DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

DATE: November 28, 2012

TO: Medicare-Medicaid Plans

FROM: Tim Engelhardt, Director
Models and Demonstration Group

SUBJECT: Readiness Reviews

Introduction

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. In order to ensure the demonstrations will preserve and strengthen Medicare-Medicaid enrollees' access to care, quality of care, and benefits, CMS and the States will assess MMPs' ability to implement and continue operations under the demonstration. We will employ a multi-pronged oversight strategy for MMPs, which at a high level, includes:

- Base requirements: Plans must meet core Medicare and Medicaid requirements, State procurement requirements, and State insurance rules (as applicable).
- Readiness review: Prior to the start of each Capitated Financial Alignment Demonstration, CMS and the State will perform an assessment of each MMP's operational capacity and ability to offer high-quality, coordinated care while adhering to all federal and State requirements. The readiness review will also inform CMS' and the State's implementation monitoring strategy by identifying areas where additional implementation and ongoing monitoring may be required.
- Implementation monitoring: Prior to the first enrollment and at regular intervals throughout the implementation process, we will ensure that MMPs are meeting objective implementation milestones as a condition for receiving enrollments. These implementation milestones, and subsequent ongoing monitoring measures, will build off of the readiness review.
- Ongoing monitoring: Over the course of each demonstration, a joint contract management team composed of CMS and State representatives will ensure that MMPs continue to adhere to program requirements and provide comprehensive, high-quality services in all aspects of the beneficiary experience.

The purpose of this memo is to share the Massachusetts readiness review tool with stakeholders and potential MMPs to provide an opportunity to give CMS feedback as we continue to work with other States developing readiness review tools.

Financial Alignment Joint Readiness Review

As described in previous CMS guidance, each MMP seeking to participate in the Capitated Financial Alignment Demonstration must meet all applicable Medicare and Medicaid program requirements. In addition to the plan selection process, all selected plans, regardless of previous Medicare or Medicaid experience, must pass a joint readiness review conducted by CMS and the State prior to enrolling beneficiaries. The readiness review represents a critical step in ensuring that MMPs have the capability and capacity to serve enrollees. Each selected plan will undergo a thorough readiness review that will assess its ability to meet federal and State requirements and its capacity to provide and ensure access to care and quality services.

All readiness reviews will include a desk review and a separate network validation review. A site visit may also be conducted for selected MMPs. We will determine which MMPs require additional validation of readiness through a site visit based on an evaluation of prior Medicare and/or Medicaid experience, responses during the application and State selection process, and the results of the desk review.

Attached is the Massachusetts readiness review plan that CMS and the Commonwealth developed based on stakeholder feedback that Massachusetts and CMS received through letters and public meetings, the Memorandum of Understanding signed on August 22, 2012, the Commonwealth's Request for Responses (RFR) from Integrated Care Organizations, and applicable Medicare and Medicaid regulations.

The Massachusetts readiness review tool is tailored to the requirements of the approved demonstration, and the State's target population. It addresses 15 functional areas of health plan operations related to the delivery of Medicare and Medicaid services including:

1. Assessment processes
2. Care coordination
3. Confidentiality
4. Enrollment
5. Enrollee and provider communications
6. Enrollee protections
7. Financial soundness
8. Organizational structure and staffing
9. Performance and quality improvement
10. Program integrity
11. Provider credentialing
12. Provider network
13. Qualifications of first-tier, downstream, and related Entities
14. Systems (e.g., claims, enrollment, payment, etc.)
15. 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 will 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.

Each State-specific readiness review tool will be completed after CMS and the State has a signed Memorandum of Understanding. CMS welcomes comments on the Massachusetts readiness review tool as we continue to work jointly with other States interested in participating in the Capitated Financial Alignment Demonstration. Please send comments to MMCOCAPSMODEL@cms.hhs.gov by December 12, 2012.

Assessment Processes

Readiness Review Criteria	Example Evidence
A. Transition to New ICO and Continuity of Care	
1. The Integrated Care Organization (ICO) ensures continuity of care for medical, behavioral, long-term services and supports (LTSS) and pharmacy services upon new enrollment. The ICO shall for 1) a period of up to 90 days, unless the assessment is done sooner and the Enrollee agrees to the shorter time period; or 2) until the ICO completes an initial assessment of service needs, whichever is longer: a. allow enrollees to maintain their current providers; b. honor prior authorizations issued by MassHealth, its contracted managed care entities; and c. reimburse providers at their current provider rates at the time of enrollment. The ICO shall also contact providers not already members of its network with information on becoming credentialed as in-network providers; and assure that enrollees who are authorized to receive personal care attendant (PCA) services at the time of enrollment with the ICO have the option to continue to receive their Fiscal Intermediary (FI) services through their current FI.	Continuity of care plan includes these provisions
2. The ICO 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 MassHealth is requiring the ICO to cover under the demonstration.	System testing outputs confirm the claims processing system correctly processes the claim; and Policies and Procedures (P&P) allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that MassHealth is requiring the ICO to cover under the demonstration.
3. The ICO assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug and drugs that MassHealth is requiring the ICO to cover under the demonstration, contain at least a 30-day supply.	System testing outputs confirm the claims processing system correctly processes the claim; and Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
4. The ICO assures that, in long term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.	System testing outputs confirm the claims processing system correctly processes the claim; and Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.

Assessment Processes

Readiness Review Criteria	Example Evidence
5. The ICO provides written notice to each enrollee within 3 business days after the temporary fill if his or her prescription is not part of the formulary.	Transition plan P&P defines a time period (within 3 business days) when it must provide enrollee with notice about temporary fill during transition time and the ability to file an exception or consult with prescriber to find alternative equivalent drug that is on the formulary.
6. The ICO has staff designated to contact enrollees when they refill a non-formulary drug or receive a non-covered service to assist them during the transition period.	Transition plan P&P states that the ICO has staff available to contact enrollees when they refill a non-formulary drug or receive a non-covered service during the transition period.
7. If, as a result of the initial assessment, the ICO proposes modifications to the enrollee's prior authorized services, the ICO shall provide written notification about, and an opportunity to appeal, the proposed modifications no less than 10 days prior to implementation of the enrollee's ICP. The enrollee shall be entitled to all appeal rights, including services pending appeal. Beyond the initial assessment period, the ICO must offer single-case out-of-network agreements to providers who: 1) are not willing to enroll in the ICO provider network, 2) are currently serving enrollees, and 3) are willing to continue serving them at the ICO's in-network rate of payment, under the following circumstances: a. The ICO's network does not have an otherwise qualified network provider to provide the services within its provider network, or transitioning the care in-house would require the enrollee to receive services from multiple providers/facilities in an uncoordinated manner which could significantly impact the enrollee's condition; b. Transitioning the enrollee to another provider could endanger life, cause suffering or pain, cause physical deformity or malfunction, or significantly disrupt the current course of treatment; or c. Transitioning the enrollee to another provider would require the enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.	P&P on continuity of care or continuity of care plan includes the required process in the situation where the ICO modifies the enrollee's prior authorized services as a result of the initial assessment.

Assessment Processes

Readiness Review Criteria	Example Evidence
B. Assessment	
1. The ICO must have a process for the following: a. Administering an initial assessment to all enrollees in person within 90 days of enrollment. b. Administering a MDS-HC by a nurse in person to all enrollees within 90 days of enrollment; this includes a full assessment of physical and behavioral health needs as well as assessment data entry into the Virtual Gateway portal.	Assessment P&P outline the process by which the ICO will administer the initial assessment. At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment within 90 days.
2. Upon enrollment and as appropriate thereafter, the ICO will perform in-person comprehensive assessments, which will be the starting point for creating an Individualized Care Plan (ICP). These assessments: a. May be done at the same time or a different time as the initial assessment; b. Must be conducted by appropriate care team members as determined by the enrollee's needs identified in the initial assessment (e.g. IL-LTSS) using a MassHealth/CMS approved assessment tool in a location that meets the needs of the enrollee; c. Will encompass social, functional, medical, behavioral, wellness and prevention domains, as well as the enrollees' strengths and goals, need for any specialists and the individualized plan for care management and coordination; and d. Identify the natural supports necessary to sustain the enrollee in his or her current place of residence.	Assessment P&P includes these requirements for the comprehensive assessment.
3. For enrollees identified in their initial assessments as needing intensive behavioral health services or LTSS, during the comprehensive assessment, the ICO will determine: a. The enrollee's understanding of available services; the enrollee's desire to self-manage all or part of his/her care plan regardless of the severity of disability, and understanding of his or her self-management responsibilities; b. The enrollee's preferences regarding privacy, services, caregivers, and daily routine; c. The enrollee's understanding of and engagement in recovery-oriented activities; d. The enrollee's preferred living situation and a risk assessment for the stability of housing; e. Risk factors for abuse and neglect in the enrollee's personal life or finances to ensure safety without compromising the enrollee's autonomy; and f. The enrollee's understanding of his/her rights.	Assessment P&P includes these requirements for the comprehensive assessment for enrollees identified in the initial assessment as needing intensive BH services or LTSS.
4. The ICO describes how the assessment and annual re-assessment are conducted for each enrollee (i.e., should be face-to-face) and ensures that it has the capacity to administer them in a format suitable to enrollee's preferences and abilities. A re-assessment will also be conducted when the enrollee experiences a major change that is: not temporary, impacts more than one area of health status, and requires interdisciplinary review or revision of the ICP.	Assessment P&P explains how and in what format the ICO will adapt its risk assessment tool to the specific needs of the target population Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current enrollees

Assessment Processes	
Readiness Review Criteria	**Example Evidence**
5. The ICO's assessment tool for the comprehensive health assessment will include the following domains: a. Immediate needs and current services, including LTSS needs; b. Health conditions and current medications; c. Functional status, including what the enrollee identifies as his/her strengths and interests; d. Mental health and substance abuse; e. Personal goals; f. Accessibility requirements (including specific communication needs, need for transfer equipment, need for personal assistance, need for appointments at the particular time of day, etc.; g. Equipment needs inducing adaptive technology; h. Transportation access; i. Housing/home environment; j. Employment status and interest; k. Involvement with other care coordinators, care teams, or other state agencies; l. Informal supports/caregiver supports; m. Social supports, including cultural and ethnic orientation towards the enrollee's presenting problems; n. Food, security, and nutrition; o. Wellness and exercise; and p. Advance directive/guardianship.	ICO's comprehensive assessment tool includes these domains.
6. The ICO has policies for staff to follow up and to document when enrollees refuse to participate in a comprehensive assessment.	Assessment P&P explains how staff from the ICO will respond to those enrollees who decline to participate in a comprehensive assessment Assessment P&P describes how the ICO staff will assist enrollees who require additional prompting/guidance about participating in the assessment (e.g., enrollees with co-morbidities such as mental health and substance abuse issues along with physical disabilities) Assessment P&P explains how the ICO will monitor those enrollees who decline to participate in the risk assessment process
7. The ICO has a procedure for working with an enrollee who agrees to do an assessment but not to do so in person.	Assessment P&P explains how the ICO will work with an enrollee to secure agreement for an in-person comprehensive assessment whenever possible, but also identifies an alternative approach that the ICO will offer an enrollee who refuses an in-person approach.

Care Coordination	
Readiness Review Criteria	**Example Evidence**
A: Care Coordinator (or Clinical Care Manager) Assignment and Interdisciplinary Care Team (ICT)	
1. The ICO has a process to ensure that every enrollee who wants an Individualized Care Team (ICT) to coordinate the delivery of services and benefits will have access to one.	Care coordination P&P defines how an ICT is formed for each enrollee.
2. The ICO describes a process for determining the composition of the ICT, including a description of how the beneficiary and/or his or her caregiver are involved in determining the ICT. At a minimum, the ICT will include the primary care provider, the enrollee's care coordinator (or Independent Living and Long Term Services and Supports (IL-LTSS) Coordinator or Clinical Care Manager, as applicable) and other individuals at the discretion of the enrollee as applicable.	Care coordination P&P defines how the ICO builds its ICT and how the beneficiary and/or his or her caregiver are involved in determining the ICT.
3. The ICO defines ICT care coordination functions to include at least the following: a. Develop and implement an individualized plan of care (ICP) with enrollee and/or care giver participation; b. Conduct ICT meetings periodically, including face-to-face meetings, at the member's discretion c. Maintain a single electronic medical record (EMR) to 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; e. Conduct conference calls among the ICO, providers, and enrollees; f. Maintain a mechanism for enrollee complaints and grievances; and g. Use secure e-mail, fax, and written correspondence to communicate.	Care coordination P&P defines the role and responsibilities of the ICT and either this P&P or other P&Ps include the specified functions.
4. ICOs will offer care coordination services to all enrollees by a Care Coordinator, IL-LTSS coordinator or Clinical Care Manager, as applicable, for medical and behavioral health services.	Care coordination P&P articulates that all beneficiaries will have a care coordinator, IL-LTSS coordinator or clinical care manager (as applicable) and explains when a clinical care manager or care coordinator is used.
5. The ICO has a process for assigning an enrollee to a Care Coordinator, Clinical Care Manager, or IL-LTSS 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 to be assigned a care coordinator based on his or her risk level and/or individual needs and outlines the process for assigning such care coordinator ICO describes reasonable measures taken to ensure that staff and enrollees are matched based on their expertise and special needs

Care Coordination	
Readiness Review Criteria	**Example Evidence**
6. The IL-LTSS coordinator will be available to an enrollee: a. at any time at the request of an enrollee with LTSS needs; b. during the initial assessment; c. when the need for community-based LTSS is identified by the enrollee or ICT; d. if the enrollee is receiving targeted case management or rehabilitation services purchased by DMH; and e. in the event of a contemplated admission to a nursing facility, psychiatric hospital, or other institution.	P&P on IL-LTSS Coordinator services includes these responsibilities.
7. The ICO has a process to ensure that an enrollee and/or care giver is able to request a change in his/her Care Coordinator, Clinical Care Manager or IL-LTSS Coordinator (as applicable)	Care coordination P&P describes the process by which an enrollee may request a change in his/her Care Coordinator, Clinical Care Manager or IL-LTSS Coordinator (as applicable)
8. The ICO will provide services through an IL-LTSS Coordinator that include (as applicable): a. representing the LTSS needs of the enrollee, b. advocating for the enrollee; c. providing education on LTSS for the care team and enrollee; d. participating in assessments; e. arranging for and coordinating (with agreement of the ICT) the authorization and provision of community LTSS resources; f. assisting enrollees with PCA services; g. monitoring the provision and functional outcomes of community LTSS to assure they are in accordance with the ICP; h. determining community-based alternatives to long-term care; and i. assessing the enrollee's appropriateness for facility-based LTSS if indicated.	P&P for IL-LTSS Coordinator services includes these requirements.
9. The Care Coordinator is accountable for providing care coordination services, which include: a. assuring appropriate referrals and timely two-way transmission of useful patient information; b. obtaining reliable and timely information about services in addition to those provided by the Primary Care Provider; c. supporting safe transitions in care for enrollees moving between settings; d. serving on ICTs; e. facilitating meetings and other activities of ICTs; and f. participating in the initial assessment of each enrollee they serve.	Care coordination P&P will outline the services of a Care Coordinator

Care Coordination

Readiness Review Criteria	Example Evidence
10. The ICO will ensure the provision of Clinical Care Management services directly or through the primary care provider, as feasible, to enrollees identified as high risk. Specific Clinical Care Management services will include: a. Assessment of the clinical risks and needs of each enrollee; b. Medication review and reconciliation; c. Medication adjustment by protocol; d. Enhanced self-management training and support for complex clinical conditions, including coaching to family members and other caregivers, as appropriate; e. Frequent enrollee contact, as appropriate; f. Identification of the enrollee's strengths, preferences and family and community supports that can assist in addressing the clinical risks; and g. Follow-up within 24 hours of an enrollee's admission to an acute hospital, and coordination with the enrollee and hospital staff to facilitate hospital discharges.	The clinical care management P&P describes the components of clinical care management and who will oversee it. The primary care provider's responsibilities for clinical care management are detailed in the contract template
11. The ICO: a. conducts training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the Commonwealth for ICT members and potential ICT members (i.e., providers and staff qualified to serve on ICTs), initially and on an annual basis; b. documents completion of training by all ICT members, including both employed and contracted personnel and has specific policies to address non-completion; and c. documents that all members of the ICT have agreed to participate in approved training.	Sample training materials for ICT members and potential ICT members include the required topics P&P on care coordination defines the consequences associated with non-completion of ICT trainings Sample attendee lists, web-based attendance confirmation, electronic training records for trainings Sample ICT participation form includes ICT's members agreement to participate in the training

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<tr><th colspan="2">Care Coordination</th></tr>
<tr><th>Readiness Review Criteria</th><th>Example Evidence</th></tr>
<tr><td>B. Plan of Care/Service Plan</td><td></td></tr>
<tr><td>1. The ICO will:
a. work with the enrollee to develop the Individualized Care Plan (ICP); and
b. use the information gathered from the assessments of the enrollee in developing the ICP.</td><td>Care planning P&P outlines a process that describes how the ICO will involve the enrollee in developing the ICP and will use the information gathered from the assessment(s) of the enrollee in developing the ICP.

Care planning P&P states that the ICO intends to provide person-centered care to all of its enrollees, and describes strategies for assuring this.</td></tr>
<tr><td>2. The ICO will ensure that the enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process, and that the enrollee receives clear information about:
a. his/her health conditions and functional limitations;
b. how family members and social supports can be involved in the care planning as the enrollee chooses;
c. self-directed care options and assistance available to self-direct care;
d. opportunities for educational and vocational activities; and
e. available treatment options, supports and/or alternative courses of care.</td><td>P&P on care planning describes how the ICO will ensure that the enrollee receives necessary assistance and the types of information specified.</td></tr>
<tr><td>3. Essential elements incorporated into the ICP include:
a. Results of the initial and comprehensive assessments;
b. Summary of the enrollee’s health;
c. Preferences for care;
d. A prioritized list of concerns, goals and objectives, and strengths;
e. Specific services and benefits;
f. The plan for addressing concerns or goals;
g. The person(s) responsible for specific interventions; and
h. The due date for the intervention.</td><td>Care planning P&P states that the ICO assures that these elements are incorporated into the plan of care.</td></tr>
<tr><td>4. The ICO specifies:
a. the frequency for ICP review and revision (at minimum upon change of condition or annually);
b. the frequency with which enrollee health data is used to assess whether the goals and objectives in the ICP are being met (at a minimum annually); and
c. the frequency for updating the ICP in response to routine and non-routine reviews and revisions, including required updates when enrollees are not meeting their plan of care goals.</td><td>Care planning P&P explains how and when the ICO reviews and revises the contents of an enrollee's plan of care, which is at a minimum upon change of condition or annually.</td></tr>
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Care Coordination	
Readiness Review Criteria	**Example Evidence**
5. For the purposes of assessment, care planning, and to provide services, the ICO is responsible for conducting outreach and networking with community-based providers to locate enrollees who may be homeless or hospitalized. The ICO must document within the Centralized Enrollee Record its efforts to locate these enrollees.	Outreach plan describes how ICO works with community-based providers to find enrollees and documents its efforts to conduct this outreach. Documentation of CBO relationships
6. The ICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP	Care planning P&P states that the ICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.
C. Personal Care	
1. The ICO has policies to provide the enrollee the following information: a. A clear explanation that self-direction of PCA services is voluntary, and that the extent to which enrollees would like to self-direct is the enrollee's choice; b. A clear explanation of the options to select self-directed supports or agency personal care; and c. An overview of the supports and resources available to assist enrollees to participate to the extent desired in self-direction.	Sample enrollee communications demonstrating that the ICO has provided the information contained within this criterion to enrollees eligible for self-direction
2. The ICO has the following policies regarding PCA services: a. the enrollee has the right to self-direct his/her own PCA services; b. if the enrollee was receiving PCA services at the time of enrollment, he/she may continue to use his/her current PCA provider; c. enrollees who did not have prior authorization for PCA services at the time of enrollment will be offered at least two personal care management (PCM) agencies to choose from (at least one of which must be an Independent Living Center); d. enrollees over age 60 must be offered PCM options via an Aging Service Access Point (ASAP) operating as an PCM; and e. enrollees can also select to have a surrogate to help them choose their PCA services.	P&P on PCA services includes these elements
3. The ICOs must have the following policies for enrollees who choose not to self-direct their PCA services or who are not able to find a surrogate to assist them to self-direct: a. the enrollee must be given the option of having his/her PCA Services provided by a PCA agency provider; b. the ICO must contract with PCA agency providers selected by enrollees and provide enrollees with the choice of at least two PCA agency providers; and c. the enrollee must be able to choose the schedule for his/her PCA and who provides PCA services to him/her.	P&P on PCA services includes these requirements

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<tr><td>4. The ICO must have the following policies regarding evaluation of PCAs:
a. The ICO must ensure that PCA evaluations are done in a timely manner to ensure appropriateness and continuity of services;
b. The ICO may contract with PCM agencies under contract with the Commonwealth to perform evaluations for PCA services; and
c. ICOs that do not contract with ILCs for PCA evaluations must provide and require training for their PCA evaluators on the independent living philosophy.</td><td>P&P on PCA services includes these requirements</td></tr>
<tr><td>D. Coordination of Services</td><td></td></tr>
<tr><td>1. The ICO has a process to monitor and audit care coordination that includes, at a minimum:
a. documenting and preserving evaluations and reports for the care coordination program; and
b. communicating these results and subsequent improvements to ICO advisory boards and/or stakeholders</td><td>Care coordination P&P explains how and when the ICO will evaluate the processes within the care coordination program.

Care coordination P&P explains how the results of the evaluation will be communicated to ICO advisory boards and/or stakeholders.</td></tr>
<tr><td>2. The ICO facilitates timely and thorough coordination between the ICO, the primary care provider, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, LTSS, etc.).</td><td>Care coordination P&P outlines how coordination between the parties will occur; this should include the mechanism by which information will be shared and how the ICO will facilitate the coordination.</td></tr>
<tr><td>3. The ICO shall require primary care providers to offer integrated primary care and behavioral health services, offering support as needed, as follows:
a. for enrollees without a behavioral health diagnosis, provide integrated Behavioral Health services through at least routine screening for depression, substance use disorders, and other behavioral health conditions; and
b. for enrollees with behavioral health conditions, deliver evidence-based behavioral health treatment, and have established protocols for referral to behavioral health specialty providers.</td><td>The primary care provider’s responsibilities for integration of primary care and behavioral health services are detailed in the contract provider template.</td></tr>
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Care Coordination	
Readiness Review Criteria	**Example Evidence**
E. Transitions Between Care Settings	
1. The ICO's outreach materials for enrollees living in institutional settings include explanation of the community supports available to them and the Money Follows the Person program, when applicable.	Sample communications the ICO plans to send to enrollees living in institutional settings contain information related to accessing community supports.
2. The ICO has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning.	P&P on care setting transitions explains how the ICO and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the ICO monitors transfers and hospital readmissions. Evidence of relationship of data sharing agreements between hospitals and plans. Sample report(s) from the ICO describe how it tracks enrollee transfers and admissions. Care coordination P&P describes the role of the Care Coordinator in monitoring care setting transitions.
3. The ICO's protocols for care setting transition planning ensure 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 ICO ensures that community supports are available prior to an enrollee's move. Care setting transitions P&P explains how the ICO 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 ICO takes to ensure continuity of care for an enrollee changing care settings.
4. The ICO's care setting transition plans include all environmental adaptations and equipment and/or technology the enrollee needs for a successful care setting transition.	Sample care setting transition plan(s) include these elements.
5. The ICO identifies issues that could lead to care setting transitions and prevents unplanned and unnecessary care setting transitions where possible, consistent with the Table 7-B (Community Support Services Provided Through Managed Care Under the demonstration) of the CMS-Massachusetts MOU (MOU).	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 that are consistent with Table 7-B of the MOU.
6. The ICO helps enrollees transition to another provider if a provider leaves the ICO's network.	P&P on care coordination and/or provider handbook includes this policy.

Care Coordination

Readiness Review Criteria	Example Evidence
7. The ICO has a process for transitioning enrollees to new providers, if needed, once the ICP is completed and signed.	P&P on care coordination and/or provider handbook includes this policy.

Confidentiality

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

Enrollment

Readiness Review Criteria	Example Evidence
A. Enrollment	
1. The ICO has enrollment policies and procedures in place that delineate the process from when the ICO receives an enrollment file from the Commonwealth to performing the initial and comprehensive assessments. This process must include, at a minimum: a. Sending enrollment material to potential enrollees; b. Using existing and available data to identify who may need additional assistance; c. Conducting initial outreach to enrollees to for initial and comprehensive health assessments; and d. Staffing to account for the increased enrollment.	P&P on enrollment delineates all the specified elements of the process.
2. The ICO is prepared to send an enrollment confirmation notice that includes the effective date of enrollment to potential enrollees within 10 days of receiving notification from the Commonwealth of all enrollments.	Enrollment/Disenrollment P&P includes policy and disenrollment notification form/materials.
3. Member services staff have cultural and disability competencies based on the target populations and must be knowledgeable in effective communication to and from individuals with disabilities through email, telephone, and other electronic means, including through the use of tools such as TTY, computer aided transcription services, qualified interpreters for the Deaf, telephone headset amplifiers, videotext displays, assistive listening systems, and closed caption decoders.	Sample of resumes of member services staff demonstrates that they have these competencies. Training modules for member services staff includes training on effective communication to and from individuals with disabilities.

Enrollment	
Readiness Review Criteria	**Example Evidence**
B. Disenrollment	
1. The ICO has policies and procedures in place to help enrollees who disenroll to transition to other ICOs (e.g. Part D) maintain continuity of care.	Enrollment P&P includes a section for transitioning members who disenroll and addresses Troop and Part D requirements for continuity of care.
2. The ICO is prepared to provide the enrollee a disenrollment notice in a format meeting CMS and Commonwealth requirements within 10 days of disenrollment.	Enrollment/Disenrollment P&P includes policy for providing this disenrollment within 10 days of disenrollment.
3. The ICO staff does not encourage an enrollee to disenroll because of challenging behavior, complex care needs, or high medical expenses.	Enrollment P&P and/or employee manual state that staff members are prohibited from encouraging enrollees with medically-challenging or complex conditions to disenroll from the ICO.
C. Enrollment Materials	
1. The ICO's member services department representatives, upon request, make available to enrollees and potential enrollees information that includes, but is not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Enrollees' rights and responsibilities; c. The procedures available to an enrollee and provider(s) to challenge or appeal the failure of the contractor to provide a covered service and to appeal any adverse actions (denials); d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. Information on all covered services and other available services or resources (e.g., state agency services) either directly or through referral or authorization; and f. The procedures for an Enrollee to change Plans or to opt out of the demonstration.	Member services department P&P on enrollee information is tailored to these requirements. Member services training materials include training on providing this information to enrollees. Screen shots of pages customer service representatives reference when answering calls from enrollees.
2. The ICO has a policy and procedure for dealing with the failure of enrollees to respond to initial contacts from the ICO (e.g., additional contacts are attempted, using different modes/times of day).	Enrollment P&P provides a step-by-step guide on steps staff should take to make additional contact with non-responsive enrollees. Sample flow chart template documents the number and types of contacts made during the initial enrollment period.

Enrollee and Provider Communications

Readiness Review Criteria	Example Evidence
A. Enrollee and Provider Communications	
1. The ICO maintains an enrollee services telephone line that is accessible via a toll-free number, and operates a minimum of twelve (12) hours a day seven (7) days a week. The ICO also requires contractors with direct enrollee contact maintain service lines during these hours.	Enrollee services telephone line 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. ICO provides actual 1-800 number for the enrollee services telephone line.
2. The ICO or a subcontractor of the ICO 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 ICO'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.	Enrollee hotline P&P states that the ICO supplies interpreters for non-English or limited English speaking enrollees. Enrollee hotline P&P details the language(s) for which the ICO staffs interpreters for the hotline. Contract with language line company includes these requirements, including mandatory hours of operation.
3. The ICO has a policy that a trained Enrollee Services Representative (ESR) answers at least 90% of calls within 30 seconds and has an abandoned call rate of less than 5%.	Enrollee services telephone line P&P states this policy and explains how the ICO tracks its wait times and call abandonment rates and analyzes and corrects any unusual or excessively long wait times and/or call abandonments.

Enrollee and Provider Communications

Readiness Review Criteria	Example Evidence
4. The ICO has a compliant website or web page dedicated to the M-MP product with links to all of the required documents: a. The ICO's service area; b. The benefits offered under the plan (including applicable conditions and limitations); c. Any applicable cost-sharing; d. The plan's drug formulary; e. The provider network and how to access services (including pharmacies, includes addresses and hours, etc.); 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; j. Quality assurance policies and procedures; k. Disenrollment rights and responsibilities; l. Potential for contract termination; m. Medication therapy management program; and n. Link to the electronic complaint form on Medicare.gov.	The ICO 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.) Each of these items is covered on the ICO's website.
5. The ICO's website may not: a. Offer financial or other incentives to induce consumers to enroll in the ICO or to refer a friend, neighbor, or other person to enroll with the ICO; b. Make any statement that has not been pre-approved by EOHHS and CMS; 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 ICO in order to obtain benefits or in order to not lose benefits; or ii. The ICO is endorsed by CMS, Medicare, the federal or state 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 members or misrepresent MassHealth, EOHHS, the ICO or CMS; or f. Engage in outreach activities which target prospective members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services.	The ICO's website is 508-compliant and is accessible to enrollees with disabilities. ICO screenshots or web links show that the ICO 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.)

Enrollee and Provider Communications	
Readiness Review Criteria	**Example Evidence**
6. The ICO must employ ESRs who are: a. Trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees; b. Trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other alternative formats; c. Capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service; d. Knowledgeable about MassHealth, Medicare, and all terms of the contract, including covered services; e. Available to enrollees to discuss and provide assistance with resolving enrollee grievances; and f. Have access to: i. The ICO's enrollee database; ii. EOHHS's Eligibility Verification System (EVS); and iii. An electronic provider directory.	P&P for ESRs includes these elements. Training materials for ESRs includes these elements. Training logs for ESRs shows that all ESRs have received the necessary training.
7. The ICO has policies and procedures that state that, with the enrollee's consent, the ICO shall assist enrollees in providing MassHealth with their current address (residential and mailing), phone numbers, and other demographic information including pregnancy, ethnicity, and race. The ICO shall update this demographic information into the change form via the My Account Page Application on the Virtual Gateway or via other information exchange processes established with MassHealth.	P&P for ESRs or other staff performing this function includes assisting enrollees in providing MassHealth with this information. P&P for updating enrollee information includes these procedures.

Enrollee and Provider Communications	
Readiness Review Criteria	**Example Evidence**
8. The ICO maintains a Nurse Advice Line, accessible by enrollees 24 hours a day, seven days a week. The Nurse Advice Line shall: a. Be staffed by a registered nurse who shall be available to respond to enrollee questions about health or medical concerns; b. Be accessible through a dedicated toll-free telephone number; c. Provide direct access to a registered nurse for medical triage and health questions, based on industry standard guidelines, to assist enrollees in determining the most appropriate level of care for their illness or condition; d. Provide general health information to enrollees and answer general health and wellness-related questions; e. Offer an automated health information audio library through which enrollees can access pre-recorded health education and wellness information on a wide variety of topics applicable to the ICO's MassHealth population; f. Provide a direct transfer to the ICO's general customer service center for nonclinical administrative questions during the ICO's hours of operation, and to the ICO's behavioral health clinical question telephone line for clinical behavioral health questions during the ICO's hours of operation; g. Offer all services in both English and Spanish, at a minimum; h. Make oral interpretation services available free-of-charge to enrollees in all non-English languages spoken by enrollees; i. Maintain the availability of services, such as TTY services or comparable services for the Deaf and hard of hearing; and j. Provide coordination with the enrollee's Care Coordinator (or IL-LTSS Coordinator or Clinical Care Manager, as applicable) and PCP, when appropriate, based on protocols established by the ICO and incorporated into the sub-contractual arrangement with the Nurse Advice Line subcontractor, if any.	Contract with Nurse Advice Line company includes all these required services. P&P on after-hours services describes these services being offered by a Nurse Advice Line.
B: Provider Hotline	
1. The ICO maintains a provider hotline that is accessible to providers and pharmacies during the entire period in which the ICO sponsor's network pharmacies or providers in its plans' service areas are open, never less than 8:00 AM to 6:00 PM, Monday through Friday	Provider hotline P&P confirms that the hotline is toll-free and available never less than 8:00 AM to 6:00 PM, Monday through Friday.
2. The ICO 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, beneficiary identification, type of request (coverage determination or appeal), physician support for an exception request, and whether the member is making an expedited or standard request); and	Provider hotline P&P includes the enumerated requirements.

Enrollee and Provider Communications

Readiness Review Criteria	Example Evidence
c. Indicates the time period in which a response to a voicemail can be expected.	
3. The ICO (or PBM) has a pharmacy technical help desk call center that is prepared for increased call volume to handle new enrollments.	The ICO (or PBM) has a staffing plan that shows how it has arrived at an estimated staffing ratio for the pharmacy technical help desk call center and how and in what timeframe it intends to staff to that ratio.
4. The ICO ensures that pharmacy technical support is available at any time any of the network pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.

Enrollee Protections

Readiness Review Criteria	Example Evidence
A: Enrollee Rights	
1. The ICO has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	Enrollee rights P&P articulates enrollees' rights, states that enrollees will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
2. The ICO policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	Enrollee rights P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on the enrollee’s condition and ability.

Enrollee Protections	
Readiness Review Criteria	**Example Evidence**
3. The ICO provides enrollees with the following rights: 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 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 request that they be amended or corrected; and f. Receive information including all enrollment notices, informational materials, and instructional materials in a manner and format that may be easily understood.	Enrollee rights P&P states that an enrollee has these rights. Staff training on enrollee rights includes these rights.
4. The ICO 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 explains that the ICO will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.
5. The ICO informs enrollees that they will not be balanced billed by a provider for any service and this is articulated through policies and procedures and staff training modules.	Enrollee rights P&P explains that the ICO informs beneficiaries that they should not be balanced billed.
6. The ICO has policies and procedures to inform enrollees of their right to reasonable accommodation.	Enrollee rights P&P states that the ICO informs enrollees of their right to reasonable accommodation.
B: Appeals and Grievances	
1. The ICO notifies enrollees at least annually about their grievances and appeals rights.	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.
2. The ICO's staff understand enrollee protections, including the organization and coverage determination and appeals and grievance processes.	Training materials contain information about the ICO"s organization and coverage determination processes and the appeals and grievance processes.
3. The ICO provides enrollees with a "Notice of Denial of Medical Coverage" that provides appeal rights.	The Notice of Denial of Medical Coverage is consistent with CMS' template.

Enrollee Protections	
Readiness Review Criteria	**Example Evidence**
4. The ICO provides enrollees with reasonable assistance in filing an appeal or grievance.	Grievances and appeals P&P explains to the extent to which the ICO will assist an enrollee in filing an appeal or grievance.
5. ICOs must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal ICO appeals. This means that such benefits will continue to be provided by providers to beneficiaries, and that ICOs must continue to pay providers for providing such services pending an internal ICO 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.
6. Appeals of ICO actions concerning Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.	Grievances and appeals P&P states that appeals of ICO decisions concerning Medicaid-only benefits may be appealed to the MassHealth Board of Hearings.
7. The ICO maintains an established process to track and maintain records on all grievances received both orally and in writing, including, at a minimum, the date of receipt, final disposition of the grievance, and the date that the ICO notified the enrollee of the disposition.	Screenshots of or reports from the tracking system in which enrollee appeals and grievances are kept includes these elements. Data summaries or reports detail the types of reporting and remediation steps that are taken to ensure appeals are correctly handled. Grievances and appeals P&P define how staff from the ICO should document grievances and appeals within the tracking system.

Enrollee Protections	
Readiness Review Criteria	**Example Evidence**
8. The ICO shall maintain the following policies and procedures for enrollee grievances: a. Enrollees shall be entitled to file internal grievances directly with the ICO. b. An enrollee grievance is an enrollee's written or oral expression of dissatisfaction with any aspect of the operations, activities or behavior of an ICO, or its providers, regardless of whether remedial action is requested. c. An enrollee may file an internal grievance at any time with the ICO or its providers, by calling or writing to the ICO or provider. d. An enrollee also may file an external grievance at any time by calling or writing to MassHealth. e. If remedial action is requested, the enrollee must submit the grievance to the ICO, his/her provider or MassHealth no later than 60 days after the event or incident triggering the grievance. f. The ICO must inform enrollees of the postal address or toll-free telephone number where an internal or external enrollee grievance may be filed. g. The ICO has a system in place for addressing enrollee grievances internally. The ICO must maintain written grievance policies and procedures, maintain records of all grievance activities, and notify MassHealth of all internal grievances. The system must meet the following standards: i. Timely acknowledgement of receipt of each enrollee grievance; ii. Timely review of each enrollee grievance; iii. Response, orally or in writing, to each enrollee grievance within a reasonable time, but no later than 30 days after the ICO receives the grievance; iv. Expedited response, orally or in writing, within 24 hours after the ICO receives the grievance to each enrollee grievance whenever an ICO extends the appeals timeframe or an ICO refuses to grant a request for an expedited appeal; and v. Availability to enrollees of information about enrollee appeals, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability. h. Enrollees may submit written or oral grievances directly to MassHealth. i. The ICO must track and resolve its grievances, or if appropriate, re-route grievances to the coverage decision or appeals processes.	P&P on grievances includes these specifications.

Enrollee Protections	
Readiness Review Criteria	**Example Evidence**
9. The ICO shall maintain the following policies and procedures for appeals for other than Part D: a. Enrollees have 60 days to file an appeal related to coverage. b. Initial appeals will be filed with the ICO. i. Subsequent appeals for traditional Medicare A and B services will be automatically forwarded to the Medicare Independent Review Entity (IRE). ii. Services for which Medicare and Medicaid overlap (including Home Heath, Durable Medical Equipment and skilled therapies, but excluding Part D) will be defined in a unified way in the three-way contract. Appeals related to these benefits will be auto-forwarded to the IRE, and may also be filed with the Board of Hearings. c. All ICO appeals must be resolved (at each level) within 30 days of their submission for standard appeals and within 72 hours of their submission for expedited appeals.	P&P on appeals includes these specifications.
10. Consistent with existing rules, if the ICO misses the applicable adjudication timeframe, Part D cases will be automatically forwarded to the IRE.	P&P on Part D appeals includes these requirements for processing appeals.
C: Enrollee Choice of PCP	
1. The ICO notifies enrollees about the process for choosing their primary care provider (PCP), including the enrollee's right to select his/her PCP.	PCP selection and assignment P&P explains how and when an enrollee may elect a new PCP. PCP selection and assignment P&P explains how primary care providers are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.
D: Emergency Services	
1. The ICO has a back-up plan in place in case an LTSS provider does not arrive to provide assistance with activities of daily living.	Emergency services P&P explains how the ICO is prepared to provide care to LTSS enrollees when an LTSS provider does not arrive to provide care.
2. The ICO can connect enrollees with emergency behavioral health services, when applicable.	Emergency services P&P explains how the ICO is prepared to provide emergency mental health services to enrollees in crisis.
3. The ICO has a crisis hotline service that is available to enrollees 24 hours per day, 7 days per week, which is staffed with behavioral health professionals who are qualified to assist in a crisis situation.	Emergency services P&P confirms that the ICO maintains a behavioral health crisis hotline that is available to enrollees 24 hours a day, 7 days per week, and that it is staffed with qualified behavioral health professionals who are qualified to assist in a crisis situation. Resumes of staff for the crisis hotline demonstrate that staff for the crisis hotline are qualified behavioral health professionals.

Financial Soundness

Readiness Review Criteria	Evidence
1. ICO must provide assurances that its provision against the risk of insolvency is adequate to ensure that its enrollees will not be liable for the entity's debts if the entity becomes insolvent. ICO must produce adequate documentation satisfying the Commonwealth that it has met its solvency requirements, including: letters of financial support (or credit, bond, loan guarantee, letter of parental guarantee, reserve guarantee, or other financial guarantees) in at least an amount that guarantees the ICO's contract obligations will be performed, a detailed plan to establish and maintain reserves or other funds necessary to cover any risks projected and not otherwise assumed by another entity, copies of all reinsurance agreements, adequate liability insurance to perform contractually agreed services, accounting system statement for incurred but not reported liabilities, detailed description of mechanisms to monitor financial solvency, and certificate from the taxing authority in the state where the ICO has its principal office attesting that the ICO is not in default. ICOs must also maintain reserves to remain solvent for a 45-day period, and provide satisfactory evidence to the State of such reserves.	Required financial documentation of solvency.

Organizational Structure and Staffing

Readiness Review Criteria	Example Evidence
A. Organizational structure and staffing	
1. The ICO maintains and updates all required points of contact in CMS ICO Management System (HPMS), including but not limited to CEO, COO, and CFO.	HPMS.
2. The ICO identifies a. A Behavioral Health Clinical Director; and b. A Director of LTSS.	Staff resumes indicate that qualified and experienced staff with appropriate expertise fill these positions.
3. The ICO must establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The ICO must also demonstrate participation of consumers with disabilities, including enrollees, within the governance structure of the ICO.	Bylaws governing ICO'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 ICO) and that the committee has a process for providing input to the ICO's governing board.
4. ICO has established a work plan and identified an individual in its organization who is responsible for Americans with Disabilities Act (ADA) compliance related to this demonstration.	The ICO submits an ADA work plan and has identified an individual responsible for oversight of ADA compliance.

Organizational Structure and Staffing	
Readiness Review Criteria	**Example Evidence**
5. The ICO has a utilization management (UM) committee that exhibits an expertise in the range of services provided by the plan (e.g., behavioral health and LTSS expertise).	Note: For ICOs with current UM committees, review will focus on the change in composition to address the new services (e.g., LTSS and BH). UM committee members are appropriate based on the target population described in the CMS-State MOU (e.g., including behavioral health providers and providers with expertise in LTSS).
6. The ICO's Quality Improvement (QI) committee includes physicians, psychologists, providers with expertise in LTSS and others, who represent a range of health care services used by enrollees in the target population.	Note: For ICOs with current QI committees, review will focus on the change in composition to address the new services (e.g., LTSS and BH). QI committee members are appropriate based on the target population described in the MOU.
7. The ICO has an individual or committee responsible for provider credentialing.	A provider credentialing point of contact or committee is reflected in org 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, pharmacy).
8. The ICO informs the Commonwealth when the points of contact at ICO change.	P&P requires the Commonwealth to be notified should any changes occur among head contact staff.
B: Sufficient Staff	
1. The ICO's hiring process includes: a. A strategic plan for hiring new employees or contractors, as needed, which must include the following positions; Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, Director of Quality Management, Behavioral Health Clinical Director (or equivalent), Director of Long Term Support Services and Supports (or equivalent), and ADA Compliance Officer; b. A timeline by which key hiring activities are to be completed; and c. A designated staff member responsible for overseeing the hiring process.	The ICO's strategic hiring plan is consistent with the volume of anticipated monthly enrollment. 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. Key leadership roles have been filled.
2. The ICO demonstrates that it has sufficient employees and/or contractor staff to complete comprehensive and ongoing assessments as required (including at least annually), in a timely manner for all enrollees through its staffing plan, which explains: a. how the ICO arrived at its estimation of sufficient staffing for this function; and a. how and in what timeframe it will staff to the level indicated; and b. how it matches the needs of various sub-populations.	The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for completing health risk assessments and how and in what timeframe it intends to staff to that ratio.

Organizational Structure and Staffing	
Readiness Review Criteria	**Example Evidence**
3. The ICO staff, contractors, or providers performing comprehensive-assessments have the appropriate education and experience for the sub-populations (e.g., experience in LTSS or behavioral health).	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate that staff meet job description requirements.
4. The ICO demonstrates that it has sufficient employees and/or contractor staff to meet the care coordination needs of the target population through its staffing plan, which explains: a. how the ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of various sub-populations.	The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for providing care coordination and how and in what timeframe it intends to staff to that ratio.
5. The qualifications for a Care Coordinator include: a. being a provider-based clinician, or b. or trained individual employed or contracted by the enrollee's primary care provider.	P&P on Care Coordinator qualifications includes those listed.
6. The qualifications for a clinical care manager include: a. being a licensed registered nurse or other individual employed by the enrollee's primary care provider or ICO; and b. being licensed to provide clinical care management.	P&P on Clinical Care Manager qualifications includes those listed.
7. The qualifications for a IL-LTSS coordinator include: a. a bachelor's degree in social work or human services or at least two years working in a human service field with the target population; b. completion of person-centered planning and person-centered direction training, experience working with disabled populations or elders in need of LTSS; c. knowledge of the home and community-based service system and how to access and arrange for services; d. experience in conducting LTSS needs assessments and monitoring LTSS delivery; e. cultural competency; f. the ability to provide informed advocacy; g. the ability to write an Individualized Care Plan; h. the ability to communicate effectively, verbally and in writing across complicated service and support systems; and i. meeting all requirements of their CBO employer.	P&P on IL-LTSS coordinator qualifications includes those listed.
8. The ICO demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight, monitoring, and quality assurance activities through its staffing plan, which explains: a. how the ICO arrived at its estimation of sufficient staffing for this function; b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of the sub-populations.	The ICO 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 how and in what timeframe it intends to staff to that ratio.

Organizational Structure and Staffing	
Readiness Review Criteria	**Example Evidence**
9. The ICO demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan, which explains: a. how the ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated; and c. how it matches the needs of the sub-populations.	The ICO 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 how and in what timeframe it intends to staff to that ratio.
10. The ICO 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 ICO arrived at its estimation of sufficient staffing for this function; and b. how and in what timeframe it will staff to the level indicated.	The ICO has a staffing plan that shows how it has arrived at an estimated staffing ratio for completing health risk assessments and how and in what timeframe it intends to staff to that ratio.
11. The plan 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.
C: Staff Training	
1. The ICO has a cultural competency and disability training plan to ensure that staff deliver culturally-competent services in both oral and written enrollee communications (e.g., person-first language, target population competencies).	The ICO'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 ICO's training materials include training on cultural competency and disability.
2. The ICO's staff are adequately trained to handle critical incident and fraud and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect and exploitation of enrollees by service providers and/or natural supports.	The ICO's training materials include training on critical incident and fraud and include these topics.

Organizational Structure and Staffing	
Readiness Review Criteria	**Example Evidence**
3. The training program for Care Coordinators includes (but is not limited to): a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. Long term services and support; f. Self-direction of PCA services; g. Behavioral health and the recovery model 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. Independent living philosophy; o. Most integrated/ least restrictive setting; p. How to identify behavioral health and LTSS needs; and q. How to obtain services to meet behavioral and LTSS needs.	The ICO's training materials for Care Coordinators include modules or sections on each of these elements.
4. The training program for primary care providers includes: a. how to identify behavioral health needs and how to obtain behavioral health services; and b. how to identify LTSS needs and how to obtain services.	The ICO's training materials for PCPs include modules or sections on behavioral health needs and services.
5. The ICO has adequate personnel and training resources so that all staff have the ability to access required training materials in a timely manner; a designated staff member is in charge of ensuring required trainings are completed on schedule.	The ICO's training materials describe which staff receive training and how often, including a schedule of training activities for new staff retraining schedule (e.g., protecting enrollee rights, assisting with grievances and appeals).
6. The ICO's staff are trained on confidentiality guidelines and have received training to meet HIPAA compliance obligations.	The ICO's training materials include training on HIPAA compliance, including confidentiality guidelines.

Organizational Structure and Staffing	
Readiness Review Criteria	**Example Evidence**
7. The ICO or PBM has scripts for its pharmacy customer service hotline staff including, but not limited to: a. Best Available Evidence policy; b. Request for pre-enrollment information; c. Benefit information; d. Cost-sharing information; e. Continuity of care requirements; f. Enrollment/disenrollments; g. Formulary information; h. Pharmacy information, including whether an enrollee's pharmacy is in the ICO's network; i. Provider information, including whether an enrollee's physician is in the ICO's network; j. Out-of-network coverage; k. Claims submission, processing, and payment; l. Formulary transition process; m. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); n. Information on extra help, including how the enrollee can obtain extra help o. Current TrOOP status; p. Information on how to obtain needed forms; q. Information on replacing an identification card; and r. Service area information.	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria.
8. The ICO ensures 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 ICO and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Assisting enrollees to obtain services and make appointments; and d. Handling or directing enrollee inquiries or grievances.	Content from training programs or orientation modules demonstrates staff from the ICO 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 ICO would walk through assisting enrollees in explaining or selecting services.
9. The ICO's training for internal beneficiary complaint and appeal staff covers accessibility obligations related to the Americans with Disabilities Act (ADA) and community integration priorities and principles.	ICO's training materials include modules on the ADA.

Performance and Quality Improvement

Readiness Review Criteria	Example Evidence
Performance and quality improvement	
1. The ICO collects and tracks critical incidents and abuse for enrollees receiving LTSS.	QI program description explains how the ICO tracks incidents and cases of abuse for enrollees receiving LTSS. Sample annual performance report includes ICO's method of tracking and reporting cases of incidents and abuse.
2. The ICO is prepared to report all Year 1 core quality measures required under the demonstration, including all Medicare Advantage (Part C) required measures, HEDIS, HOS and CAHPS data, as well as measures related to behavioral health, care coordination/transitions, LTSS as required by the MOU (see Figure 7-1), and all patient ED wait times prior to inpatient behavioral health admission.	QI program description details how the ICO collects these measures for its enrollees. Sample annual performance report includes ICO's method of reporting these measures.
3. The ICO 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 explaining health's plans means of collecting and reviewing drug quality measures. Sample annual performance report includes ICO's method of reporting these measures.
4. The ICO has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities.	The ICO has a detailed plan that explains how the ICO monitors first-tier, downstream, and related entities (e.g., via monthly reviews or reports, on-site visits).
5. The ICO, as a condition of payment, complies with the requirements mandating that Provider Preventable Conditions be reported and that payment for these conditions be prohibited.	P&P for reporting Provider Preventable Conditions and non-payment of those conditions. ICO provider contract templates include provisions on provider preventable conditions.

Program Integrity

Readiness Review Criteria	Example Evidence
1. In accordance with 42 CFR §438.608, 42 CFR §422.503, and 42 CFR §423.504 the ICO shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against Fraud and Abuse. The arrangements or procedures must include the following: a. Written policies, procedures, and standards of conduct articulate the organization's commitment to comply with all applicable Federal and State standards, describe compliance expectations, and implement the compliance program; b. Written policies, procedures, and standards of conduct provide guidance to employees and others on how to deal with potential compliance issues, identify how to communicate compliance issues	The ICO's compliance plan includes these arrangements and/or procedures.

Program Integrity	
Readiness Review Criteria	**Example Evidence**
to appropriate compliance personnel, and describe how potential compliance issues are investigated and resolved by the organization; c. Policies, procedures, and standards of conduct include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits, remedial actions, and reporting to appropriate officials; d. The designation of a compliance officer and compliance committee who report directly to and are accountable to the organization's CEO or other senior management; the compliance officer is an employee of the ICO; e. The compliance officer and committee periodically submit reports to the health plan's governing body on the activities and status of the compliance program, including those issues that are identified, investigated, and resolved; f. The ICO's governing body is knowledgeable about the content and operation of the compliance program and exercises oversight, with respect to its implementation and effectiveness; g. Effective training materials and education programs that ensure that employees, management, governing body members, and any of the organization's first tier, downstream, and related entities understand and are able to comply with the compliance program. The training occurs at least annually and is part of the orientation for everyone who is required to have the training; h. Effective lines of communication between the compliance officer and the Contractor's employees; i. Enforcement of standards through well-publicized disciplinary guidelines; and j. Provision for prompt response to detected offenses, and for development of corrective action initiatives.	
2. The ICO shall: a. Develop a comprehensive internal Fraud and Abuse program, as part of the Contractor's compliance program to prevent and detect program violations; b. In accordance with Mass. Gen. Laws. ch. 12, section 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution; c. Upon a complaint of Fraud or Abuse from any source or upon identifying any questionable practices, conduct a preliminary review to determine whether in the Contractor's judgment, there is reason to believe that the Provider, the Enrollee, or a Contractor employee, has engaged in Fraud or Abuse, and where reason exists, report the matter in writing to EOHHS within ten days; d. If such preliminary review, or any further review or audit of a Provider suspected of Fraud involves contacting the Provider in question, the Contractor shall first notify EOHHS and receive its approval prior to initiating such contact; e. Make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by the Contractor, or its parent organization, its Providers or its subcontractors; f. Require providers to implement corrective actions or terminate Provider Contracts, as appropriate; g. Submit on an annual basis a fraud and abuse report according to the format specified by EOHHS,	The ICO's compliance plan includes these arrangements and/or procedures.

Program Integrity	
Readiness Review Criteria	**Example Evidence**
and submit ad hoc reports as needed, or as requested by EOHHS; h. Have the CEO or CFO certify in writing on an annual basis to EOHHS, using the appropriate certification checklist, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with this Contract and has not been made aware of any instances of Fraud and Abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS; i. Notify EOHHS upon contact by the Medicaid Fraud Division (MFD), the Bureau of Special Investigations (BSI) or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any subcontractors or Material Subcontractors, shall cooperate fully with the MFD, BSI and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding; and j. Notify EOHHS of all Provider overpayments above $75,000, or any voluntary Provider disclosures resulting in receipt of overpayments in excess of $75,000, even if there is no suspicion of fraudulent activity.	

Provider Credentialing

Readiness Review Criteria	Example Evidence
A: Provider Organization Credentialing	
1. The ICO shall: a. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the ICO's provider network that require, at a minimum, that the scope and structure of the processes be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the Board of Registration in Medicine at 243 CMR 3.13; b. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards and relevant state regulations; c. Maintain a documented re-credentialing process that shall occur regularly and that requires that physician providers and other licensed and certified professional providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards.	Provider credentialing P&P includes these requirements.
2. Prior to contracting with a new provider, the ICO verifies the following: a. A valid license to practice medicine, when applicable; b. A valid DEA certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. Malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions; i. Medicare or Medicaid sanctions; and j. Malpractice history.	Provider credentialing P&P states that the ICO will review these documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.
3. The ICO requires all contracted laboratories to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The ICO submits a CLIA certificate or a waiver of CLIA certification along with a CLIA identification number for each laboratory with which the ICO has contracted.
4. The ICO maintains a policy with respect to board certification for primary care providers and specialty physicians that ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for primary care providers and specialty physicians in the ICO's service area.	P&P on provider credentialing ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network is approximately equivalent to the community average.

Provider Network

Readiness Review Criteria	Example Evidence
A: Establishment and Maintenance of Network, including Capacity and Services Offered	
1. The ICO has a set of procedures that govern participation in the medical, behavioral, pharmacy, and LTSS provider networks, including written rules of participation that cover: a. terms of payment; b. credentialing; and c. other rules directly related to participation decisions. When an ICO makes a material change in its participation procedures, it agrees to submit written notice to CMS and Massachusetts before the change is in effect.	The ICO'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 Massachusetts prior to changes taking effect.
2. The ICO has a clear plan to meet the Medicare and Medicaid provider network standards that 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 (i.e., training, experience, and specialization) of providers required to furnish the contracted services including pharmacies and LTSS 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' places of residence; g. Access to specialty care services for enrollees within a reasonable distance from enrollees' places of residence; h. Access to at least two outpatient behavioral health providers within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence; i. Access to at least two community LTSS Providers for each covered LTSS service within a 15-mile radius or 30 minutes from the Enrollee's ZIP code of residence; j. Access to pharmacy services for enrollees within a reasonable distance from enrollees' places of residence; k. Access to facility services for enrollees within a reasonable distance from enrollees' places of residence, including outpatient dialysis; and l. Out-of-network providers.	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. Review of fully contracted network during network validation (following the completion of rates) • ICOs will submit HSD tables for fully contracted Medicare network • ICOs will submit lists of Medicaid providers and maps for fully contracted Medicaid network
3. The ICO has processes to monitor the pharmacy networks and to continually contract with providers in order to maintain the networks to meet Medicare Part D requirements.	Proof that the plan covers mail order, long-term care pharmacy, and home infusion therapy. The ICO contracts with any willing pharmacy provider.

Provider Network	
Readiness Review Criteria	**Example Evidence**
4. The ICO meets the network adequacy standards for specialists and specialty facilities that are directly linked to the target population; these may include CMHCs, ID/DD service providers, centers for independent living, wheelchair vendors, and seating specialists.	Provider network P&P includes this requirement. Provider network P&P defines how it will monitor and maintain the LTSS network. Review of fully contracted network during network validation review (following the completion of rates) • ICOs will submit HSD tables for fully contracted Medicare network • ICOs will submit lists of Medicaid providers and maps for fully contracted Medicaid network
5. The ICOs has executed written agreements with all Medicare medical, behavioral, and pharmacy network providers.	Sample of contract signature pages show executed contracts.
6. The ICOs has executed written agreements with all Medicaid medical, behavioral, and LTSS network providers required by the State.	Sample of contract signature pages show executed contracts.
7. The ICO has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS, and pharmacy provider networks are trained in cultural competency in delivering services to the following target populations: a. Adults with serious mental illness; b. Enrollees with substance abuse disorders; c. Enrollees with a dual diagnosis of mental health and substance abuse; d. Enrollees with a dual diagnosis of intellectual disabilities and mental health; e. Adults with disabilities who are homeless; f. Enrollees with complex medical needs; g. Enrollees with physical disabilities; h. Enrollees with Traumatic Brain Injury; i. Enrollees with intellectual disabilities; j. Enrollees with dementia/Alzheimer's; k. Enrollees with ESRD; l. Enrollees with HIV/AIDS; m. Adults with physical disabilities; n. Adults with developmental disabilities; o. Adults with disabilities with multiple chronic illnesses or functional or cognitive limitations; and p. Older adults.	Provider network P&P explains how its primary care, specialty, behavioral health, LTSS, and pharmacy providers are prepared to meet the additional competencies necessary to serve enrollees within the target population. Provider training materials for all of these groups include sections on cultural competency when serving target populations.

Provider Network

Readiness Review Criteria	Example Evidence
8. The ICO has a policy and procedure that states that it establishes a panel of primary care providers (PCPs) from which enrollees may select a PCP.	P&P describes PCP requirements and minimum required numbers of PCPs for counties or other plan areas and for sub-populations of enrollees if applicable.
9. The ICO has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explain how and when services outside of the network may be covered and under what circumstances.
10. Medical, pharmacy, behavioral, and LTSS networks' providers have the capacity to accept new enrollees.	Samples of patient panel sizes for primary care and specialty providers within the ICO's network are within normal ranges.
11. The ICO collects and tracks requests, referrals, and use of non-network providers.	P&P explains how the ICO tracks all requests and referrals to non-network providers.
12. The ICO provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage from in-network and out-of-network providers
13. The ICO ensures that enrollees have access to the most current and accurate information, by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes timeframes for updating provider directory and search functionality (for online provider directories).
14. In establishing and maintaining its provider network, the ICO must consider the following: a. Anticipated enrollment by sub-population; b. Expected utilization of services, taking into consideration the cultural and ethnic diversity, and other demographic characteristics and health care needs of specific MassHealth populations enrolled with the ICO; c. The numbers and types (in terms of training, experience and specialization) of Providers required to furnish covered services; d. The number of network providers who are not accepting new patients; and e. The geographic location of providers and enrollees, considering distance, travel time, and the means of transportation ordinarily used by enrollees.	Provider network P&P includes these requirements.

Provider Network

Readiness Review Criteria	Example Evidence
15. The ICO shall meet the following requirements in contracting with Community-Based Organizations (CBO): a. ICO shall contract with multiple CBOs, including at least one Independent Living Center (ILC), where geographically feasible, in its service area for the ILLTSS Coordinator. b. The ICO must contract with an adequate number of CBOs to allow enrollees a choice of at least two IL-LTSS Coordinators. Additional CBOs may include, but are not limited to, Recovery Learning Communities, ASAPs, and other CBOs serving people with disabilities. c. The ICO must offer enrollees over the age of 60 the option of receiving IL-LTSS Coordinator services through an Aging Services Access Point (ASAP). d. The ICO shall not have a direct or indirect financial ownership interest in an entity that serves as a CBO which is contracted to provide IL-LTSS Coordinators. e. Providers of facility- or community-based LTSS that are compensated by the ICO may not function as IL-LTSS Coordinators, except if the ICO obtains a waiver of this requirement from EOHHS. For the purposes of this provision, an organization compensated by the ICO to provide only evaluation, assessment, coordination, skills training, peer supports and Fiscal Intermediary (FI) services is not considered a provider of LTSS.	Provider network P&P is includes these requirements.
16. The ICO must maintain relationships with the Emergency Service Programs (ESPs) that are located within the ICO's service area to provide ESP services. Each ICO must execute and maintain contracts with ESPs that are not run by the Department of Mental Health. ICOs are not required to contract with the DMH ESPs; however, ICOs are required to coordinate admissions and triage with DMH ESPs as they would with any contracted ESP. Of the ESPs identified in Appendix G of the RFR, the DMH ESPs are: Brockton Multi-Service Center, Cape & Islands Emergency Services, Corrigan Mental Health Center, and Norton Emergency Services.	Provider network P&P is includes this requirement.
17. The ICO delivers preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.	P&P on preventive services or covered services includes this requirement.
18. The ICO delivers prenatal and postpartum services to pregnant enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.	P&P on covered services planning services includes these requirements.
B: Accessibility	
1. The ICO medical, behavioral, pharmacy, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the ICO will alert its enrollees of providers able to accommodate enrollees with disabilities (e.g., icons in provider directory, information available upon request).

Provider Network	
Readiness Review Criteria	**Example Evidence**
2. Medical, behavioral, LTSS, and pharmacy network providers provide linguistically- and culturally-competent services.	Template includes requirements for translation services as appropriate (e.g., hospitals required to have Spanish translator on call at all times). Provider training includes training on cultural competency.
3. Medical, behavioral, LTSS, and pharmacy network 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 c. Utilize clear signage and way finding (e.g., color and symbol signage) throughout facilities d. Provide secure access for staff-only areas.	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees. Templates require providers to take these actions as condition for participation.
C: Provider Training	
1. The ICO requires disability, literacy and competency training for its medical, behavioral, LTSS, and pharmacy providers, including information about the following: a. Various types of chronic conditions prevalent within the target population b. Awareness of personal prejudices c. Legal obligations to comply with the ADA d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs e. Types of barriers encountered by the target population f. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model g. Use of evidence-based practices and specific levels of quality outcomes h. Working with enrollees with mental health diagnoses, including crisis prevention and treatment.	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.
2. The ICO's training for all providers and ICT members includes coordinating with behavioral health and LTSS providers, information about accessing behavioral health and LTSS, and lists of community supports available.	Provider training materials include modules on coordination of care, behavioral health services, LTSS, and community supports, see also care coordinator training in the care coordination section.
3. The ICO provides training to providers that their contracts require there be no balance billing under the demonstration.	Provider training materials and provider handbook include information informing them of no balance billing.
4. The ICO has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	Data systems management guidelines for LTSS providers address LTSS providers who are not required to have National Provider Identifiers (NPIs).

Provider Network	
Readiness Review Criteria	**Example Evidence**
D: Provider Handbook	
1. The ICO prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. ICO contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; and h. Provider billing and reporting.	Each of the listed elements is included in the provider handbook.
2. The ICO makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers to ensure in dealing with enrollees who require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on ICO website, information about local organizations serving specific subpopulations of the target population).
3. The ICO prepares a pharmacy handbook.	Each of the listed elements is included in the pharmacy handbook: a. Updates and revisions b. ICO contact information c. Enrollee information d. Enrollee benefits e. Enrollee rights and responsibilities f. Provider billing and reporting.
E: Ongoing Assurance of Network Adequacy Standards	
1. The ICO ensures that the hours of operation of all of its network, including medical, behavioral, LTSS, and pharmacy providers, are convenient to the population served and do not discriminate against ICO enrollees (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals); plan services are available 24 hours a day, 7 days a week, when medically necessary.	Provider contract templates include provision requiring non-discrimination against enrollees and convenient hours of operation.
2. The ICO has a policy and procedure that states that the provider network arranges for necessary specialty care, LTSS, and behavioral health.	P&P on provider network states that the provider network arranges for necessary specialty care. List of network providers includes specialties in all geographic regions.

Qualifications of First-Tier, Downstream, and Related Entities

Readiness Review Criteria	Example Evidence
1. If the ICO proposes to subcontract with a Material Subcontractor for any services (either exclusively, or in combination with any other services under the Contract), the ICO shall, for each proposed Material Subcontractor identify the services to be performed by the Material Subcontractor and; 1. Provide all of the information in RFR Sections 9.7 (Financial Ability/Financial Solvency Standards) for each Material Subcontractor. 2. Submit the resume of the individual in each Material Subcontractor organization responsible for overseeing such Material Subcontract.	P&P on material subcontractors, financial documentation material subcontractor resumes.
2. Material Subcontractors maintain at their own expense, insurance in standard amounts to cover workers' compensation, public liability and property damage insurance, medical malpractice and professional liability insurance and any other insurance that may be necessary for the performance of the work under the Contract. The ICO must provide EOHHS and CMS with certificates of the above insurance coverage.	P&P on material subcontractors, certificates of insurance.
3. Material Subcontractors demonstrate any services they provide are coordinated, integrated and delivered in a person-centered manner to maximize independent living, community-based care, and the health and well-being of Enrollees.	P&P on material subcontractors, sample service plans.

Systems

Readiness Review Criteria	Example Evidence
A: Data Exchange	
1. The ICO has developed a system to electronically exchange data with the State, CMS, subcontractors, and providers. Specifically, requires: a. ICO has established the appropriate External Point of Contact (EPOC) and has a plan for authorizing submitters and other users, and b. ICO has completed the connectivity testing with the MAPD Help Desk.	Documentation that ICO has EPOC. Documentation that ICO completed testing with MAPD Help Desk. Information technology P&P explains how the ICO utilizes network connectivity to connect CMS, the State, and any applicable subcontractors, at a minimum MARx, PDE, 4Rx, and encounter data.

Systems	
Readiness Review Criteria	**Example Evidence**
2. The ICO 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 g. Prescription drug event (PDE) data.	System specifications explain how enrollment, encounter, transaction, personal and provider data are stored. Documentation specifying system design, quality controls, and data permissions and addressing the anticipated volume for each type of data, monthly. The ICO's data is 5010 compliant.
3. The ICO is able to exchange Part D data with the TrOOP Facilitator.	ICO demonstrates systems "test" of sample Part D data exchange with TrOOP Facilitator.
4. The ICO is able to make timely and accurate submissions of Part D pricing data for posting on the Medicare Plan Finder.	P&P on Information technology includes the steps the ICO's IT staff take to ensure timely and accurate submission of pricing data for posting on the Medicare Plan Finder.
5. The ICO reviews Medicare Part D monthly Patient Safety Reports via the Patient Safety Analysis website.	Quality P &P explains process for reviewing monthly patient safety reports.
6. The ICO's financial information reporting (FIR) processor is certified by the Transaction Facilitator.	ICO is able to provide Transaction Facilitator certification documentation for its FIR.
B: Data Security	
1. The ICO has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	The ICO demonstrates an ability to continue operations in the event of a disaster, including maintenance of back-up data at a separate location. The ICO has a detailed plan to restore full operations within a specified timeframe.
2. The ICO facilitates the secure, effective transmission of data.	System specifications explain how tools and utilities support secure connectivity and system access, including, at a minimum, encryption and password protection procedures. ICO demonstrates the necessary infrastructure, tools, and/or utilities to support secure connectivity and access to the system.

Systems	
Readiness Review Criteria	**Example Evidence**
3. The ICO maintains a history of changes, adjustments, and audit trails for current and past data systems.	The ICO is able to provide changes, adjustments, and audit trails for the sample of historic data. The system manual describes the tracking of changes and adjustments to current and past data system records, including claims, encounters, membership, and provider systems.
4. The ICO complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (Standard Unique Health Identifier for Health Care Providers.	NPI is included in provider contracting, claims processing, and other applicable areas.
C: Enrollment Systems	
1. The system generates and maintains records pertinent to enrollment including: a. Name b. Medicare HIC # c. Medicaid ID d. Birth date e. Family status f. Gender g. Language capability h. Special Needs i. Phone number j. Physical address k. Power of attorney or other representative l. Emergency contact m. Enrollment start date n. Enrollment end date	Required elements are described in the enrollment system manual and specifications. The ICO has built-in system structure to prevent obvious errors in data entry (e.g., ID numbers have the required number of digits, inability to enter a birth year that has not yet occurred).
2. The ICO's system has the capacity to process the expected volume of enrollees.	System specifications and information technology P&P explain any system limitations that would inhibit the importation of a large volume of enrollees and the steps the ICO will take to remedy these deficiencies if necessary. Results from systems test demonstrating the plan has capacity to process expected volume of enrollees.

Systems	
Readiness Review Criteria	**Example Evidence**
3. The ICO maintains the enrollment system and addresses technological issues as they arise.	Specifications describe required routine maintenance. Specifications describe process and chain of command for resolving unexpected issues.
4. The ICO has reviewed and implemented CMS guidance for MARx system software improvements.	ICO has a designated individual responsible for monitoring HPMS memoranda for forthcoming changes.
5. The ICO audits the enrollment system on a regular basis.	The ICO has a specific process and schedule for auditing enrollment system and data.
6. The ICO enrollment system has interface capability with the Virtual Gateway for access to MDS-HC for assessment data entry. Access to POSC is also needed to verify eligibility and access 834 transactions. Access to the data warehouse for report encounter data.	System specifications and information technology P&P explain capability to interface with these systems and P&P on how and when this will occur. Systems test.
7. ICO can demonstrate its system has capacity to collect all specified elements. Specifically, the ICO's Centralized Enrollee Record (CER) includes data fields in which to capture enrollees' answers to questions on the specified demographics: race, ethnicity, disability type, primary language, and homelessness.	Plan's Centralized Enrollee Record (CER) includes data fields in which to capture enrollees' answers to questions on the specified demographics: race, ethnicity, disability type, primary language, and homelessness.
C: Claims Processing	
1. The ICO processes accurate, timely, and HIPAA-compliant claims and adjustments 'and can calculate adjudication rates.	Training materials and records of training attendance for staff processing claims Specific edits on claims (first fill, emergency, OON), as they are adjudicated, noting whether the edits are performed pre- or post-payment and are manual or automated.
2. The ICO processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and LTSS claims adjustment.	Data systems management guidelines identifies the 45-day requirement.
3. The claims systems have the capacity to process the volume of claims anticipated under the demonstration.	Successful systems tests.
4. The claims system fee schedule includes all medical and LTSS Medicare and Medicaid services.	Fee schedule for claims system includes all services covered under the demonstration.
5. The claims processing system properly adjudicates claims for prescription and over the counter drugs.	ICO pays claims appropriately based on test of sample. Contract with PBM includes list of over-the-counter drugs and drugs covered by Medicare and Medicaid.

Systems	
Readiness Review Criteria	**Example Evidence**
6. The ICO is able to monitor acceptance rates for optical character recognition (OCR) vendor.	The ICO monitors the number of paper claims accepted and timeframe for acceptance in the OCR format, the time between day and conducts data validity checks for accuracy.
D: Claims Payment	
1. The ICO pays 95% of "clean medical and LTSS claims" within 30 days of receipt.	P&P on claims payment describes clean claims payment procedure. Contracts with providers regarding ICO's responsibility for claims payment. Reports monitoring the number of days between receipt and payment of claims.
2. The ICO 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 ICO pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	P&P on claims payment describes clean claims payment procedure. Contracts with providers regarding ICO's responsibility for claims payment. Reports monitoring the number of days between receipt and payment of claims.
3. The ICO assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement under the plan.	P&P on claims payment describes clean claims payment procedure. Contracts with providers regarding ICO's responsibility for claims payment. Reports monitoring the number of days between receipt and payment of claims.
4. The ICO's claims processing system checks claims payment logic to identify erroneous payments.	P&P on claims payment describes checks for claims payment logic (e.g., duplicate payments, incompatibility between gender and procedure, procedure code-diagnosis edits, gender code-diagnosis edits). If procured or maintained from a vendor, contract between vendor and ICO.

Systems	
Readiness Review Criteria	**Example Evidence**
5. The ICO's claims processing system checks for pricing errors to identify erroneous payments.	P&P on claims payment describes checks for pricing errors (e.g., payment for the service does not correspond with the pricing schedule on file for the date of service). If procured or maintained from a vendor, contract between vendor and ICO.
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. Competency of provider staff to serve enrollees of the target population l. Credentialing information m. Proximity to public transportation.	Required elements are described in the provider system manual and specifications.
F: Pharmacy Systems	
1. The ICO generates and maintains records on the pharmacy networks, including locations and operating hours.	Required elements are described in the pharmacy system manual and specifications. Specifications describe required routine maintenance. Specifications describe process and chain of command for resolving unexpected issues.
2. The ICO updates records providers and deletes records of no longer participating pharmacies.	Pharmacy system manual provides instructions and timelines for updating records, including adding pharmacies and contract terminations. Specifications describe any automated processes that update pharmacy records, so that changes to pharmacy data cascade to other systems, as applicable.

Systems	
Readiness Review Criteria	**Example Evidence**
3. The ICO audits the pharmacy system on a regular basis.	The ICO has a specific process and schedule for auditing the pharmacy system and data, by staff whose primary responsibility is not related to pharmacy.
4. The ICO can submit Prescription Drug Event Data (PDEs) on a monthly basis.	The ICO can provide sample PDE submission and notes in the pharmacy systems manual that this occurs monthly.
5. The ICO has access to the Acumen PDE Analysis and Reports website.	ICO demonstrates that is has access to the website.
6. The ICO is prepared to ensure pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and beneficiary identifiers.	ICO ensures pharmacies are able to properly bill for claims and coordinate with secondary payers.
7. The ICO's system identifies enrollees that fill a prescription during the transition period and require outreach and assistance in requesting an exception or a substitute formulary drug.	The ICO provides a screen print of a "flag" or systems manual documentation that indicates how an enrollee event is identified that event that requires outreach.
G: Encounter Data System	
1. The ICO has a system for producing medical and LTSS encounter data that is, at a minimum, 99% complete and 95% accurate.	The ICO is able to provide a description of processes and procedures for producing and submitting encounter data that meet this standard for completion and accuracy. For plans that pay medical providers on a capitated basis, there is a detailed description of how medical providers are to report claims to the ICO.
2. The ICO verifies the accuracy of PDE encounter data consistent with the Part D requirements.	The ICO is able to provide a description of processes and procedures for producing and submitting PDE encounter data. Successful transmission of PDE files.
H: Care Coordination System	
1. The system generates and maintains records necessary for care coordination, including: a. Enrollee data (from the enrollment system); b. Provider network; c. Inter-disciplinary care team membership for specific enrollees; d. Enrollee assessments; e. Enrollee plans of care;	Required elements are described in the Care Coordination system manual and specifications.

Systems

Readiness Review Criteria	Example Evidence
f. Interdisciplinary care team case notes; and g. Claims information.	
2. The ICO maintains the care coordination system and addresses technological issues as they arise.	Specifications describe required routine maintenance. Specifications describe process and chain of command for resolving unexpected issues and the required response times to resolve issues. Manual backup procedure for system downtime.
3. The ICO verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Specifications describe automated processes for finding data anomalies. Specifications describe processes for manually overwriting data in the instance of an error.
4. The enrollee assessments and plans of care are available to enrollee interdisciplinary care teams and any of the enrollee's other providers.	Specifications and manual describe how ICT members and other providers can access the risk assessment and plan of care, either by accessing the system directly or working with the care coordinator to receive needed information.
5. The care coordination system includes a mechanism to alert interdisciplinary care team members of ED use or inpatient admissions.	Specifications and manual describe alert system to notify ICT members when an enrollee ends up in the hospital.
6. The ICO has systems and mechanisms designed to make enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same enrollee may be seen for care, especially for enrollees identified as homeless.	Required elements are described in the care coordination system manual and specifications.

Utilization Management

Readiness Review Criteria	Example Evidence
A: The ICO has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services.	

Utilization Management	
Readiness Review Criteria	**Example Evidence**
1. The ICO's UM program description specifies procedures under which the enrollee may self-refer services requiring prior authorization, and services requiring a referral.	The ICO's UM program description explains for which services an enrollee can self-refer and services for which the enrollee or provider must obtain prior authorization. The ICO's UM program description outlines for which specialties and services an enrollee or provider must obtain a referral.
2. Medically Necessary services are defined as services: a. For Medicare Part C and D services: that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. b. For MassHealth services: i. That are provided in accordance with MassHealth regulations at 130 CMR 450.204; ii. That are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; iii. For which there is no other medical service or site of service, comparable in effect, available, and suitable for the enrollee requesting the service, that is more conservative or less costly; and iv. That are of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.	The ICO's UM program description and prescription drug manual include these definitions of medical necessity.
3. The UM program description defines the review criteria used, information sources, and process used to review and approve the provision of services and prescription drugs	The ICO's UM program description and prescription drug manual list the rationale the ICO uses to determine which services and prescription drugs it approves (e.g., review criteria used, information sources, review processes).
4. The UM program description describes policies and systems to detect both under- and over-utilization of services and prescription drugs.	The ICO's UM program description details how the ICO monitors its under and overutilization of services (e.g., regular data analysis, periodic review meetings).
5. The UM program description includes the methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The ICO's UM program description 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).

Utilization Management	
Readiness Review Criteria	**Example Evidence**
6. The ICO outlines its process for authorizing out-of-network services; if specialties necessary for enrollees are not available within the network, the ICO 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 ICO's network.
7. The ICO provides evidence that enrollees are able to obtain a second opinion from a qualified health professional at no cost.	The enrollee handbook, UM program description, and the prescription drug manual note the right for enrollees to obtain a second opinion.
8. The ICO describes its processes for communicating to all providers which services require prior authorizations and ensuring that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The ICO's UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The ICO's provider materials describe prior authorization requirements and procedures.
B: Utilization management guidelines	
1. The ICO 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 ICO's members; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and member education and service coverage.	The ICO's P&P on practice guidelines includes these requirements.
2. The ICO shall ensure its provider contracts require: a. That no payment shall be made by the contractor to a provider for a provider-preventable condition; and b. As a condition of payment from the ICO, that all providers comply with reporting requirements on provider-preventable conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS.	The ICO's UM program description instructs staff to determine whether a claim is for a provider-preventable condition and states that such claims will be denied. Provider contract templates include these requirements pertaining to provider-preventable conditions.

Utilization Management	
Readiness Review Criteria	**Example Evidence**
3. The ICO shall develop and implement policies and procedures for the identification, reporting and non-payment of provider-preventable conditions that are consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The ICO's policies and procedures shall also be consistent with the following: a. The ICO shall not pay a provider for a Provider Preventable Condition. b. The ICO shall require, as a condition of payment from the ICO, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the ICO and/or EOHHS. c. The ICO shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee. d. An ICO may limit reductions in Provider payments to the extent that the following apply: i. The identified Provider Preventable Condition would otherwise result in an increase in payment. ii. The ICO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.	P&Ps on identification, reporting and non-payment of provider-preventable conditions include these requirements.
4. The ICO shall report all identified provider-preventable conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements.	Sample report template for reporting provider-preventable conditions.
5. The ICO shall ensure that its non-payment for provider-preventable conditions does not prevent enrollee access to services.	The ICO's UM program description states that non-payment for provider-preventable conditions does not prevent enrollee access to services.

Utilization Management	
Readiness Review Criteria	**Example Evidence**
6. The ICO shall develop and maintain behavioral health inpatient services and diversionary services authorization policies and procedures, which shall, at a minimum, require the ICO to have: a. If prior authorization is required for any behavioral health inpatient services admission or diversionary service, assure the availability of such prior authorization 24 hours a day, seven days a week; b. A plan and a system in place to direct enrollees to the least intensive but clinically appropriate service; c. A system to provide an initial authorization and communicate the initial authorized length of stay to the enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within 30 minutes, and within two hours for non-emergency inpatient authorization and in writing within 24 hours of admission; d. Processes to ensure placement for enrollees who require behavioral health inpatient services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed; e. A system to concurrently review Behavioral Health Inpatient Services to monitor medical necessity for the need for continued stay, and achievement of behavioral health inpatient services treatment goals; f. Verification and authorization of all adjustments to behavioral health inpatient services treatment plans and diversionary services treatment plans; and g. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP and other providers, such as community based mental health services providers, as appropriate.	The ICO's UM program description and P&P describe authorization policies and procedures for behavioral health inpatient services and diversionary services authorization that include these standards.
7. The ICO develops and maintains non-diversionary services authorization policies and procedures. Such policies and procedures shall be submitted to EOHHS for review and approval.	The ICO's UM program description and P&Ps address non-diversionary services authorization policies and procedures.
8. The ICO develops and maintains behavioral health outpatient services policies and procedures that include, but are not limited to, the following: a. Policies and procedures to automatically authorize at least 12 behavioral health outpatient services; b. Policies and procedures for the authorization of all behavioral health outpatient Services beyond the initial 12 outpatient services; c. Policies and procedures to authorize behavioral health outpatient services based upon behavioral health clinical criteria; and d. Policies and procedures based upon behavioral health clinical criteria to review and approve or deny all requests for behavioral health outpatient services based on clinical criteria.	The ICO's UM program description and P&Ps address authorization of behavioral health services consistent with these requirements.

Utilization Management

Readiness Review Criteria	Example Evidence
9. The ICO must develop an authorization process for LTSS and flexible community-based services that consider the enrollee's entire ICP. a. At a minimum, ICO authorizations of LTSS listed in Appendix C, Table 1 must comply with MassHealth FFS authorization criteria for those covered services. b. However, the ICO has the discretion to authorize LTSS and flexible community-based services more broadly in terms of criteria, amount, duration and scope, if the ICO determines that such authorization would provide sufficient value to the enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the enrollee as well as cost-effectiveness (the role of the service in preventing higher-cost alternative care such as acute medical or psychiatric hospitalization, institutional long-term care, or emergency department use).	The ICO's UM program description and/or P&P on coverage determination process address LTSS and flexible community-based services and are consistent with these requirements.
C: The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.	
1. The ICO 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 ICO's UM program description describes the type of communications that will be sent to enrollees, regarding their receipt or denial of referrals of service authorizations. Sample "Notice of Denial of Medical Coverage" is consistent with CMS template.
2. For the processing of requests for initial and continuing authorizations of covered services, the ICO 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; c. Consult with the requesting provider when appropriate.	The ICO's UM program description explains the process for obtaining initial and continuing authorizations for services. Prescription drug manual explains the process for obtaining approval for prescription drug coverage that is considered urgent.

Utilization Management	
Readiness Review Criteria	**Example Evidence**
3. The ICO ensures that prior authorization requirements are not applied to the following services: a. Emergency and post-stabilization services, including emergency behavioral health care b. Urgent care c. Crisis stabilization, including mental health d. Urgent care support for home and community service-based recipients: i. Outside the service area, and ii. Within the service area under unusual or extraordinary circumstances when the contracted medical provider is unavailable or inaccessible e. Family planning services f. Preventive services g. Communicable disease services, including STD and HIV testing h. Post-stabilization care services i. Out-of-area renal dialysis services.	The ICO's UM program description lists those services that are not subject to prior authorization and this list is consistent with the required elements.
4. The ICO follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §§422.568, 422.570 and 422.572. For overlap services, the ICO follows the contract.	The ICO's UM program description includes these requirements.
5. The ICO shall assure that all behavioral health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). The ICO must comply with the requirements for demonstrating parity quantitative treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.	The ICO's UM program description and behavioral health services authorization P&P state that behavioral health authorization and utilization management activities comply with federal mental health parity law.
6. 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. Behavioral health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.	The ICO's UM program description includes this requirement. Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply ICO policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.
7. The ICO shall ensure that a physician and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees in the emergency department, if necessary. The ICO shall institute a record keeping process documenting the amount of time each enrollee spends in a hospital emergency department awaiting admission to a behavioral health inpatient bed.	The ICO's UM program description states that a physician and behavioral health provider are available 24/7 for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees in the emergencies. The ICO has a P&P that describes the record-keeping process described in the criterion.