OHIO READINESS REVIEW PLAN
PHASE 1 –APRIL 15, 2013

Financial Alignment Capitated Readiness Review
Ohio Readiness Review Tool

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

CMS and Ohio have agreed to conduct the readiness reviews in phases to ensure alignment of the demonstration readiness with final Medicaid waiver provisions. The first phase includes criteria related to following health plan operational areas:

- Confidentiality
- Enrollee protections (excluding Appeals and Grievances)
- Enrollee and provider communications
- Provider Credentialing
- Provider Network
- Utilization Management

The Ohio readiness review tool for phase one is attached. Tools used for other phases will be posted as they are finalized and will cover the following areas:

- Assessment processes
- Care Management
- Monitoring of first-tier, downstream, and related entities
- Organizational Structure and Staffing
- Performance and Quality Improvement
- Systems (e.g., claims, enrollment, payment, etc.)

For each phase, the state-specific readiness review tools are based on stakeholder feedback received through letters and public meetings, the content of the Memorandum of Understanding signed on December 11, 2012 the Ohio Medicaid Request for Applications, Ohio Readiness Review Tools (used for Medicaid plans) and applicable Medicare and Medicaid regulations. The Ohio readiness review tool is tailored to the requirements of the approved demonstration, and the State's target population.

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

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

Confidentiality		
Readiness Review Criteria	**Example Evidence**	**Reference**
1. The ICDS Plan provides a privacy notice to enrollees, which explains the policies and procedures for the use and protection of protected health information (PHI).	Sample privacy notice to be sent to enrollees explains how the ICDS Plan will safeguard PHI.	45 CFR §160 45 CFR §162 45 CFR §164
2. The ICDS Plan provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers explains how the ICDS Plan will safeguard PHI and the provider's role in safeguarding PHI.	45 CFR §160 45 CFR §162 45 CFR §164
3. The ICDS Plan: a. Uses a standard letter to comply with the requirements of 45 CFR §164.404(d)(1); and b. Has a policy and procedure to report breaches of unsecured PHI to Medicaid using Medicaid's MCP Reporting Form for Breach of Unsecured Protected Health Information.	Copy of letter ICDS Plan uses to comply with 45 CFR §164.404(d)(1) Policy and procedure includes the requirements in the criterion.	45 CFR 164.404(d)(2)

Enrollee and Provider Communications		
Readiness Review Criteria	**Example Evidence**	**Reference**
A. Enrollee Communications		
1. The ICDS Plan operates an enrollee services telephone line that is accessible nationwide via a toll-free number, and operates a minimum of twelve hours per day, Monday through Friday, except major holidays. The ICDS Plan also requires contractors with direct enrollee contact to maintain service lines during these hours. [1]	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical and behavioral health, LTSS, and pharmacy services. Contract template with subcontractors with direct enrollee contact requires maintenance of enrollee service telephone line that operates during these hours. ICDS Plan provides actual 1-800 number for the enrollee services telephone line.	42 CFR §422.111(h)(1) 42 CFR §423.128(d)(1) CMS Marketing Guidelines, 40. General Marketing Requirements, 40.8. Hours of Operation Requirements for Marketing Materials, p. 21 42 CFR §422.112(a)(7)(i) & (ii), §423.128(d). CMS Marketing Guidelines, 80. Telephonic Activities and Scripts, 80. 1, Customer Service Call Center Requirements, p. 63 42 CFR §422.111(h)(1), §423.128(d)(1). MOU, Appendix 7, page 74
2. The ICDS Plan, or a subcontractor of the ICDS Plan, 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 ICDS Plan'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.[2]	Contract with language line company includes these requirements, including mandatory hours of operation.	42 CFR §422.111(h)(1) 42 CFR §438.10(c)(4) 42 CFR §423.128(d)(1) CMS Marketing Guidelines, 30. Plan Sponsor Responsibilities, 30.7. Requirements Pertaining to Non-English Speaking Populations, p. 12 42 CFR §422.2264(e), §423.2264(e) CMS Marketing

[1] This criterion has been greyed-out to indicate that assessment has been deferred until a later date. ICDS Plans' websites will be reviewed by CMS during review of marketing materials.
[2] This criterion has been greyed-out to indicate that assessment has been deferred until a later date. ICDS Plans' websites will be reviewed by CMS during review of marketing materials.

		Guidelines, 40. General Marketing Requirements, 40.8. Hours of Operation Requirements for Marketing Materials, pp. 20-21 42 CFR §422.112(a)(7)(i) & (ii), §423.128(d)1
B: Provider Hotline		
1. The ICDS Plan maintains a toll-free provider hotline that is accessible to providers and pharmacies 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 ICDS Plan 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 enrollee is making an expedited or standard request); and c. Indicates the time period in which a response to a voicemail can be expected.	Provider hotline P&P includes the enumerated requirements.	
3. The ICDS Plan or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume to handle new enrollments.	The ICDS Plan (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.	42 CFR §423.128(d)(1) CMS Marketing Guidelines, Appendix 5. Pharmacy Technical Help/Coverage Determinations and Appeals Call Center Requirements Pharmacy Technical Help Call Center Requirements, p. 19
4. The ICDS Plan ensures that pharmacy technical support is available to respond to inquiries from pharmacies and providers regarding the beneficiary's Medicare prescription drug benefit at any time that any of the network's pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.	42 CFR §423.128(d)(1), CMS Marketing Guidelines, Appendix 5. Pharmacy Technical Help/Coverage Determinations and Appeals Call Center Requirements, p. 19

Enrollee Protections		
Readiness Review Criteria	**Example Evidence**	**Reference**
A: Enrollee Rights		
1. The ICDS Plan 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 enrollees who violate this policy.	42 CFR §438.100(c)
2. The ICDS Plan provides enrollees with the following rights: a. To receive all services that the ICDS Plan must provide; b. To be treated with respect and with regard for your dignity and privacy; c. To be sure that your medical record information will be kept private; d. To be given information about your health, which may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you; e. To be able to take part in decisions about your health care unless it is not in your best interest; f. To get information on any medical care treatment, given in a way that you can follow; g. To be sure others cannot hear or see you when you are getting medical care; h. To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations; i. To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed; j. To be able to say yes or no to having any information about you given out unless [Name of Plan] has to by law; k. To be able to say no to treatment or therapy. If you say no, the doctor or ICDS Plan must talk to you about what could happen and they must put a note in your medical record about it; l. To be able to file an appeal, a grievance (complaint) or state hearing; m. To be able to get all ICDS Plan written enrollee information from the ICDS Plan; i. At no cost to you; ii. In the prevalent non-English languages of enrollees in the ICDS Plan's service area; and iii. In other ways, to help with the special needs of enrollees who may have trouble reading the information for any reason; n. To be able to get help free of charge from [Name of Plan] and its providers if you do not speak English or need help in understanding information; o. To be able to get help with sign language if you are hearing impaired; p. To be told if the health care provider is a student and	Enrollee rights P&P states that an enrollee has these rights. Staff training on enrollee rights includes these rights.	42 CFR §438.100(b)

Enrollee Protections		
Readiness Review Criteria	**Example Evidence**	**Reference**
to be able to refuse his/her care; q. To be told of any experimental care and to be able to refuse to be part of the care; r. To make advance directives (a living will). See the pamphlet in your new enrollee packet which explains about advance directives; s. To file any complaint about not following your advance directive with the Ohio Department of Health; t. To change your primary care provider (PCP) to another PCP on your ICDS Plan's panel at least monthly; u. To be given reasonable accommodation if you are disabled; v. To be free to carry out your rights and know that the ICDS Plan, the ICDS Plan's providers or Medicaid will not hold this against you; w. To know that the ICDS Plan must follow all federal and state laws, and other laws about privacy that apply; x. To choose the provider that gives you care whenever possible and appropriate; y. If you are a female, to be able to go to a woman's health provider on your ICDS Plan's panel for covered woman's health services; z. To be able to get a second opinion from a qualified provider on the ICDS Plan's panel, and if a qualified provider is not able to see you, your ICDS Plan must set up a visit with a provider not on their panel; aa. To get information about your ICDS Plan from the state; and bb. To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Medicaid Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.		
3. The ICDS Plan does not discriminate against enrollees due to: a. Race; b. Color; c. Religion; d. Gender; e. Sexual orientation; f. Age; g. National origin; h. Veteran's status; i. Ancestry; j. Medical condition (including physical and mental illness); k. Claims experience; l. Receipt of health care; m. Medical history; n. Genetic information; o. Evidence of insurability; or Disability.	Enrollee rights P&P addresses that the ICDS Plan will not discriminate against enrollees based on the enumerated reasons. Staff training includes non-discrimination component of enrollee rights.	42 CFR §422.110(a)
4. The ICDS Plan informs enrollees that they will not be balanced billed nor billed for cost sharing by a provider	Enrollee rights P&P explains that the ICDS Plan informs beneficiaries that	Section 1902(n)(3)(B) of the Social Security Act

Enrollee Protections		
Readiness Review Criteria	**Example Evidence**	**Reference**
for any service with the exception of Part D copays. This is articulated through policies and procedures and staff and provider training modules.	they should not be balanced billed, nor billed for cost sharing with the exception of Part D copays. Training materials for providers and staff cover this rule.	42 CFR §438.106
C: Enrollee Choice of PCP		
1. The ICDS Plan provides enrollees with information regarding: a. The enrollee's responsibility to select a PCP from the ICDS Plan's provider directory; b. The enrollee's ability to change PCPs, no less often than monthly; c. How an enrollee requests a change; d. The ICDS Plan's procedures for processing PCP change requests after the initial month of ICDS Plan membership; and e. How the ICDS Plan will provide written confirmation to the enrollee of any new PCP selection prior to or on the effective date of the change.	PCP selection and assignment P&P explains how and when an enrollee may elect a new PCP. PCP selection and assignment P&P explains how PCPs are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.	

Monitoring of First Tier, Downstream, and Related Entities		
Readiness Review Criteria	**Example Evidence**	**Reference**
The ICDS Plan has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the ICDS Plan. The plan is consistent with the ICDS Plan's responsibilities under federal regulations and NCQA accreditation standards.	The ICDS Plan has a detailed plan that explains how the ICDS Plan monitors first-tier, downstream, and related entities (e.g., via monthly reviews or reports, on-site visits).	

Performance and Quality Improvement		
Readiness Review Criteria	**Example Evidence**	**Reference**
Performance and quality improvement		
1. The ICDS Plan collects prescription drug quality measures consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.	QI program description explains the ICDS Plan's means of collecting and reviewing drug quality measures. Sample annual performance report includes the ICDS Plan's method of reporting these measures.	42 CFR §423.153(c)
2. The ICDS Plan is prepared to report all quality measures required under the Demonstration, including all Medicare Advantage required measures, HEDIS, HOS and CAHPS data, as well as measures related to behavioral health; care management/transitions; LTSS, as required by the CMS-state MOU; and other specific measures, as required by the CMS-state MOU.[3]	QI program description details how the ICDS Plan collects these measures for its enrollees. Sample annual performance report includes ICDS Plan's method of reporting these measures.	MOU, Appendix 7, pp. 76-90

[3] This criterion is greyed-out to indicate that assessment has been deferred until CMS and the state have provided ICDS Plans with additional guidance.

Provider Credentialing		
Readiness Review Criteria	**Example Evidence**	**Reference**
1. The ICDS Plan requires all contracted laboratories to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The ICDS Plan submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.	42 CFR §493
2. The ICDS Plan has a policy that it only contracts with a HCBS provider if the provider has an active Medicaid provider agreement specific to the contracted service on file with the Medicaid agency.	P&P on provider credentialing or HCBS providers states that the ICDS plan will verify the existence of the HCBS provider's Medicaid provider agreement specific to that service before entering into a contract.	

Provider Network		
Readiness Review Criteria	**Readiness Review Criteria**	**Readiness Review Criteria**
A: Establishment and Maintenance of Network, including Capacity and Services Offered		
1. The ICDS Plan 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 ICDS Plan makes a material change in its participation procedures, it agrees to submit written notice to CMS and the state before the change is in effect.	The ICDS Plan'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 the state prior to changes taking effect.	42 CFR §422.202(a) 42 CFR §438.214
2. The ICDS Plan has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including pharmacies and LTSS providers; d. Whether providers are accepting new enrollees; e. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location provides access for enrollees; f. Access to primary care services for enrollees within a reasonable distance of enrollees' residence; g. Access to specialty care services for enrollees within a reasonable distance from enrollees' places of residence; h. Access to pharmacy services for enrollees within a reasonable distance from enrollees' places of residence; i. Access to facility services for enrollees within a reasonable distance from enrollees' places of residence, including outpatient dialysis; j. Out-of-network providers; k. Access to Certified Nurse Practitioner (CNP) services in each region whether or not the ICDS Plan contracts with CNPs; l. Access to Certified Nurse Midwives (CNM) services in each region whether or not the ICDS Plan contracts with CNMs; m. All state Medicaid requirements regarding network adequacy for dental and vision services in the tables in Appendix H to the Medicaid provider agreement.	Provider network P&P details ICDS Plan's plan to meet the enumerated Medicare and Medicaid provider network requirements.	42 CFR §422.112 42 CFR §423.120
3. The ICDS Plan has processes to monitor the pharmacy network and to continually contract with providers in order to maintain the networks to meet Medicare Part D requirements.	Evidence that the ICDS Plan covers mail order, long-term care pharmacy, and home infusion therapy.	

	The ICDS Plan contracts with any willing pharmacy provider.	
4. The ICDS Plan 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.	42 CFR §422.112
5. The ICDS Plan has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the enrollee's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.	42 CFR §423.124 42 CFR §438.206
6. The ICDS Plan collects and tracks requests, referrals, and use of non-network providers.	P&P explains how the ICDS Plan tracks all requests and referrals to non-network providers.	
7. The ICDS Plan provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.	42 CFR §438.206(b)(3)
8. The ICDS Plan ensures that enrollees have access to the most current and accurate information by updating its online provider directory and search functionality for enrollees on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).	
B: Accessibility		
1. The ICDS Plan 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 ICDS Plan alerts its enrollees of providers able to accommodate enrollees with disabilities (e.g. ICDS Plans in provider directory, information available upon request).	
2. 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; and c. Utilize clear signage and way finding (e.g. color and symbol signage) throughout facilities.	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees. Templates require providers to take these actions as condition for participation. Policy and procedure document addresses these requirements.	
C: Provider Training		
1. The ICDS Plan provides training for all providers and ICT members on a. ADA accessibility requirements; b. The ICDS Plan's Model of Care; c. Coordinating with behavioral health and LTSS providers, d. Information about accessing behavioral health and	Provider training materials include modules on the enumerated topics.	Medicare Managed Care Manual Chapter 16 (Rev. 98, Issued: 05-20-11), b. Special Needs Plans, 90. Model of Care, 90.7. MOC Training for Personnel and Provider Network

LTSS; e. The prohibition on balance billing; and f. Community supports available.		
D: Provider Handbook		
1. The ICDS Plan prepares a clearly written 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. ICDS Plan 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.	Provider handbook that includes each of the listed elements.	
2. The ICDS Plan prepares a pharmacy handbook that includes at least the following elements: a. Updates and revisions; b. ICDS Plan contact information; c. Enrollee information; d. Enrollee benefits; e. Enrollee rights and responsibilities; and f. Provider billing and reporting.	Pharmacy handbook that includes each of the listed elements.	
E: Ongoing Assurance of Network Adequacy Standards		
1. The ICDS Plan ensures that the hours of operation of all of its network providers, including medical, behavioral, LTSS, and pharmacy, are convenient to the population served and do not discriminate against ICDS Plan enrollees (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that plan services are available 24 hours a day, 7 days a week, when medically necessary.	Provider contract templates include provisions requiring non-discrimination against enrollees and convenient hours of operation.	42 CFR §422.112(a)(7) 42 CFR §438.206(c)(1)(ii)
2. The ICDS Plan has a policy and procedure that states that the provider network arranges for necessary specialty care, LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care.	42 CFR §422.112(a)(3) 42 CFR §438.207(b)(1)
3. The ICDS Plan will reimburse an out-of-network provider for emergent or urgent care at the Medicare or Medicaid fee-for-service rate applicable for the service. When the service would traditionally be covered under Medicare, the Medicare fee-for-service rate applies.		MOU, Appendix 7, page 64

Utilization Management		
Readiness Review Criteria	**Example Evidence**	**Reference**
A: The ICDS Plan has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services		
1. The ICDS Plan specifies: a. All self-referral services, including at a minimum, qualified family planning services and women's routine and preventive health care services provided by a woman's health specialist (e.g., obstetrics, gynecology, certified nurse midwife); and b. The circumstances and procedures under which the enrollee may self-refer services.	The UM program description explains for which services an enrollee can self-refer and services for which the enrollee or provider must obtain prior authorization.	
2. The definition of medically necessary services utilized by the ICDS Plan complies with the requirements specified in the CMS-state MOU. These include: a. (per Medicare) 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. (per Ohio Medicaid): Unless a more specific definition regarding medical necessity or coverage requirements for a particular category of service is specified within division-level 5101:3 of the Administrative Code, "medically necessary services" are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must: (1) Meet generally accepted standards of medical practice; (2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; (3) Be appropriate to the intensity of service and level of setting; (4) Provide unique, essential, and appropriate information when used for diagnostic purposes; (5) Be the lowest cost alternative that effectively addresses and treats the medical problem; and (6) Meet general principles regarding reimbursement for Medicaid covered services found in rule 510:3-1-02 of the Administrative Code; and c. Where there is overlap between Medicare and Medicaid benefits, ICDS Plans will be required to abide by the more generous of the applicable Medicare and Ohio Medicaid standards.	The UM program descriptions include these definitions of medical necessity.	MOU, Appendix 7, page 57
3. The ICDS Plan defines the review criteria used, information sources, and process used to review and approve the provision of services and prescription drugs.	The UM program description lists the rationale the ICDS Plan uses to determine which services and prescription drugs it approves (e.g., review criteria used, information	

Utilization Management		
Readiness Review Criteria	**Example Evidence**	**Reference**
	sources, review processes).	
4. The UM program description for the ICDS Plan describes policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description details how the ICDS Plan monitors its under and overutilization of services (e.g., regular data analysis, periodic review meetings).	42 CFR §438.240(b)(3) 42 CFR §423.153(a)(2)
5. The UM program description for the ICDS Plan includes the methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The 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).	42 CFR §422.202(b)(1)
6. The ICDS Plan outlines its process for authorizing out-of-network services; if specialties necessary for enrollees are not available within the network, the ICDS Plan 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 ICDS Plan's network.	42 CFR §438.206(b)(4)
7. The ICDS Plan 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.	42 CFR §438.206(b)(3)
8. The ICDS Plan describes its processes for communicating to all providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required timeframes for prior authorization (e.g. periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The ICDS Plan's provider materials describe prior authorization requirements and procedures.	
B: Utilization Management Guidelines		
1. The ICDS Plan 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 ICDS Plan's enrollees; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and enrollee education and service coverage.	The ICDS Plan's practice guidelines P&P include these requirements.	42 CFR §422.202(b)(1) 42 CFR §422.202(b)(3) 42 CFR §438.236
C: The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.		
1. The ICDS Plan 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 ICDS Plan's UM program describes the type of communications sent to enrollees, regarding their receipt or denial of referrals of service	42 CFR §438.210(c) 42 CFR §438.404(a)

Utilization Management		
Readiness Review Criteria	**Example Evidence**	**Reference**
	authorizations.	
2. For the processing of requests for initial and continuing authorizations of covered services, the ICDS Plan shall: a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consult with the requesting provider when appropriate.	The UM program description explains the process for obtaining initial and continuing authorizations for services. The prescription drug manual explains the process for obtaining approval for prescription drug coverage that is considered urgent.	42 CFR §438.210(b)
3. The ICDS Plan ensures that prior authorization requirements are not applied to the: d. Emergency services, including behavioral health care; e. Urgent care; f. Crisis stabilization, including mental health; g. Family planning services; h. Preventive services; i. Communicable disease services, including STI and HIV testing; j. Out-of-area renal dialysis services; and k. Other services as specified in the CMS-state MOU.	The UM program description lists those services that are not subject to prior authorization and this list is consistent with the required elements.	42 CFR §438.114 42 CFR §422.113(c)
4. The ICDS Plan 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 ICDS Plan follows the contract.[4]	The UM program description includes these requirements.	42 CFR §438.210(d) 42 CFR §422.568 42 CFR §422.570 42 CFR §422.572
5. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment.	The UM program description includes this requirement. Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply ICDS Plan policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.	42 CFR §438.210(b)(3)

[4] This part of this criterion is greyed-out to indicate that assessment has been deferred until CMS and the state have provided ICDS Plans with additional guidance.