi-Cal's Health Care Options.
- Choice Guide: DHCS has vetted with stakeholders and will make available a booklet explaining plan choices and continuity of care provisions.

The California Readiness Review Tool sections that are relevant to Enrollee Communications include Table 5. Enrollee and Provider Communications, Point A, Bullets 1-5: Pages 19-20.

10. HRAs:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(2) utilizing the California Readiness Review Tool to ensure the managed care health plans perform an assessment process. The following sections of the California Readiness Review Tool are relevant to HRAs:

- Table 1. Assessment Processes, Point B: Pages 2-5.
- Table 7. Organizational Structure and Staffing, Point B, Bullets 2-5: Pages 25-26.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-002 on "Health Risk Assessment and Risk Stratification Requirements" released June 24, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-002.pdf)

11. Primary Care:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(3) utilizing the California Readiness Review Tool to ensure the managed care plans arrange for primary care. The California Readiness Review Tool sections relevant to Primary Care include Table 4. Enrollee Protections, Point C: Page 18.

Partial duals, as discussed in W&I Code §14182.17(d)(3)(B) and (C), cannot participate in Cal MediConnect. Existing Medi-Cal contract provisions apply to the partial duals population that offer protections on access to primary and specialty care physicians.

12. Care Coordination:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(4) utilizing the California Readiness Review Tool to ensure the managed care plans perform care coordination and care management activities. The following sections of the California Readiness Review Tool are relevant to Care Coordination and Interdisciplinary Care Team:

- Table 2. Care Coordination, Points A-C: Pages 6-12.
- Table 3. Confidentiality: Page 13.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 2-3: Page 28.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 9-11: Pages 31-32.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-005 on "Continuity of Care" released November 27, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf)

13. Network Directory, Long-Term Care Supports and Services, and Out of Network Care:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(5) utilizing the California Readiness Review Tool to ensure the managed care plans comply with network adequacy requirements. The following sections of the California Readiness Review Tool are relevant to Network Directory, LTSS, and Out-of-Network Care:

- Table 5. Enrollee and Provider Communications, Point A, Bullet 6: Page 21.
- Table 5. Enrollee and Provider Communications, Point B: Page 22.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 8: Page 30.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 12: Page 32.
- Table 10. Provider Network, Point A, Bullets 6-13: Page 37.
- Table 10. Provider Network, Point G: Page 41.

14. Care Management:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(6) utilizing the California Readiness Review Tool to ensure the managed care health plans address medical and social care management needs. The following sections of the California Readiness Review Tool are relevant to Care Management:

- Table 7. Organizational Structure and Staffing, Point C, Bullet 1: Page 28.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 4, 6-7: Page 29.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-006 on "Care Plan Option Services" released December 6, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-006.pdf)

15. Grievance and Appeals Processes:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(7) utilizing the California Readiness Review Tool to ensure the managed care health plans provide a grievance and appeal process. The following sections of the California Readiness Review Tool are relevant to Grievance and Appeals Processes:

- Table 4. Enrollee Protections, Points A-B: Pages 14-17.
- Table 7. Organizational Structure and Staffing, Point B, Bullets 7-8: Page 27.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 5: Page 29.

16. Set and Implement Quality Measures:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(e)(1) utilizing the California Readiness Review Tool to monitor the managed care health plans' performance and accountability for provision of services. The following

sections of the California Readiness Review Tool are relevant to Set and Implement Quality Measures:

- Table 6. Monitoring of First-Tier, Downstream, and Related Entities: Page 23.
- Table 7. Organizational Structure and Staffing, Point B, Bullet 9: Page 27.
- Table 8. Performance and Quality Improvement: Pages 33-34.

DHCS will continue to work with CMS and their contractor, Research Triangle Institute, to develop a plan for plan oversight. The stakeholder process on quality, which included four meetings between May and August 2012, continues.[4]

17. Stakeholder Outreach:

DHCS conducted a readiness review of all the requirements at W&I Code §14182.17(e)(3) utilizing the California Readiness Review Tool to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual-eligible beneficiaries. The following sections of the California Readiness Review Tool are relevant to Stakeholder Outreach:

- Table 5. Enrollee and Provider Communications, Point A, Bullets 7-9: Page 21.
- Table 7. Organizational Structure and Staffing, Point A, Bullet 3: Page 24.

[4] For more information, please see: http://www.calduals.org/implementation/workgroup/quality/

APPENDIX A: State Plan Readiness Reporting Requirement Statute

Welfare and Institutions Code Section 14182.17

(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:

(1) Ensure timely and appropriate communications with beneficiaries as follows:

(A) At least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at not more than a sixth-grade reading level that includes, at a minimum, how the Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with problems they encounter.

(B) Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.

(C) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.

(D) Ensure that managed care health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.

(E) Ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures, that are offered by the plan or are available through the Medi-Cal program.

(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a nonformulary drug.

(G) Contingent upon available private or public funds other than moneys from the General Fund, contract with community-based, nonprofit consumer, or health insurance

assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.

(H) Develop, with stakeholder input, informing and enrollment materials and an enrollment process in the demonstration site counties. The department shall ensure all of the following prior to implementing enrollment:

(i) Enrollment materials shall be made public at least 60 days prior to the first mailing of notices to dual eligible beneficiaries, and the department shall work with stakeholders to incorporate public comment into the materials.

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

(iii) The materials shall plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan.

(iv) The materials shall plainly state that the beneficiary shall be enrolled in a Medi-Cal managed care health plan even if he or she chooses to stay in fee-for-service Medicare.

(v) The materials shall plainly explain all of the following:

(I) The plan choices.

(II) Continuity of care provisions.

(III) How to determine which providers are enrolled in each plan.

(IV) How to obtain assistance with the choice forms.

(vi) The enrollment contractor recognizes, in compliance with existing statutes and regulations, authorized representatives, including, but not limited to, a caregiver, family member, conservator, or a legal services advocate, who is recognized by any of the services or programs that the person is already receiving or participating in.

(I) Make available to the public and to all Medi-Cal providers copies of all beneficiary notices in advance of the date the notices are sent to beneficiaries. These copies shall be available on the department’s Internet Web site.

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.

(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.

(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.

(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(3) Ensure that the managed care health plans arrange for primary care by doing all of the following:

(A) Except for beneficiaries enrolled in the demonstration project pursuant to Section 14132.275, forgo interference with a beneficiary's choice of primary care physician under Medicare, and not assign a full-benefit dual eligible beneficiary to a primary care physician unless it is determined through the risk stratification and assessment process

that assignment is necessary, in order to properly coordinate the care of the beneficiary or upon the beneficiary's request.

(B) Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan.

(C) Provide a mechanism for partial-benefit dual eligible enrollees to request a specialist or clinic as a primary care provider if these services are being provided through the Medi-Cal managed care health plan. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollees.

(4) Ensure that the managed care health plans perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(A) Reflect a member-centered, outcome-based approach to care planning, consistent with the CMS model of care approach and with federal Medicare requirements and guidance.

(B) Adhere to a beneficiary's determination about the appropriate involvement of his or her medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(C) Develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system, including transitions among levels of care and between service locations.

(D) Develop individual care plans for higher risk beneficiaries based on the results of the risk assessment process with a particular focus on long-term services and supports.

(E) Use nurses, social workers, the beneficiary's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or receiving long-term services and supports.

(F) Consider behavioral health needs of beneficiaries and coordinate those services with the county mental health department as part of the beneficiary's care management plan when appropriate.

(G) Facilitate a beneficiary's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorders treatment services.

(H) Monitor skilled nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. Plans

shall monitor and support beneficiaries in the community to avoid further institutionalization.

(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows:

(A) Provide access to providers that comply with applicable state and federal law, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(B) Meet provider network adequacy standards for long-term services and supports that the department shall develop.

(C) Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and the Internet, and in accessible formats, upon request.

(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.

(E) Contract with and assign patients to safety net and traditional providers as defined in subdivisions (hh) and (jj), respectively, of Section 53810 of Title 22 of the California Code of Regulations, including small and private practice providers who have traditionally treated dual eligible patients, based on available medical history to ensure access to care and services. A managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(F) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

(I) Employ care managers directly or contract with nonprofit or proprietary organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

(6) Ensure that the managed care health plans address medical and social needs as follows:

(A) Offer services beyond those required by Medicare and Medi-Cal at the managed care health plan's discretion.

(B) Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the managed care health plan's responsibilities.

(C) Facilitate communication among a beneficiary's health care and personal care providers, including long-term services and supports and behavioral health providers when appropriate.

(D) Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the beneficiary, including referrals to address any physical or cognitive barriers to access.

(F) Utilize the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) (A) Ensure that the managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process that does both of the following:

(i) Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the department. Each managed care health plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(ii) Complies with a Medicare and Medi-Cal grievance and appeal process, as applicable. The appeals process shall not diminish the grievance and appeals rights of IHSS recipients pursuant to Section 10950.

(B) In no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program.

(e) The department shall do all of the following:

(1) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(C) Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.

(D) Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a joint report, from the department and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following:

(i) The independent audit report required to be submitted annually to the Department of Managed Health Care by managed care health plans participating in the demonstration project authorized by Section 14132.275.

(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and

completed for the previous calendar year by the Department of Managed Health Care and the department.

(2) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(3) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(4) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(B) Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic transition plan, and submit that plan to the Legislature within 90 days of the effective date of this section. The plan shall include, but is not limited to, the following components:

(i) A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

(ii) Explanations of the operational steps, timelines, and key milestones for determining when and how the components of paragraphs (1) to (9), inclusive, shall be implemented.

(iii) The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

(iv) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plan, and how their feedback shall be taken into consideration after transition activities begin.

(C) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued

consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.

(D) No later than 90 days prior to the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9), inclusive. **(Note: 14182.17 (e)(1) and (3) in existing statute, were previously in statute as 14182.17 (d)(8) and (9)**.

Welfare and Institutions Code 14087.48:

14087.48. (a) For purposes of this section "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care physicians, specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to,

procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments.

(7) The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan's primary care and facility sites have been reviewed and evaluated by the department.

THE TABLES REFERENCED IN THIS REPORT FOLLOW THIS PAGE

Financial Alignment Capitated Readiness Review
California 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 California have developed a state-specific readiness review tool based on stakeholder feedback that California and CMS received through letters and public meetings, the content of the Memorandum of Understanding signed on March 27, 2013, the California Request for Solutions (RFS), and applicable Medicare and Medicaid regulations. The California readiness review tool is attached.

The California readiness review tool is tailored to the requirements of the approved demonstration, and the State's target population. 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 will address key areas that directly impact a beneficiary's ability to receive services including, but not limited to: assessment processes, care coordination, provider network, staffing, and systems to ensure that the organization has the capacity to handle the increase in enrollment of the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria also focus on whether a MMP has the appropriate beneficiary protections in place, including but not limited to, whether the MMP has policies that adhere to the Americans with Disabilities Act, uses person-centered language and reinforces beneficiary roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models of behavioral health services. 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. The California readiness review tool includes shaded grey rows indicating where criteria are deferred for a short period, contingent upon CMS and California providing MMPs with additional guidance. Additional criteria related to enrollment functions and systems will also be provided when additional guidance is released. Assessment of all criteria, including enrollment criteria and those in shaded grey, will be completed before MMPs receive enrollment.

CALIFORNIA READINESS REVIEW DOCUMENT

Table 1. Assessment Processes

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Transition to New MMP and Continuity of Care			
1. The Medicare-Medicaid Plan (MMP) assures continuity of care for medical, mental and behavioral, and long-term services and supports (LTSS), upon new enrollment. The MMP must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for: a. A period, up to six months, for primary and specialty Medicare services, if all of the following criteria are met: i. The enrollee demonstrates an existing relationship with the provider, prior to enrollment; ii. The provider is willing to accept payment from the MMP based on the current Medicare fee schedule; and iii. The MMP would not otherwise exclude the provider from their provider network due to documented quality of care concerns. b. A period, up to 12 months, for Medi-Cal services covered under this Demonstration other than in-home supportive services (IHSS), if all of the following criteria are met: i. The enrollee demonstrates an existing relationship with the provider, prior to enrollment; ii. The provider is willing to accept payment from the MMP based on the MMP's rate for the service offered or applicable Medi-Cal rate, whichever is higher; and iii. The MMP determines the provider meets applicable professional standards and would not otherwise exclude the provider from its provider network due to documented quality of care concerns.	The MMP's continuity of care plan or P&P addresses this criterion. Training and outreach modules describe these provisions for staff. The MMP's continuity of care plan or P&P includes provisions for permitting enrollees to retain their current providers and services, including covered waiver services, in accordance with the requirements in the CMS-California MOU. The MMP has staff designated to contact enrollees when they receive a non-covered service.	X	X
2. 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 or is a drug that California is requiring the MMP to cover under the Demonstration.	P&P allows and defines a time period (at a minimum within the first 90 days of coverage) when it will provide temporary fills on refills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that California is requiring the MMP to cover under the Demonstration.	X	X
2. The MMP assures that, in outpatient settings and within the first 90 days of coverage, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that California is requiring the MMP to cover under the Demonstration contain at least a 30-day supply.	Transition plan or drug dispensing P&P defines temporary drug supply in outpatient settings as at least 30 days.	X	X
3. The MMP assures that, in long-term care settings such as a nursing facility, sub-acute care facility, or an assisted living facility, 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 or drug dispensing P&P defines temporary drug supply in long-term care settings to be at least 91 days.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP provides written notice to enrollees, within three business days of temporary fills, if their drug 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.	X	X
5. The MMP takes steps to provide enrollees that use the transition benefit with appropriate assistance and information necessary to enable them to understand the transition. This includes contacting those enrollees to ensure they have the necessary information to enable them to switch to a formulary product or as an alternative pursue necessary prior authorizations or formulary exceptions.	Transition plan P&P states that the MMP contacts enrollees when they refill a non-formulary drug or receive a non-covered service during the 90 day transition period, and provides assistance for transitioning to formulary drugs, including filing an exception or consulting with the prescriber to find alternative equivalent drugs on the formulary.	X	X
6. The MMP has a signed local Behavioral Health Memorandum of Understanding (BH-MOU) to assure seamless access and delivery of behavioral health services. The local BH-MOU will include at least the following concepts specific to the Demonstration: a. Delineation of roles and responsibilities; b. Policies and procedures for sharing beneficiary-specific information including medication list and service utilization information; c. Policies and procedures for care coordination; and d. Agreement on the specifically described Shared Accountability performance measures and financial incentives tied to achieving the quality withhold.	The MMP submits signed MOU that includes all provisions described in the CMS-California MOU.	X	
B. Assessment			
1. The MMP has a CMS- and California-approved mechanism or algorithm for risk stratification of enrollees that includes the review of historical Medi-Cal fee-for-service utilization data and Medicare data to prioritize assessment to higher-risk and lower-risk groups and inform care planning.	The MMP must submit the algorithm or mechanism to complete risk stratification for CMS review and approval. Assessment P&P outlines the process for determining each risk group consistent with California requirements.	X	X
2. Upon enrollment the MMP will perform a health risk assessment, which will be the starting point for creating the enrollee's individualized care plan and will serve as the basis for further assessment of needs that may include, but are not limited to, mental health, substance use, chronic physical conditions, self-direction, incapacity in key activities of daily living, dementia, cognitive status and the capacity to make informed decisions. The assessment tool used for this assessment must: a. Include a universal set of questions such as the SF-12; and b. Be approved by California and CMS.	The MMP must submit the algorithm or mechanism to complete risk stratification for CMS review and approval.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
3. The MMP describes how the health risk assessment and annual re-assessment are conducted for each enrollee, and assures that it has the capacity to administer them in a format suitable to the enrollee's preferences and abilities. The MMP will assess the enrollee's needs and health or functional status, and the preference of the enrollee when determining if the HRA will be completed in person (face-to-face in home or physician office) or by telephone. MMPs are required to contact enrollees within the required assessment timeframes through a variety of communication methods that will include repeated documented efforts to contact each enrollee.	Assessment P&P explains how staff from the MMP will respond to those enrollees who decline to participate in a health risk assessment. Assessment P&P describes how the MMP staff will assist enrollees who require additional prompting and/or guidance about participating in the assessment (e.g., enrollees with comorbidities, such as mental health and substance abuse issues, along with physical disabilities).	X	X
4. The MMP has a process for administering a comprehensive assessment of the individual's physical behavioral health and functional needs, using a health risk assessment tool approved by CMS and California, as follows: a. To all enrollees within 90 calendar days of enrollment; and b. To enrollees identified by the risk-stratification mechanism as higher-risk, within 45 calendar days.	Assessment P&P outlines the process by which the MMP will administer the assessment and use an HRA assessment tool approved by the state and CMS. 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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP's assessment process includes these required elements: a. Review of all Medicare and Medi-Cal utilization data (including Medicare Parts A, B, and D, and Medi-Cal IHSS, multipurpose senior service program (MSSP), skilled nursing facility (SNF), and behavioral health pharmacy data); b. Review of results of previously-administered assessments, and other medical, IHSS, nursing facility, and behavioral health assessments; c. Identification of referrals to LTSS and appropriate home- and community-based services, such as mental health and behavioral health, IHSS, community-based adult services (CBAS), MSSP, personal care services, and nutrition programs; d. Preference of the enrollee in determining if assessment is completed in person or by telephone; e. Identification of caregivers and authorized representatives who may be involved in the individualized care plan with the enrollee's approval; f. Identification of the beneficiary's current need for supports or services that should be addressed in the immediate future; g. Identification of the need for referrals to resolve any physical or cognitive barriers to access; access means that the enrollee is not impeded physically, or by lack of provider availability, to contact and receive the full spectrum of Medically Necessary Covered Services. h. Identification of the need for facilitating communication among the enrollee's health care providers, including mental health and substance abuse providers, when appropriate; i. Identification of the need to provide other activities or services to assist enrollees in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health or functional status; and j. Identification of the need for more complex care coordination, such as discharge planning.	The MMP's P&Ps related to the assessment process covers these domains.	X	X
6. The MMP shall utilize all information received through the health risk assessment process to make referrals to LTSS agencies for those enrollees.	Assessment P&P includes these requirements for the comprehensive assessment for enrollees identified in the initial assessment as needing LTSS.	X	X
7. The MMP specifies how the results of the health risk assessment are communicated to the enrollee's primary care provider (PCP).	Assessment P&P explains how the MMP communicates the results of the assessment to the enrollees' PCPs. The MMP provides a sample communication to a PCP.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
8. The MMP conducts reassessments as often as the health, functional, or social needs of the enrollee requires, and at least annually. The MMP shall consider the reason why the assessment needs to be updated, the enrollee's needs and health or functional status, and the preference of the enrollee when determining the mode by which updates will be completed.	Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current enrollees.	X	X

Table 2. Care Coordination

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Care Coordinator Assignment and Interdisciplinary Care Team (ICT)			
1. The MMP has a process to assure that it offers an interdisciplinary care team (ICT) to coordinate the delivery of services and benefits to every enrollee.	Care coordination P&P includes this assurance.	X	X
2. The MMP describes a process for determining the composition of the ICT, including a description of how the enrollee and/or his or her caregiver (if so designated) are involved in determining the ICT's composition. The process includes securing authorization from the enrollee, or his/her legal representative, to include the enrollee's selected IHSS provider as a member of the Interdisciplinary Care Team. Each ICT will designate a team leader. The MMP's P&P states that members of the ICT may include: a. The enrollee/caregiver/designated surrogate; b. The designated primary care physician; c. Nurse; d. Care manager; e. Social worker; f. Patient navigator; g. County IHSS social worker; h. MSSP coordinator; i. Pharmacist; j. Behavioral health service providers; k. Other professional staff within the provider network; and l. IHSS provider with approval from the IHSS beneficiary.	Care coordination P&P defines how the MMP builds its ICT and how the enrollee and/or his or her caregiver are involved in determining the ICT.	X	X
3. The MMP defines ICT care coordination functions to include, at a minimum, the following: a. Develop and implement an individualized care plan with enrollee and/or caregiver participation; b. Conduct ICT meetings periodically, including at the enrollee's discretion; c. Manage communication and information flow regarding referrals, transitions, and care delivered outside the primary care site; d. Maintain a call line or other mechanism for enrollee inquiries and input, and a process for referring to other agencies, such as LTSS or behavioral health agencies, as appropriate; e. Conduct conference calls among the MMP, providers, and enrollees; f. Maintain a mechanism for enrollee complaints and grievances; and g. Use secure email, fax, web portals or written correspondence to communicate. The MMP must take the enrollee's individual needs (e.g., communication, cognitive, or other barriers) into account in communicating with the enrollee.	Care coordination P&P defines the role, responsibilities, and specified functions of the ICT. Care coordination P & P describes how ICT will operate and communicate, how activities will be documented and maintained, frequency of meetings, notification about ICT meetings, and how ICT reports are disseminated to all members. Complaints and grievance documents include written and audio materials available in languages that meet needs of the target population, in plain language, and in alternative formats.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP has a process for assigning a care coordinator to each enrollee needing or requesting one. This should include assigning an enrollee to 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).	Care coordination P&P requires each enrollee who needs or requests a care coordinator to be assigned to one. The MMP describes reasonable measures taken to assure that care coordinators and enrollees are matched based on their expertise and special needs.	X	X
5. The MMP: a. Conducts training for ICT members and potential ICT members, initially and on an annual basis on: i. The person-centered planning processes; ii. Cultural competence, iii. Accessibility and accommodations, iv. Independent living and recovery, and wellness principles; and v. Information about available LTSS services, eligibility for these services, and program limitations. b. Make training opportunities available to IHSS provider if they choose to participate.	Sample training materials for ICT members and potential ICT members include the required topics. Care coordination P&P states that completion of training if ICT members will be documented and defines the consequences associated with non-completion of ICT trainings.	X	X
6. The MMP has a policy permitting them to offer the following HCBS services in order to enhance a member's care, allowing them to stay in their own homes safely and preventing institutionalization. a. These services could include, but are not limited to: b. Supplemental personal care services c. Supplemental chore d. Supplemental protective supervision e. In home skilled nursing care and therapies services for chronic conditions f. Respite care (in home or out-of-home) g. Nutritional supplements and home delivered meals	MMP P&Ps describe how it monitors the appropriateness of HCBS.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
B. Individualized Care Plan			
1. The MMP will: a. Work with the enrollee to develop the individualized care plan; and b. Use the information gathered from the assessments of the enrollee in developing the individualized care plan.	Care planning P&P outlines a process that describes how the MMP will involve the enrollee in developing the individualized care plan and will use the information gathered from the health risk assessment(s) of the enrollee in developing the individualized care plan. Care planning P&P states that the MMP intends to provide person-centered care to all enrollees, and describes strategies for assuring this.	X	X
2. The MMP assures that the enrollee receives any necessary assistance and accommodations to prepare for, and fully participate in, the care planning process, which includes providing the enrollee with: a. Educational material on his or her conditions and care options; b. Information on how family members and social supports can be involved in care planning, as the enrollee chooses; c. Self-directed care options and assistance available to self-direct care; d. Information on how to access available LTSS, including IHSS services if applicable; e. Available treatment options, supports, and/or alternative courses of care; and f. The ability to opt out of the individualized care plan process.	Care planning P&P describes how the MMP will assure that the enrollee receives necessary assistance and the types of information specified.	X	X
3. Essential elements incorporated into the individualized care plan include, but are not limited to: a. Enrollee goals and preferences; b. Measurable objectives and timetables to meet medical needs; c. Behavioral health and long-term support needs; and d. Timeframes for reassessment.	Care planning P&P states that the MMP assures that these elements are incorporated into the individualized care plan.	X	X
4. The MMP specifies: a. The frequency for individualized care plan review and revision (at minimum, upon change of health status or annually), including a discussion on how health data is used to assess whether goals and objectives are being met; b. The engagement of enrollees and/or their representatives to play an active role in designing their care plan; c. The frequency for updating the individualized care plan, in response to routine and non-routine reviews and revisions, including required updates when enrollees are not meeting their individualized care plan goals.	Care planning P&P explains how and when the MMP reviews and revises the contents of an enrollee's individualized care plan, which is, at a minimum, upon change of condition or annually.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The person-centered planning process identifies the strengths, capacities, and preferences of the enrollee and provides additional care options, including options as appropriate for transitioning a person from a nursing facility to the community. The planning process also identifies the enrollee's long-term care needs and the resources available to meet those needs.	Care planning P&P explains the process for an enrollee to participate in the creation of his or her individualized care plan and provides guidelines for ICT members working with enrollees.	X	X
6. The individualized care plan promotes the use of the least restrictive, and most inclusive, setting the enrollee chooses, as appropriate to provide care in the least restrictive setting.	Care planning P&P encourages care coordinators to develop individualized care plans that allow the enrollee to reside within the setting that is least restrictive, based on enrollee preference, and describes use of LTSS, such as adaptive aids, home modifications, and personal care, to support independent living.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
C. Coordination of Services			
1. Participating plans have care coordination and management activities that reflect a person-centered, outcome-based approach. Specifically, this care coordination will: a. Follow the beneficiary's direction about the level of involvement of his or her caregivers or medical providers; b. Span medical and LTSS care systems, with a focus on transitions between service locations; c. Consider behavioral health needs and coordinate with county services as appropriate; d. Develop individualized care plans with enrollees; e. Be performed by nurses, social workers, primary care providers, if appropriate, other medical professionals and health plan care coordinators, as applicable; and f. Ensure access to appropriate community resources and monitor skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between the facilities and community.	Care Coordination P&Ps include these criteria.	X	X
2. 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 care coordination results and subsequent improvements to MMP advisory boards and/or stakeholders, when such disclosures are allowed and consistent with confidentiality regulations, policies, and procedures.	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.	X	X
3. The MMP facilitates timely and thorough service coordination between the MMP, the enrollee's primary care provider, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, LTSS, etc.).	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.	X	X
4. The MMP's policies and procedures for coordinating care in nursing facilities and subacute care facilities comply with California Coordinated Care Initiative (CCI) Care Coordination Standards.	The Care Coordination P&Ps addressing nursing facilities and subacute care facilities comply with California CCI Care Coordination Standards.	X	X
5. The MMP has policies and procedures that: a. Govern how the MMP makes referrals to MSSP sites including: i. Referring eligible MMP enrollees to MSSP sites if there is an open waiver slot available; and ii. Offering enrollee alternate services if no slot is available); and b. Define the respective care management roles and responsibilities of the MMP ICT and MSSP care managers.	The Care Coordination P&Ps describe the referral process to MSSP sites, including the roles and responsibilities of the MMP ICT and MSSP care managers.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
6. The MMP develops a care coordination and management model that supports appropriate referrals of MMP enrollees to the MSSP for assessment, eligibility determination, and services.	The Care Coordination P&Ps describe how the care coordination model supports referrals of enrollees to MSSP.	X	X
D. Transitions between Care Settings			
1. The MMP offers and explains options related to nursing facilities and sub-acute care facilities to enrollees.	Care Coordination P&Ps explain how options related to nursing facilities and sub-acute care facilities. Training materials for care coordinators explain the options related to nursing facilities and sub-acute care facilities.	X	X
2. The MMP's policies and procedures ensure enrollees have the opportunity to transition from nursing facilities (NF) and subacute care facilities (SCFs) to community settings.	Care Coordination or Care Transition P&Ps provide a description of when enrollees can transition from NF and SCFs to community settings.	X	X
3. The MMP has policies and procedures 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 re-admissions, and how the MMP monitors transfers and hospital re-admissions.Sample report(s) from the MMP describe how it tracks enrollee transfers and admissions. Care coordination P&P describes the care coordinator's role in monitoring care setting transitions.	X	X
4. The MMP's protocols for care setting transition planning assure that all community supports, including housing, are in place prior to the enrollee's move, and that providers are fully knowledgeable and prepared to support the enrollee, including interface and coordination with and among clinical services and LTSS.	Care setting transitions P&P explains how the MMP assures 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 assure continuity of care for an enrollee changing care settings.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP's care setting transition plans will assess all environmental adaptations, equipment, and/or technology the enrollee needs for a successful care setting transition.	Sample care setting transition plan(s) include these elements.	X	X
6. The MMP identifies issues that could lead to care setting transitions and prevents unplanned and unnecessary care setting transitions where possible.	Care setting transition plan P&P outlines a process for managing the care setting transition process that includes methodologies for identifying issues that could lead to transitions and for preventing unplanned and unnecessary care transitions.	X	X
7. 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.	X	X
8. The MMP transitions enrollees to new providers, if needed, once the individualized care plan is completed.	Care coordination P&P and/or provider handbook includes policy.	X	X
9. The MMP has policies and procedures for a post-acute care admission into: a. hospice at the beneficiary's home; b. a distinct part of a psychiatric or rehabilitation unit of a hospital; c. a home-based community setting; d. a long-term care facility; or e. a transition into the home.	Care coordination P&P and/or provider handbook includes policy.	X	X
10. The MMP has policies and procedures for an acute care transfers from a hospital inpatient facility to another hospital inpatient facility.	Care coordination P&P and/or provider handbook includes policy.	X	X

Table 3. Confidentiality

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
1. The MMP provides a privacy notice to enrollees, which explains the policies and procedures for the use and safeguarding of protected health information (PHI).	Sample privacy notice to be sent to enrollees or P&P explains how the MMP will safeguard PHI.	X	X
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 or P&P explains how the MMP will safeguard PHI and the provider's role in safeguarding PHI.	X	X
3. For IHSS, CBAS, MSSP, NF, and SCF, the MMP has a policy and procedure to ensure compliance with HIPAA. Subcontracted plans have a policy and procedure to ensure compliance with HIPAA for NF and SCF.		X	X
4. For IHSS, the MMP has a policy and procedure to allow IHSS providers to speak on behalf of enrollee, if the enrollee so authorizes, consistent with HIPAA.		X	X
5. For MSSP, the MMP has a policy and procedure that governs data sharing agreements with all entities that receive confidential information about MMP enrollees. The policy and procedure states that such agreements must conform with applicable state and federal rules and policy.		X	X

Table 4. Enrollee Protections

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Enrollee Rights			
1. The MMP has established enrollee rights and protections, and assures that the enrollee is free to exercise those rights without negative consequences, consistent with CMS and California regulations.	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.	X	X
2. The MMP's policies articulate that the MMP will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition, individual communication style, 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.	X	X
3. The MMP provides enrollees with the following rights to: a. Be treated with respect and with due consideration for his or her dignity and privacy; b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition(s) and ability to understand; c. Participate in decisions regarding his or her health care, including the right to refuse treatment; d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; e. Request and receive a copy of his or her medical records, and to request that the medical records be amended or corrected; f. Receive information, including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood; and g. Reasonable accommodations.	Enrollee rights P&P states that an enrollee has these rights. Staff training on enrollee rights includes these rights.	X	X
4. 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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP informs enrollees that they will not be balance billed by a provider for any service; this is articulated through policies and procedures and staff and provider training modules.	Enrollee rights P&P explains that the MMP informs enrollees that they will not be balanced billed. Training materials for providers and staff cover this rule.	X	X
B. Appeals and Grievances			
1. The MMP notifies enrollees, at least annually, about their grievances and appeals rights. The MMP informs enrollees what adverse actions can be appealed, the process for appealing, and the plan entity or outside organization responsible for addressing such appeals.	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 enrollee need.	X	X
2. The MMP staff understands enrollee protections, including the organization and coverage determination and appeals and grievance processes.	Training materials contain information about the MMP's organization and coverage determination processes and the appeals and grievance processes. Grievances and appeals P&P explains how and when an enrollee can appeal an adverse action.	X	X
3. The MMP provides enrollees with reasonable assistance in filing an appeal or grievance. For long-term supports and services (LTSS) for which the MMP is not responsible, such assistance may be limited to providing toll-free numbers or directing the enrollee to the appropriate county social services or other designated agency.	Grievances and appeals P&P explains to the extent to which the MMP will assist an enrollee in filing an appeal or grievance.	X	X
4. The MMP enrollee advocate is available to assist enrollees in determining whether to file a grievance or an appeal.	Grievances and appeals P&P. Organizational chart includes an enrollee advocate. Enrollee advocate resume and job description.	X	X
5. The MMP must provide continuing benefits 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 enrollees, and that the MMP must continue to pay providers for providing such services, pending an internal MMP appeal.	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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
6. The MMP maintains an established process to track and maintain records on all grievances and appeals, received both orally and in writing, including, 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 include these elements. Data summaries or reports detail the types of reporting and remediation steps that are taken to assure grievances are correctly handled. Grievances P&P define how staff from the MMP should document grievances within the tracking system.	X	X
7. The MMP maintains policies and procedures for enrollee grievances in accordance with the requirements specified in the CMS-California MOU. These policies and procedures include the following: a. Enrollees shall be entitled to file internal grievances directly with the MMP; b. Each MMP must track and resolve its grievances, or if appropriate, re-route the grievances to the coverage decision or appeals processes; c. Grievances for IHSS hours authorized by counties shall be referred to county agencies, consistent with the IHSS grievance and appeals process governed by California law and regulation; and d. After receiving the county's report on the resolution of the grievance, the MMP reports the resolution to the State.	The MMP/County MOU will describe the system of sharing information on the dispensation of Fair Hearing cases.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
8. The MMP maintains policies and procedures for appeals other than for Part D, county-authorized IHSS hours, and county-authorized behavioral health services that include the following elements: a. Enrollees are permitted to seek a state fair hearing at any time for Medi-Cal-covered services; b. The MMP does not adjudicate appeals from county decisions about IHSS and behavioral health services; c. The MMP makes available a navigation office or enrollee services office to support enrollees pursuing appeals; d. Initial appeals must be filed with the MMP within 90 days of the enrollee's receipt of the Notice of Action from the MMP; e. Second level appeals are handled as follows: i. Appeals of Medicare benefits are automatically sent by the MMP to the Medicare Independent Review Entity (IRE) if the MMP upholds the initial denial; ii. For certain Medi-Cal appeals, enrollees may request an Independent Medical Review (IMR) regarding the notice of action provided they have not requested a state fair hearing; f. Third-level appeals for Medicare benefits are handled as follows: i. Appeals of Medicare benefits are filed with the Office of Medicare Hearings and Appeals (OMHA); ii. Appeals of Medi-Cal benefits are processed as state fair hearings; g. Procedures for appeals of services for which Medicare and Medicaid overlap (which include home health, durable medical equipment and skilled therapies, among others) will be defined in the three-way contract and will include the following: i. Enrollees, their authorized representatives, and providers will have the same number of days to file an appeal as allowed under current law; and ii. Enrollees will retain their right to a State Fair Hearing regardless of the designated appeal pathway; h. All appeals must be resolved in the timeframes allowed by current law; and i. The MMP uses the single, integrated notice of appeal rights to enrollees for all services. (CMS/State will provide a template for this.)	Appeals P&P includes these specifications. The MMP/County MOU describes the system of sharing information on the dispensation of Fair Hearing cases.	X	X
9. The MMP maintains Part D appeal policies and procedures that are consistent with the requirements of the Part D program.	Part D appeals P&P are consistent with Part D requirements	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
C. Enrollee Choice of PCP			
1. The MMP has policies and procedures that explain how enrollees select a primary care provider (PCP) and articulate that enrollees can select a specialist to act 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 explain that an enrollee can select a specialist as a PCP. PCP selection and assignment P&P explains how primary care providers are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.	X	X
D. Emergency Services			
1. The MMP has a back-up plan in place in case an LTSS provider does not arrive to provide assistance with activities of daily living, which includes; a. Identifying services that need to be provided on the day(s) the provider does not show up; b. Assessing informal resources that may be available (e.g., family, neighbors, etc.); and c. When necessary, consulting with the county social services agencies or public authorities about available resources. The MMP back-up may include authorizing temporary assistance through qualified agencies that have been certified and approved by the California Department of Social Services and authorizing a Medicare/Medi-Cal Home Health Agency to provide services.	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. MOUs with counties or Public Authorities, and/or contracts with qualified agencies.	X	X
2. The MMP can connect enrollees in crisis with emergency behavioral health services, when applicable.	Emergency services P&P addresses how the MMP connects enrollees in crisis with emergency behavioral health services.	X	X

Table 5. Enrollee and Provider Communications

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Enrollee and Provider Communications			
1. The MMP maintains an enrollee call center that conforms, at a minimum, to current Medicare Advantage standards. a. The MMP also requires medical contractors with direct enrollee contact to maintain their enrollee call centers during these hours. b. Staff answering calls to the MMP and MMP contractor enrollee call centers shall: i. Be adequately trained about MMP-covered services and the process for accessing these services; and ii. Have access to information regarding LTSS and other community services, along with verified telephone numbers for making referrals.	Enrollee services hotline P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS, and drugs. Contract template with subcontractors with direct enrollee contact requires maintenance of enrollee service telephone line that operates during these hours. The MMP provides actual 1-800 number for the enrollee services telephone line, and evidence that staff are qualified and trained.	X	X
2. The MMP maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency enrollees. 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. The language line is TDD/TTY accessible.	Contract with language line company includes these requirements.	X	X
3. The MMP has a policy that trained enrollee services representatives answer at least 80% of calls within 30 seconds and has a disconnected call rate of less than 5%.	Enrollee services hotline P&P states this policy and explains how the MMP tracks wait times and call abandonment rates and analyzes and corrects any unusual or excessively long wait times and/or disconnects.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP has a compliant website or web page dedicated to the MMP product, with links to all of the required documents: a. The MMP's service area; b. The benefits offered by the plan (including applicable conditions and limitations), with information about how to access services whose eligibility and assessments are conducted outside of the plan; c. Any applicable cost sharing; d. The MMP's drug formulary; e. The provider network and how to access services (including pharmacies, addresses, and hours of operation); f. Out-of-network coverage (including pharmacies); g. Coverage of emergency services; h. Prior authorization and review rules; i. Grievances, organization and coverage determinations, and appeals (contains sufficient information about the types of grievances and appeals available, how to initiate the appeals and grievances, and how to obtain assistance with the appeal or grievance); j. Quality assurance policies and procedures; k. Disenrollment rights and responsibilities; l. Potential for contract termination; m. Medication therapy management program; n. Informing materials published in alternative formats (e.g., large print, Braille, audio CD); and o. Link to the electronic complaint form on www.Medicare.gov.	The MMP has a website devoted to the plan offered in the Demonstration. (Note: a website mock-up or screenshots of the website are acceptable; an active link is not necessary for the readiness review.) The MMP's website contains each of these items.	X	X
5. The MMP's website may not: a. Offer financial or other incentives to induce consumers to enroll in the MMP or to refer a friend, neighbor, or other person to enroll with the MMP; b. Make any statement that has not been pre-approved by CMS and California; c. Include any material that is inaccurate or false, or that misleads, confuses, or defrauds the recipient of the material, including, but not limited to, any assertion or statement, whether written or oral, that: i. The recipient of the material must enroll in the MMP in order to obtain benefits or in order to not lose benefits; or ii. The MMP is endorsed by CMS, Medicare, the federal or California government, or similar entity. d. Seek to influence an individual's enrollment, in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance); e. Engage in any activities which could mislead, confuse, or defraud prospective or current enrollees or misrepresent California, the MMP, or CMS; or f. Engage in outreach activities that target prospective enrollees based on health status or future need for health care services, or that otherwise may discriminate against individuals eligible for health care services.	The MMP's website is 508 compliant and is accessible to enrollees with disabilities. The MMP provides screenshots or web links that show the MMP is complying with the specified outreach rules. (Note: a website mock-up or screenshots of the website are acceptable; an active link is not necessary for the readiness review).	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
6. Plans must ensure that 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 (excluding IHSS providers) by phone, written materials, and Internet website upon request, b. How to contact the Public Authority and other registries who assist IHSS recipients in finding eligible providers; c. Enrollees rights and responsibilities; d. The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials); e. How to access oral interpretation services and written materials in threshold languages and alternative, cognitively accessible formats; f. Information on all Participating Plan covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and g. The procedures for an enrollee to change plans or to opt out of the Demonstration.	Customer service department P&P includes these specified elements. Training materials for ESRs includes these specified elements.	X	X
7. MMP develops a process to solicit stakeholder and member participation in advisory groups for the planning and implementation activities relating to the provision of services for dual eligible beneficiaries.	P&P of advisory meeting. List of members of MMP's advisory groups.		
8. The MMP must demonstrate a local stakeholder process that includes health plans, providers, community programs, consumers, and other interested stakeholders in the development, implementation, and continued operation of the project. The MMP must certify that: a. MMP has at least one dual eligible individual on the advisory board for its company b. MMP has created an advisory board of dually eligible consumers reporting to the board of directors. c. The MMP has sought community-level stakeholder input into the development of the demonstration, with specific examples provided of how the plan was developed or changed in response to community comment.	List of board of directors, Agenda and Minutes of stakeholder and advisory board meetings		
9. MMP shows a stakeholder process that includes, at a minimum, one public stakeholder meeting on a quarterly basis, and publishes minutes of that meeting on their website within 15 days of the start of the next quarter.	Schedule of upcoming stakeholder meetings. Agenda and minutes of previous stakeholders meetings.		

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
B. Provider Hotline			
1. The MMP staffs an answering service or voicemail system for the provider hotline during non-business hours, which meets the following criteria: a. Indicates that the voicemail is secure; b. Lists the information that must be provided so the case can be worked, (e.g., provider identification, enrollee identification, type of request [coverage determination or appeal], physician support for an exception request, and whether the enrollee is making an expedited or standard request); and c. Indicates the time period in which a response to a voicemail can be expected.	Provider hotline P&P includes the enumerated requirements.	X	X
2. The MMP assures that its pharmacy benefit manager (PBM) has a pharmacy technical help-desk call center that is prepared for increased call volume to handle new enrollments.	The MMP demonstrates how an estimated staffing ratio for the pharmacy technical help-desk call center was determined, and how, and in what timeframe, it intends to staff to that ratio.	X	X
3. The MMP assures that pharmacy technical support is available to respond to inquiries from pharmacies and providers regarding the beneficiary's Medicare prescription drug benefit 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.	X	X

Table 6. Monitoring of First-Tier, Downstream, and Related Entities

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
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.	Monitoring P&Ps provide information on how the MMP or sub-plan monitors all first-tier, downstream, and related entities.	X	X

Table 7. Organizational Structure and Staffing

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Governing Body and Management Team			
1. The MMP maintains and updates all required points of contact in the CMS Health Plan Management System (HPMS), including, but not limited to Chief Executive Officer (CEO), Chief Operating Officer (COO), and Chief Financial Officer (CFO).	HPMS.	X	X
2. The MMP employs and maintains points of contact for: a. A clinical director of behavioral health (or equivalent); b. A substance use specialist (may be the Director of Behavioral Health); c. A single point of contact for long-term services and supports (or equivalent); d. A single point of contact for care coordination (may be the director of long-term services and supports, LTSS); and e. A single point of contact for pharmacy services.	Staff resumes indicate that qualified and experienced staff with expertise related to the position fills each of these job positions.	X	X
3. 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. Process by which MMP identifies consumers for participation.	X	X
4. The MMP's quality improvement (QI) committee includes physicians, psychologists, pharmacists and other care providers with expertise in LTSS and behavioral health, who represent a range of health care services used by Medicare-Medicaid enrollees.	QI committee members are appropriate based on the target population described in the CMS-California 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).	X	X
5. 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, and behavioral).	A provider credentialing point of contact or committee is reflected in 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, and behavioral).	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
B. Sufficient Staff			
1. The MMP's hiring or contracting process includes: a. A plan for hiring new employees or contractors; b. A timeline by which key hiring activities are to be completed; c. A designated staff member responsible for overseeing the hiring process; and d. New hire orientation and training.	Recruitment approach provides detail and timelines (e.g., job postings, advertising, use of head-hunters), job descriptions, and resumes of staff responsible for overseeing recruitment. A designated staff member has been assigned and new hires attend orientation and training. Key leadership roles have been filled.	X	X
2. The MMP demonstrates that it has sufficient employees and/or contractors, or has plans to hire sufficient staff, to complete enrollee assessments, as required (including at least annually), in a timely manner for all enrollees through its staffing plan, which explains: a. How the MMP arrived at its estimation of sufficient staffing for this function; and b. In what timeframe it will staff to the level indicated.	The MMP's hiring plan is consistent with the volume of anticipated monthly enrollment given the number of eligible beneficiaries in the service area. The MMP has a staffing plan that shows how it has arrived at an estimated staffing ratio for completing health risk assessments, in what timeframe it intends to staff to that ratio.	X	X
3. The MMP staff, contractors, or providers performing health risk assessments have the appropriate education and experience for the target population (e.g., experience in LTSS or behavioral health).	Job descriptions include relevant educational and experience requirements consistent with needs of target population. A subset of job postings seeks staff experienced with mental illness and LTSS. Resumes for selected staff meet job description requirements.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP demonstrates that it has sufficient employees and/or contractor staff or plans to hire sufficient staff to meet the care coordination needs of the target population through its staffing plan, which explains: a. How the MMP arrived at its estimation of sufficient staffing for this function; and b. In what timeframe it will staff to the level indicated.	The MMP has a staffing plan that shows how it has arrived at an estimated staffing ratio for providing care coordination and in what timeframe it intends to staff to that ratio that is reflective of the number of eligible beneficiaries in the service area. Planned number of staff or contractors dedicated to care coordination is appropriate. The MMP has identified staff or contractors specialized to meet the needs of enrollees with behavioral health diagnoses or needing LTSS.	X	X
5. The MMP care coordination staff or contractors have the appropriate education and experience to meet requirements and the service needs of the population (e.g., MMPs have appropriate number of care coordination staff with RNs/MSWs when California requires enrollees stratified to the highest risk level have a registered nurse/certified social work care manager, or the MMP hires appropriate number of care coordinators with behavioral health experience to meet the needs of enrollees with severe mental illness [SMI]).	Job descriptions for care coordination positions are appropriate, as defined by California and include staff with clinical experience, behavioral health experience, and/or experience with coordinating LTSS.	X	X
6. The MMP demonstrates that it has sufficient employees and/or contractor staff or plans to hire sufficient staff to handle care coordination oversight, monitoring, and quality assurance activities through its staffing plan, which explains: a. How the MMP arrived at its estimation of sufficient staffing for this function; and b. In what timeframe, it will staff to the level indicated.	The MMP has a staffing plan that shows how it has arrived at an estimated staffing ratio for care coordination oversight, monitoring, and quality assurance activities, and in what timeframe it intends to staff to that ratio that is reflective of the number of eligible beneficiaries in the service area. Planned number of staff dedicated to oversight and quality assurance is appropriate compared to estimated enrollment.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
7. The MMP demonstrates that it has sufficient employees and/or contractor staff or plans to hire sufficient staff to handle organization and coverage determinations and appeals and grievances through its staffing plan, which explains: a. How the MMP arrived at its estimation of sufficient staffing for this function; and b. In what timeframe it will staff to the level indicated.	The MMP has a staffing plan that shows how it has arrived at an estimated staffing ratio for organization and coverage determinations and appeals and grievances, and in what timeframe it intends to staff to that ratio. Planned number and qualifications of staff dedicated to coverage determinations, appeals and grievances is appropriate compared to estimated enrollment.	X	X
8. The MMP demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations through its staffing plan, which explains: a. How the MMP arrived at its estimation of sufficient staffing for this function; and b. In what timeframe it will staff to the level indicated.	The MMP has a staffing plan that shows how it has arrived at an estimated staffing ratio for call center operations reflective of the eligible beneficiaries in the service area, and in what timeframe, it intends to staff to that ratio. Number of staff dedicated to call center operations including the percent of time staff is dedicated to the Demonstration, compared to estimated monthly enrollments. If contracted out, compare subcontractor staffing level solely dedicated to this MMP to monthly enrollment.	X	X
9. 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 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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
C. Staff Training			
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.	X	X
2. The MMP staff is adequately trained to handle critical incident and abuse reporting. Training includes, but is not limited to, 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 fraud and abuse reporting. Description of which staff are trained on incident reporting, how often, and a schedule of training activities for new staff. Staff will contact and follow up with the appropriate authorities when critical events or incidents are reported during an exchange between an enrollee and enrollee communications staff.	X	X
3. The MMP has a policy and procedure to train all MMP staff on the addition of LTSS and social services to MMP operations.		X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. 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 social services, including eligibility requirements, services covered, assessment criteria, time frames for initial and yearly assessments, maximum services available, the appeals process and roles and responsibilities of county social service offices and Public Authorities in in-home supportive services (IHSS); f. Self-direction of services; g. Behavioral health; h. Care transitions; i. Skilled nursing needs; j. Abuse and neglect reporting; k. Pharmacy and Part D services; l. Community resources; m. Enrollee rights and responsibilities; n. Most integrated/least restrictive setting; o. How to identify behavioral health and LTSS needs; p. How to obtain services to meet behavioral and LTSS needs; q. Dementia care management for specially-designated care coordination staff; r. MSSP care management for specially designated care coordination staff; and s. Independent-living philosophy.	The MMP's training materials for care coordinators include modules or sections on each of these elements.	X	X
5. The MMP assigns and trains staff to address and expeditiously process provider grievances, appeals, and complaints.		X	X
6. The MMP's training for internal beneficiary complaint and appeal staff covers accessibility obligations related to the Americans with Disabilities Act (ADA).	The MMP's training materials include modules on the ADA.	X	X
7. The MMP's staff is trained on confidentiality guidelines and has received training to meet HIPAA compliance obligations.	The MMP's training materials include training on HIPAA compliance and confidentiality guidelines. HIPAA compliance plan describes which staff receive confidentiality training and how often and a schedule of training activities for new staff.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
8. The MMP assures that its 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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
9. The MMP assures that enrollee services telephone line and pharmacy customer service hotline staff have been adequately trained in the following areas: a. Explaining the operation of the MMP and the roles of participating providers; b. Providing enrollees with the identity, locations, qualifications, and availability of providers; c. Referring IHSS recipients to the appropriate Public Authority for assistance in finding eligible providers; d. Assisting enrollees in the selection of a primary care provider; e. Assisting enrollees to obtain services and make appointments; f. Enrollee rights and responsibilities; g. Handling or directing enrollee inquiries or grievances; h. The procedures available to enrollees and providers to challenge or appeal the failure of a contractor to provide a covered service and to appeal any adverse actions (denials); i. How to access oral interpretation services and written material in threshold languages and alternative, cognitively accessible formats; j. Explaining all MMP covered services and other available services or resources (e.g., state agency services either directly or through referral or authorization); k. Explaining the transition policy to new or potential enrollees; and l. The procedures for an enrollee to change plans or to opt out of the demonstration. In addition, the MMP assures that enrollee services telephone line staff have been adequately trained in referring IHSS recipients to the appropriate Public Authority for assistance in finding eligible providers.	Content from training programs or orientation modules demonstrates staff from the MMP trains its enrollee services telephone line staff and pharmacy customer service line personnel on the enumerated 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.	X	X
10. The MMP has a proposed method for providing initial and ongoing training, which includes plans for: a. Having MMP staff train LTSS agency staff on MMP benefits and procedures, and b. Having LTSS agency staff train MMP staff on: i. LTSS agency LTSS programs; ii. Eligibility and assessment criteria; iii. Services available; and iv. How to review and understand data made available to the plans electronically (e.g., IHSS case management information payroll systems (CMIPS) data).	The MOU between the MMP and LTSS agency describes the method for providing the initial and ongoing training delineated in the criterion.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
11. The MMP has a proposed method for providing initial and ongoing training for staff regarding the availability of and coordination procedures for specialty Medi-Cal mental health and Drug Medi-Cal services available at the counties. This includes: a. Having MMP staff train county behavioral health staff on MMP benefits and procedures; and b. Having county behavioral health staff train MMP staff on: i. County behavioral health programs;, ii. Eligibility; and assessment criteria; iii. Services available; and iv. How to exchange information.	The MOU between the MMP and BH agency describes the method for providing the initial and ongoing training delineated in the criterion.	X	X
12. The MMP shall develop enrollee education materials and provider manuals for contracted providers that describe the availability of behavioral health services and the processes for care coordination, which include, at a minimum: a. The enrollee problem resolution processes;, b. The authorization process; c. Provider cultural and linguistic requirements; d. Regulatory and contractual requirements; and e. Other activities and services needed to assist beneficiaries in optimizing their health status, including assistance with self-management skills or techniques, health education and other modalities to improve health status.	Content from enrollee education materials and provider manuals for contracted providers.	X	X

Table 8. Performance and Quality Improvement

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
Performance and Quality Improvement			
1. The MMP collects and tracks critical incidents by enrollee and makes referrals to appropriate agencies for follow up. The MMP also makes referrals to local Adult Protective Services (APS) agencies or, when appropriate, law enforcement, and tracks the number of cases referred for enrollees, including those receiving long-term services and supports (LTSS).	Quality Improvement (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 critical incidents and cases of abuse.	X	X
2. The MMP is prepared to report all Year 1 quality measures required under the Demonstration, including: a. All Medicare Advantage (Part C) required measures; b. Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data; and c. Measures related to behavioral health, care coordination/transitions, and LTSS, as required by the CMS-California MOU.	QI program description details how the MMP collects these measures for its enrollees. Sample annual performance report includes MMP's method of reporting these measures.	X	X
3. The MMP collects prescription drug quality measures consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.	QI program description explains the MMP's means of collecting and reviewing drug quality measures. Sample annual performance report includes the MMP's method of reporting these measures.	X	X
4. The MMP, as a condition of payment, complies with the requirements mandating that provider preventable conditions be reported and that payment for these conditions be prohibited.	Provider reporting requirements or preventable conditions P&P states that the MMP complies with reporting requirements for provider preventable conditions (PPC) as defined as Health Care Acquired Condition (HCAC) and Other Provider Preventable Condition (OPPC) in Title 42 of the Code of Federal Regulations, Parts 434, 438,and 447. P&P states that the MMP complies with reporting requirements for preventable conditions. The MMP provider contract templates include provisions on provider preventable conditions.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP's QI program description meets California requirements and includes elements such as: a. Mechanisms for monitoring and ensuring quality of all service sites and services delivered by the MMP, including, but not limited to: i. Personal care services as describe in a contract between the MMP and the California Department of Social Services (DSS) ii. Nursing facilities; and iii. Behavioral health services.; b. Mechanisms to assess access to, and availability of, care for all covered services; c. Methods to target quality improvements and how to coordinate such activities with state and d. Time-frames in which performance targets are expected to be achieved.	QI program description details processes for monitoring quality and assessment mechanisms in compliance with California requirements. Performance reports highlight access to availability of care for all enrollee subpopulations.	X	X
6. The MMP's MOU with the county to provide behavioral health services specifies the performance tracking measures that the county will provide and report to the MMP.	Behavioral Health MOU between MMP and the county includes performance measures and reporting requirements.	X	X
7. The MMP has a policy and procedure that: a. Details how contracted Community Based Adult Services (CBAS) centers will adhere to MMP-established quality assurance provisions; and b. Defines how MMP will adhere to quality assurance provisions and individual data and other standards and requirements as specified by the California Department of Social Services including state or any other applicable state/federal quality assurance requirements.		X	X

Table 9. Provider Credentialing

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
1. The MMP developed and maintains written policies and procedures, in accordance with DHCS Policy Letter 02-03, that include initial credentialing, re-credentialing, recertification, and reappointment of physicians, including primary care providers and specialists. These policies and procedures must be reviewed and approved by the MMP governing body, or designee. The MMP shall ensure that the responsibility for recommendations regarding credentialing decisions will rest with a credentialing committee or other peer review body.	The MMP demonstrates California approval of their provider credentialing P&P. Provider credentialing P&P includes these required elements.	X	X
2. The MMP ensures that all providers of covered services are: a. Qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered; b. Are in good standing in the Medicare and Medicaid/Medi-Cal programs; c. Have a valid National Provider Identifier (NPI) number; and d. Have not been terminated from either Medicare or Medicaid/Medi-Cal or placed on the Suspended and Ineligible Provider List.	Provider credentialing P&P includes each of these requirements for network providers including: nurse practitioners, certified nurse midwives, clinical nurse specialists, and physician assistants.	X	X
3. If the MMP chooses to delegate credentialing and re-credentialing activities, the MMP complies with California rules of Delegation of Quality Improvement Activities that will be established in the contract with the MMP.	Provider credentialing P&P either demonstrates that the MMP will not be delegating these activities, or if the MMP is delegating these activities, demonstrates compliance with California requirements.	X	X
4. The MMP shall: a. Implement and maintain a system for reporting serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities; and b. Implement and maintain policies and procedures for disciplinary actions including, reducing, suspending, or terminating a practitioner's privileges.	Provider credentialing P&P describes these systems and requirements.	X	X
5. The MMP establishes and maintains a provider appeal process.	Provider appeals P&P	X	X
6. The MMP ensures 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.	X	X

Table 10. Provider Network

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A: Establishment and Maintenance of Network, including Capacity and Services Offered			
1. The MMP has a set of procedures that govern participation in the medical, behavioral, pharmacy, and long-term services and supports (LTSS) provider networks (excluding in-home supportive services (IHSS) providers), including written rules of participation that cover: a. Terms of payment; b. Licensing; c. Credentialing; and d. Other rules directly related to participation decisions.	The MMP's rules for participation for medical, behavioral, pharmacy, and LTSS provider networks include all necessary items and specify that written notice of material changes in the rules will be submitted to CMS and California prior to changes taking effect.	X	X
2. 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 pharmacies and LTSS providers (excluding IHSS providers); d. Whether providers are accepting new enrollees; e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides access for enrollees; f. Access to primary care services for enrollees within a reasonable distance of enrollees' residence; g. Access to specialty care services for enrollees within a reasonable distance from enrollees' places of residence; h. Access to pharmacy services for enrollees within a reasonable distance from enrollees' places of residence; i. Access to facility services for enrollees within a reasonable distance from enrollees' places of residence, including outpatient dialysis; j. Assessment of out-of-network providers to determine if they should be contracted for provider network services; and k. All California Medi-Cal requirements regarding network adequacy.	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.	X	X
3. The MMP has processes to monitor and maintain the pharmacy networks to meet Medicare Part D requirements.	Evidence that the MMP covers mail order, long-term care pharmacy, and home infusion therapy.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS (excluding IHSS), and pharmacy provider networks are trained in cultural competency for delivering services to the target populations in the Demonstration	Provider network P&P explains how its primary care, specialty, behavioral health, LTSS, and pharmacy providers are trained in cultural competency for delivering services to the target population. Provider training materials for all of these groups include modules on cultural competency when serving target populations.	X	X
5. 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.	Provider network 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.	X	X
6. The health plan ensures that it will maintain sufficient LTSS and behavioral health provider networks, that meet State Medicaid requirements	Provider network P&P defines how it will monitor and maintain the LTSS network.	X	X
7. For IHSS, the MMP has a policy and procedure to refer an enrollee to the appropriate county social service agency or Public Authority when the enrollee needs a new provider.		X	X
8. The MMP has a policy and procedure to contract with all willing licensed and certified CBAS centers within the MMP's covered zip codes and adjacent areas accessible to enrollees.		X	
9. The MMP has a policy and procedure that governs how the MMP will: a. Make referrals to CBAS centers b. Communicates with CBAS centers; c. Shares enrollee health information; and d. Coordinates care between the MMP and the CBAS center.		X	X
10. 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.	Provider network P&P explains how and when services outside of the network may be covered and circumstances where such coverage would occur.	X	X
11. The MMP provides for a second opinion from a qualified health care professional in network, or arranges for the enrollee to obtain one out of 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.	X	X
12. The MMP ensures that enrollees have access to the most current and accurate information by updating its online provider directory (excluding IHSS providers) 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).	X	X
13. The MMP has a policy and procedure to allocate to MSSP providers the same level of funding those providers would have otherwise received under their MSSP contract with CDA until December 31, 2014.	Provider network P&P addresses these standards.	X	

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
14. The MMP has a policy and procedure to reimburse out-of-network providers at Medicare or Medicaid fee-for-service (FFS) rates applicable for that service in emergency situations; in cases when the service would traditionally be covered by Medicare FFS, the Medicare FFS rate applies.	Provider network P&P includes a provision for paying out-of-network providers at applicable rates in urgent or emergency situations.	X	X
B. In-Home Supportive Services (IHSS) Contracting Requirements			
1. The MMP has a policy and procedure to develop and execute MOUs with county agencies that reflect an agreement between the MMP and county agency regarding roles and responsibilities for IHSS. If a Subcontracted Plan, the policy and procedure reflects coordination of these services with the Prime Contractor Plan.	If a Prime Contracted Plan, there are P&Ps to develop the MOU or the plan provides copies of the MOU. If a Subcontracted Plan, there are P&Ps that describe the coordination with the Prime contracted plan.	X	X
2. The MMP-County MOU for IHSS covers at least the first 12 months of the demonstration period.	MMP-County MOU.	X	
3. The MMP-County MOU for IHSS covers the following elements: a. Assessment, approval, authorization for enrollee initial and continuing need for services; b. Provider enrollment, orientation, and documentation; c. Performance of quality assurance activities, including routine case reviews, home visits, and detecting and reporting suspected fraud, pursuant to California law; d. Advisory Committee appointment; and e. Retain enrollment documentation consistent with California law. The MMP-Public Authority MOU covers the following elements: a. Completion of criminal background checks; b. Provision of assistance to IHSS members with locating a provider; c. Acting as employer of record and providing access to trained IHSS workers and backup providers; and d. Sharing of confidential data.	MMP-County and Public Authority MOUs covers the elements listed in the criteria.	X	
C. Multipurpose Senior Service Program (MSSP) Organization Contracting Requirements			
1. The MMP executes agreements with all MSSP organizations in the MMP's covered zip code to provide MSSP waiver services to eligible enrollees.	MMP P&Ps discusses how the MMP plans to contract with all MSSP organizations and articulates this requirement.	X	
2. The MMP contracts with MSSP sites/organizations to provide MSSP waiver participants with required waiver services.	MMP P&Ps discusses how the MMP plans to contract with all MSSP organizations and articulates this requirement.	X	

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
D. Nursing Facility(NF)/Subacute Care Facility (SCF) Contracting Requirements			
1. The MMP's policies and procedures address transfer of enrollees out of the NF or SCF should the NF or SCF lose its license or go out of business.	MMP Provider Network P&Ps discuss how the MMP plans to transfers enrollees out of the NF or SCF should the NF or SCF lose its license or go out of business.	X	X
E. Accessibility			
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 communicates to its enrollees about providers able to accommodate enrollees with disabilities (e.g., MMPs in provider directory, information available upon request).	X	X
2. Medical, behavioral, LTSS, and pharmacy network providers provide linguistically- and culturally-competent services.	Provider training includes training on linguistic and cultural competency.	X	X
3. Medical, behavioral, CBAS, and NF providers exhibit competency in the following areas: a. Utilize waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities; b. Accessibility along public transportation routes, and/or provide enough parking; and c. Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities.	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees.	X	X
4. The MMP collects information on the physical accessibility of medical, behavioral, and LTSS providers (excluding IHSS providers and MSSP sites) offices.	Provider network P&P explains data collection on the accessibility of its' providers offices, reporting of accessibility data to enrollees, and efforts to rectify accessibility issues.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
F. Provider Training			
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 Americans with Disabilities Act (ADA) requirements and Section 504 of the Rehabilitation Act; d. Definitions and concepts, such as communication access, alternative formats, 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; h. Use of culturally sensitive practices and access for beneficiaries requiring threshold languages; i. Working with enrollees with mental health diagnoses, including crisis prevention and treatment; and j. Working with enrollees with substance use conditions, including diagnosis and treatment.	Each of the listed elements is included in the provider training curriculum.	X	X
2. The MMP's model of care training for all network providers and interdisciplinary care team (ICT) members includes: a. Coordinating with behavioral health and LTSS providers; b. Information about accessing behavioral health and LTSS; and c. 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).	X	X
3. The MMP provides initial and recurring training to network providers on the following: a. MMP operations; b. Provider communications; c. Enrollee rights (including that there be no balance billing); d. MMP policies and procedures; e. Claims submission and payment; f. Coordination of benefits; and g. Conflict resolution.	Provider training materials include modules on these topics.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The training program for PCPs includes: a. How to appropriately refer beneficiaries for behavioral health services, and ensure that access was provided as medically necessary; and b. How to identify LTSS needs and appropriately refer for LTSS services.	The MMP's training materials for PCPs include modules on behavioral health and LTSS needs and services.	X	X
G. Provider Handbook			
1. The MMP prepares an understandable and accessible provider handbook , which includes the following: a. Updates and revisions; b. Overview and model of care; c. MMP contact information; d. Enrollee benefits; e. Quality improvement for health services programs; f. Enrollee rights and responsibilities; and g. Provider billing and reporting.	Each of the listed elements is included in the provider handbook.	X	X
2. The MMP makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers who work with enrollees that require culturally and, linguistically-competent and/or disability-competent care.	Provider handbook includes information on how to access language lines and resources 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).	X	X
H. Ongoing Assurance of Network Adequacy Standards			
1. The MMP ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, and pharmacy, 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 MMP services are available 24 hours a day, 7 days a week, when medically necessary.	Provider network P&P states that the MMP provides these assurances.	X	X
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, LTSS, and behavioral health.	X	X
3. The MMP must contract with a sufficient number of nursing facilities to meet projected enrollee needs.		X	X

Table 11. Systems

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. Data Exchange			
1. The MMP has developed a system to electronically exchange data with CMS, California, subcontractors, providers and the Health Insurance Exchange (2014). Specifically, the MMP has: a. Established the appropriate External Point of Contact (EPOC): b. Has a plan for authorizing EPOC submitters and other users; and c. Completed connectivity testing with the MAPD Help Desk.	Baseline documentation should include data architecture/data exchange diagram that illustrates connectivity to CMS, the state or any applicable subcontractor, with data exchange protocols (e.g.,SFTP). Supporting documentation should include: 1. EPOC designation letter or other proof that MMP has established an appropriate EPOC. 2. Screenshot or other demonstration of connectivity with MAPD Help Desk. 3. P&P showing process by which EPOC will approve other submitters.	X	X
2. 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 and assessment information; f. Provider data.	Baseline documentation should include policies and procedures for securing, processing, and validating the exchange of data (including EDI system specifications for transmitting ANSI compliant file formats, e.g., 834, 835, 837 transactions. Supporting documentation should include: 1. Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/rejection reports. 2. Documentation of current rejection thresholds and data reconciliation processes. 3. Proposed file layouts for transmitting data (e.g., Items 2a-2f). 4. Documentation of MMP's transaction sets with CMS, the State, and other third party vendors in accordance with state and federal standards.	X	X
3. The MMP's contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the true out-of-pocket (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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
4. The MMP's contracted PBM is able to make timely and accurate submissions of Part D pricing data for posting on the Medicare Plan Finder.	Baseline documentation should include PBM (Pharmacy Systems Contractor) P&Ps that detail the processes and data requirements to ensure timely and accurate submission of pricing data for posting on the Medicare Plan Finder. Supporting documentation should include screenshots or other demonstrations of successful transmission of data to the Medicare Plan Finder.	X	X
5. The MMP has access to the Acumen PDE Analysis and Reports Website and has a formal process for reviewing the Medicare Part D Monthly Patient Safety Reports.	Baseline documentation should include the MMP's Quality of Care P&Ps that outlines the process for reviewing and acting upon the Part D monthly patient safety reports. Supporting documentation should include screenshot or other demonstration of successful access to Acumen's PDE website along with meeting minutes highlighting the MMP's review and use of PDE reports.	X	X
6. 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, and highlight how they are being incorporated into current business practices.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
B. Data Security			
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. Summary of systems recovery priorities; and 2. Proof of disaster recovery plan validation and testing P&Ps for communicating business continuity requirements to subcontractors, e.g., copy of the Disaster/Business Continuity plans for third party systems vendors-e.g., PBM.	X	X
2. The MMP facilitates the secure, effective transmission of data.	Baseline documentation should include: 1. Data architecture/data exchange diagram detailing file exchange protocols. 2. MMP's Data Security and Privacy P&P. 3. MMP's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. Supplemental documentation may include: 1. List of network monitoring tools utilized to detect/ mitigate potential compromises to systems security. 2. Documentation of processes to document a breach in data integrity and any associated corrective actions.	X	X
4. 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. Supplemental documentation may include: 1. Log of changes, adjustments, and audit trails for a sample of historical data. 2. List of department team members authorized to make system changes and managers responsible for oversight.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (NPI), which is a 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(s) of provider data/records illustrating that the NPI data field is consistently populated in provider contracting, claims, and other applicable systems.	X	X
C. Claims Processing			
1. The MMP processes timely, accurate, and HIPAA-compliant claims and adjustments, and can calculate adjudication 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.). Supplemental documentation may include: 1. Overview of claims department that includes the number of staff and years of claims processing experience, as well as anticipated staffing for the Demonstration. 2. Information related to claims edits (first fill, emergency, OON), as they are adjudicated, noting whether the edits are performed pre- or post-payment, are manual, or if they are automated.	X	X
2. The MMP processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding retroactive medical and LTSS claims adjustments.	Baseline documentation should include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and LTSS.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
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.	X	X
4. The claims system and operational workflows will be configured to accommodate a fee schedule that includes all medical, applicable LTSS and behavioral health services, and 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. Identification of the individuals or department responsible for configuring new fee schedules. 3. Screen shots of the modules where the fee schedules will be configured and identify how these services are captured within the system.	X	X
5. The claims processing system will be configured to properly adjudicate claims for prescription and 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 prescription and over-the-counter drugs for the Demonstration. 2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs. 3. Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
D. Claims Payment			
1. The MMP pays 95% of "clean medical and LTSS claims" within 30 days of receipt and 99% within 90 days.	Baseline documentation should include: 1. Claims P&P that describes clean claims payment requirements and standards. 2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims. Supplemental documentation may include examples of provider contracts that detail the MMP's turnaround time commitment for claims payment.	X	X
2. The MMP's 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 procedures and requirements for meeting processing standards. 2. PBM P&Ps that define distinct interest payment requirements for clean electronic and all other claims. PBM produced claims payment report sample that reports the average number of days between receipt and payment of current clean claims as well as metric specifications (e.g., definition of a clean claim).	X	X
3. The MMP's PBM ensures that pharmacies located in, or having a contract with, a long-term care facility must have no less than 30 days or 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 Part D sponsor claims from long term care facilities.	X	X
4. The MMP's claims processing system pays MSSP, contracted CBAS centers, NFs and SCFs in a timeframe that is consistent with the regulatory timeframe for all other contracted MMP providers.	Baseline documentation should include the MMP's claims payment P&P that specifies regulatory timeframes for payments to contracted CBAS centers, NFs and SCFs.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The MMP's claims processing system applies logic edits to identify erroneous claims.	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. Supplemental documentation may include a process flow, screenshot, or sample report indicating the identification and evaluation of erroneous claims.	X	X
6. The MMP's claims processing system checks for pricing errors to prevent 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&Ps. Supplemental documentation may include a process flow, screenshot, or sample report indicating the identification and evaluation of potential pricing errors.	X	X
E. Provider Systems			
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. Note, if all the required fields aren't currently captured in the provider system data fields, provide an explanation of how this information will be captured in the system along with an implementation timeline.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
F. Pharmacy Systems			
1. The MMP ensures that the PBM generates and maintains records on the pharmacy networks, including locations.	Baseline documentation should include: 1. 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.	X	X
2. The MMP ensures that the PBM updates records of pharmacy providers and deletes records of pharmacies no longer participating.	Baseline documentation should include the PBM's P&P for updating/maintaining pharmacy provider network information. Supplemental information may include the specifications or workflow diagrams that describe any automated/manual processes to update pharmacy records, so that changes to pharmacy data cascade to other systems, as applicable.	X	X
3. The MMP audits the PBM's pharmacy system on a regular basis.	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. Supplemental documentation may include the auditing tools and metrics used by the MMPs, or the MMP's contract if audits are outlined in documents.	X	X
4. The MMP ensures that the PBM submits prescription drug event (PDE) data on a monthly basis.	Baseline documentation should include: 1. 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.	X	X
5. The MMP ensures that the PBM is prepared to ensure that pharmacies can clearly determine that claims are for Part D-covered drugs or Medicaid–covered drugs, and secondary payers can properly coordinate benefits.	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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
6. The PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine Part D and Medicaid-covered drugs and coordinate benefits properly in the event of systems downtime.	Baseline documentation should include information about the PBM's disaster recovery and business continuity plan of ensuring the proper identification of benefit coverage and continued coordination of benefits with secondary payers.	X	X
7. The MMP ensures that the PBM's system identifies enrollees that fill a prescription during the 90-day transition period, and requires outreach and assistance in requesting an exception or a substitute formulary drug.	Baseline documentation should include the MMP's P&P for filling prescriptions during the transition period including how information regarding the identification of enrollees in transition will be maintained. Documentation should also identify P&Ps for provider and enrollee outreach for non-formulary or medications that require a PA during the 90-day transition period.	X	X
G. Care Coordination and Care Quality Improvement Systems			
a. The system generates and maintains records necessary for care coordination, including, but not limited to: Enrollee data (from the enrollment system); b. Provider network; c. Interdisciplinary care team (ICT) membership for specific enrollees; d. Enrollee assessments; e. Enrollee plans of care; f. ICT case notes; and g. Claims information.	Baseline documentation should include: 1. An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements. 2. Description of software solutions (e.g., care management solutions) that will be used to support the systems infrastructure of the care coordination process. This includes documentation of enhancements made to customize systems to facilitate management of the demonstration population. 3. Screen shots of the application(s)/modules(s) that support these requirements.	X	X
2. The MMP maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include: 1. The MMP's Help Desk P&Ps for tracking, escalation, and resolution of systems-related issues. 2. The MMP's Change Management P&Ps for modifying/updating existing systems and IT processes to facilitate operational needs. Supplemental documentation may include the MMP's Business Continuity Plan for operations when the Care Coordination system is down or inaccessible to external care team members.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
3. The MMP verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include: 1. MMP's P&Ps related to the monitoring and resolution of data quality issues. Note: this should include the process and controls for ICT members (internal and external) with access to update existing data entries. 2. Screen shots of inherent data quality validation features in the applications used to track care management information. (e.g., data driven selections for assessment responses, field masks and validation, etc.). 3. Description of processes to monitor ongoing the accuracy and validity of information in the care coordination system along with resolution steps.	X	X
4. The MMP makes plans of care available to the interdisciplinary care team (ICT), provider network and enrollee either in original form or copies and maintained in accordance with industry practices and State and Federal regulatory requirements for privacy, security and preservation from destruction.	Baseline documentation should include: 1. An outline of the care coordinate system that highlights data elements from the care plan that will be available to the ICT, provider network and enrollee. 2. The policies and procedures for distributing and securing this information, and the assignment and monitoring of system access. 3. A description of who will and how they will access information in the care coordination system. 4. Description of software solutions (e.g., Web-based EMR or care management solutions) that will be used to support the systems infrastructure of the care coordination process. 5. Screen shots of the application(s)/modules(s) that will support these workflows and data requirements, if available. 6. Sample business and data use agreements, and confidentiality policies that govern access to information.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
5. The care coordination system includes a mechanism to alert ICT members of emergency department use or inpatient admissions.	Baseline documentation should include: 1. The MMP's P&Ps for monitoring emergency department and inpatient admissions. 2. A description of the MMP's process for notifying the ICT members when an enrollee is admitted to the hospital including communication timing guidelines. Supplemental documentation may include screen shots of the systems and/or triggers that will utilized to notify the ICT members of these hospital related events, as well as sample reports.	X	X
6. The MMP utilizes healthcare technology to drive improvements in care quality.	Baseline documentation should include a description of how the MMP incorporates technology for improving care quality. Supplemental documentation may include examples of where the use of technology has improved the quality of care for similar enrollee populations.		
7. The MMP deploys healthcare technology solutions in the at-risk enrollee living environments to reduce preventable nursing home admissions.	Baseline documentation should include a description of how the MMP incorporates healthcare technology for reducing preventable admissions. Supplemental documentation may include examples of where the deployment of technology in the enrollee's living environment prevented nursing home or hospital admissions.		

Table 12. Utilization Management

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
A. The MMP has a utilization management (UM) program to process requests for initial and continuing authorizations of covered service			
1. The MMP specifies procedures under which the enrollee may utilize services requiring prior authorization and services requiring a referral, and specifies procedures for self-referrals for services.	The UM program description explains which services require prior authorization and which services require a referral. The MMP UM program description describes the services for which enrollees may self-refer.	X	X
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 §1395(y); b. For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 California Code of Regulations (CCR) Section 51303. 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 of the applicable Medicare and California Medi-Cal standards.	The UM program includes these definitions of medical necessity.	X	X
3. The MMP defines the review criteria used, information sources, and process used to review and approve the provision of services and prescription drugs.	The UM program description for the MMP includes these elements.	X	X
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 details how the MMP monitors under- and overutilization of services (e.g., regular data analysis, periodic review meetings).	X	X
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 description 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).	X	X
6. The MMP's policies and procedures address authorization and reauthorization for placements in contracted nursing facilities and subacute care facilities.		X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
7. The MMP outlines its process for authorizing out-of-network services; if specialties necessary for enrollees are not available within the network, the MMP will make such services available.	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.	X	X
8. 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.	X	X
9. The MMP's policies for adoption and dissemination of practice guidelines require that the guidelines: a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the MMP's enrollees; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and enrollee education and service coverage.	The MMP's practice guidelines P&P include these requirements.	X	X
B. The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.			
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.	X	X
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 description 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.	X	X

Readiness Review Criteria	Suggested Evidence	Applicable for Prime	Applicable for Subcontracted Plan
3. The MMP ensures that prior authorization requirements are not applied to: a. Emergency and post-stabilization services, including emergency behavioral health care; b. Urgent care; c. Crisis stabilization, including mental health; d. Urgent care for home and community service-based recipients; e. Family planning services; f. Preventive services; g. Basic prenatal care; h. Communicable disease services, including STI and HIV testing; and i. Out-of-area renal dialysis services.	The UM program descriptions for the MMP lists those services that are not subject to prior authorization; this list is consistent with the required elements.	X	X
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, 42 CFR §422.570, and 42 CFR §422.572. For overlap services, the MMP follows the contract.	The UM program description for the MMP states the plan will conform to these requirements.	X	X
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 and for manager 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.	X	X
6. The MMP describes how it notifies the requesting provider of any decision to deny, approve, modify, or delay a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (including coverage of prescription drugs).	The UM program description describes how the MMP will notify the requesting provider of coverage review decisions.	X	X

Appendix: Acronym List

Name of Acronym	Definition
ADA	Americans with Disabilities Act
APS	Adult Protective Services
BH-MOU	Behavioral Health Memorandum of Understanding
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBAS	Community Based Adult Services
CCR	California Code of Regulations
CDA	California Department of Aging
CDSS	California Department of Social Services
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
CMIPS	Case Management Information and Payroll Systems
CMS	Centers for Medicare and Medicaid Services
COO	Chief Operating Officer
DEA	Drug Enforcement Agency
DME	Durable Medical Equipment
DHCS	Department of Health Care Services (California)
EPOC	External Point of Contact
ESR	Enrollee Services Representative
FAD	Financial Alignment Demonstration
FIR	Financial Information Reporting
FFS	Fee-for-Service
GRR	General Readiness Review
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIC	Health Insurance Claim
HIV	Human Immunodeficiency Virus
HIPAA	Health Insurance Portability and Accountability Act
HOS	Health Outcomes Survey
HPMS	Health Plan Management System
HRA	Health Risk Assessment
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
IMR	Independent Medical Review
IRE	Independent Review Entity
LTSS	Long Term Supports and Services
MAPD	Medicare Advantage Prescription Drug
MARx	Medicare Advantage Prescription Drug Program
MMP	Medicare-Medicaid Plan
MOC	Model of Care

Name of Acronym	Definition
MOU	Memorandum of Understanding
MSSP	Multipurpose Senior Service Program
NCQA	National Committee on Quality Assurance
NPI	National Provider Identifier
P&P	Policy and Procedure
PBM	Pharmacy Benefit Manager
PCP	Primary Care Provider
PDE	Prescription Drug Event
PDF	Portable Document Format
PHI	Protected Health Information
QI	Quality Improvement
SCF	Subacute Care Facility
SMI	Severe Mental Illness
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
STI	Sexually Transmitted Infection
TDD/TTY	Telecommunications Device for the Deaf/Tele-Typewrite
TrOOP	True Out of Pocket
UM	Utilization Management