**Financial Alignment Capitated Readiness Review**
**Michigan 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 Michigan have developed a state-specific readiness review tool based on stakeholder feedback received through letters and public meetings, the content of the Memorandum of Understanding signed on April 3, 2014 and applicable Medicare and Medicaid regulations. The Michigan readiness review tool is attached.

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

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

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

All readiness reviews will include a desk review, site visit, and a separate network validation review. 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.

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | **Assessment Processes** | |
| | *A. Transition to New ICO and Continuity of Care* | |
| 101 | For Habilitation Supports Waiver Enrollees and Enrollees Receiving Specialty Services and Supports Program through the PIHP, for non-PIHP provided services the ICO allows:<br>a. Allows the Enrollee to maintain his/her current provider at the time of enrollment for 180 days or continue with single case agreements; and<br>b. The ICO must honor existing plans of care, level of services, and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner)<br><br>For all other Enrollees the ICO allows Enrollees to:<br>c. Allows the Enrollee to maintain his/her current provider at the time of enrollment for 90 days or continue with single case agreements; and<br>d. Honors existing plans of care, level of services, and prior authorizations (PAs) until the authorization ends or 180 days from enrollment, whichever is sooner) | Continuity of care plan includes these provisions. |
| 102 | During the transition periods referenced in criterion 101, change from the existing provider can only occur in the following circumstances:<br>a. Enrollee requests a change;<br>b. The provider chooses to discontinue providing services to an enrollee as currently allowed by Medicare or Medicaid; or<br>c. The ICO, CMS, or MDCH identifies provider performance issues that affect an enrollee's health and welfare. | Continuity of care plan includes these provisions. |
| 103 | During the transition period, ICOs will advise Enrollees and providers if and when they have received care that would not otherwise be covered at an in-network level.<br><br>On an ongoing basis, and as appropriate, ICOs must also contact providers currently serving ICO Enrollees, but who are not already members of their network with information on becoming credentialed as in-network providers. | Continuity of care plan includes these provisions, including information on how the ICO will advise Enrollees and providers that the beneficiary received care out of network, and frequency by which ICOs will contact providers not already members of their network with information on becoming credentialed as in-network providers. |
| 104 | The ICO has policies and procedures to:<br>a. Accept and honor established service plans provided on paper or electronically transferred from FFS or prior plans when Enrollees transition with service plans in place;<br>b. Ensure timely transfer of IICSPs to other ICOs or other plans when an ICO Enrollee is disenrolling from the ICO. | Continuity of care plan includes these provisions. |
| 105 | The ICO allows Enrollees who reside in nursing facilities to maintain current nursing facility providers for the duration of the Demonstration. | Continuity of care plan includes these provisions. |

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| 106 | The ICO provides, within the first 90 days of coverage:<br>a. A temporary supply of drugs, consistent with the requirements of Chapter 6 of the Prescription Drug Benefit Manual, when the Participant requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug; and<br>b. A 90-day supply of drugs when an Enrollee requests a refill of a non-Part D drug that is covered by Medicaid. | Transition plan P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on refills of non-formulary drugs that otherwise meet the definition of a Part D drug and non-Part D drugs that are covered by Medicaid. |
| 107 | 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. | 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. |
| 108 | The ICO provides written notice to each Enrollee, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary. | Transition plan P&P defines a time period (within 3 business days) when it must provide Enrollee with notice about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary. |
| | *B. Assessment* | |
| 109 | a. At a minimum, the ICO uses the information received from the initial screening (conducted by Michigan's Enrollment Broker at the time of enrollment), as well as other assessments, referrals and program level data (from the MDCH MMIS system, CHAMPS), and utilization data (from the MDCH Data Warehouse) within 15 calendar days of enrollment to identify and prioritize Enrollees needing a Level I Assessment.<br>b. If initial screening results are not available, the ICO conducts the initial screening via telephone or in person within 15 calendar days of enrollment. The ICO may conduct a Level I Assessment and include the initial screening questions during the same contact. All outreach efforts to complete the initial screening to the Enrollee or service providers are documented by the ICO. | ICO's assessment P&Ps or other documentation must include the criteria and thresholds indicating how to prioritize completion of the Level I Assessment in accordance with criterion requirements. |
| 110 | The ICO Care Coordinator will conduct a Level I Assessment:<br>a) Within 45 calendar days of enrollment. Enrollees identified with immediate needs or as having high risk should have assessments completed in person earlier than 45 days, as appropriate;<br>b) In collaboration with the appropriate PIHP or LTSS Supports Coordinator or nursing facility if the enrollee is active in PIHP or LTSS in the last 12 months;<br>c) In collaboration with family members or other individuals if requested by the enrollee;<br>i. Using an MDCH approved tool | ICO's assessment P&Ps or other documentation must include the criteria and thresholds indicating procedures for completing the Level I Assessment in accordance with criterion requirements. |
| 111 | The ICO's Level One Assessment includes the following domains:<br>i. Individual preferences, strengths, and goals including self-determination arrangements;<br>ii. Natural supports, including family and community caregiver capacity and social strengths and needs;<br>iii. Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and enrollee health literacy;<br>iv. Current services, including those covered by Medicare and Medicaid, local services, and care transition needs;<br>v. Medical health risk, status, and history, including but not limited to medications (prescription, over- | ICO's assessment or assessment P&Ps include the required domains. |

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| | the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections;<br>vi. Behavioral health (BH), Intellectual/Developmental Disability (I/DD) and Substance Use Disorder (SUD) risk status; BH, SUD, and I/DD history and needs, including medications;<br>vii. Nutritional strengths and needs;<br>viii. Activities of daily living and instrumental activities of daily living, including any assistive technology used or needed and immediate environmental or housing needs;<br>ix. Cognitive strengths and needs;<br>x. Long-term services and supports;<br>xi. Quality of life including physical, mental, and psycho-social well-being;<br>xii. Discussion of abuse, neglect, or exploitation; and.<br>xiii. Advance directive (choice to execute, incorporate in the IICSP, and assure provider knowledge of enrollee's directives). | |
| 112 | The ICO will coordinate with the primary care provider to ensure that Enrollees with complex medical needs identified in the Level I Assessment have further follow-up relevant to these needs. | Assessment P&P includes this requirement. |
| 113 | Based on the findings from the Level I Assessment:<br>a) The ICO will collaborate with the regional PIHP to ensure that the Level II Assessment is conducted for Enrollees identified as having BH, SUD or I/DD needs.<br>b) The ICO will ensure that the Level II Assessment is conducted for Enrollees demonstrating LTSS needs.<br>c) The ICO will identify Enrollees with mild to moderate behavioral health needs and determine plan provider based on standardized triggers. | Assessment P&P that explains how the ICO will use Level I Assessment findings. |
| 114 | Level II Assessments:<br>a) Will be conducted in-person within 15 days of completion of the Level I Assessment; and<br>b) Will be conducted by professionally knowledgeable and trained staff—such as LTSS Supports Coordinators or assigned PIHP Supports Coordinators or Case Managers—who have experience working with the population. | Assessment P&P explains how often and when the assessment is provided to new and current Enrollees and who completes it. |
| 115 | The ICO has policies and procedures that address the following for Level I and Level II assessments:<br>a) Meeting the required assessment timeframes;<br>b) Contacting the enrollee within the required assessment timeframes. This may require repeated attempts, including collaborating with service providers, all of which should be documented;<br>c) Making assessment materials available upon request in the enrollee's preferred written or spoken language and/or alternate formats that effectively communicate the information;<br>d) Including appropriate involvement of caregivers, family members, and/or other allies, and obtaining the enrollee's consent when the desire for such involvement is identified;<br>e) Identifying the enrollee's medical care and supportive service needs, including those for primary care, specialty care, durable medical equipment (DME), assistive devices, medications, LTSS, HCBS, BH and I/DD, and SUD, and other necessities and preferences that will inform the development of an Individual Integrated Care and Supports Plan (IICSP);<br>f) Identifying and assessing the need for other activities, services, and supports to assist Enrollees in optimizing their health status, including assisting with self-management skills or techniques, health | Assessment P&P that demonstrate that the ICO will meet these requirements. |

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| | education, and other modalities to improve the quality of life and the ability to live in the community.<br>g) Utilizing the Care Coordination platform to incorporate assessment results into the Integrated Care Bridge Record (ICBR) within five days of completion.<br>h) Collaborating with PIHPs, the LTSS representative, and the nursing facility representative, as applicable, in conducting the Level I Assessment. | |
| 116 | The ICO performs reassessments including analysis of medical, LTSS, BH, SUD, and I/DD utilization data and, if needed, updates the enrollee's Individual Integrated Care and Supports Plan IICSP:<br>a) Within 12 months of the last assessment;<br>b) If the enrollee experiences a major change impacting health status;<br>c) As often as desired by the enrollee. | Assessment P&P explains how often and when re-assessments are provided Enrollees. |
| 117 | For Enrollees receiving Nursing Facility Level of Care services, the reassessment must confirm that the enrollee continues to meet the Michigan Medicaid Nursing Facility Level of Care standards. If the standards are not met, the ICO will initiate planning for transitioning the enrollee to more appropriate services and supports. | Assessment P & P that demonstrates these requirements. |
| 118 | The ICO has policies and procedures in place for staff to document when the enrollee refuses to participate in the assessment process. | Assessment P&P that includes these provisions. |
| | **Care Coordination** | |
| | *A:Care Management and Integrated Care Team (ICT)* | |
| 201 | An Integrated Care Team (ICT) will be offered to the enrollee. | ICT P&P that demonstrates this requirement. |
| 202 | The ICO Care Coordinator:<br>a) Will be responsible to:<br>i. Support an on-going person-centered planning process;<br>ii. Conduct Level I Assessment and assess clinical risk and needs;<br>iii. Facilitate timely access to primary care, specialty care, BH, SUD, and I/DD services, medications, and other health services needed by the enrollee, including referrals to address any physical or cognitive barriers;<br>iv. Create and maintain an Integrated Care Bridge Record (ICBR) for each enrollee to manage communication and information regarding referrals, transitions, and care delivery;<br>v. Facilitate communication among the enrollee's providers through the use of the Care Coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;<br>vi. Notify ICT of the enrollee's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;<br>vii. Facilitate face-to-face meetings, conference calls, and other activities of the ICT;<br>viii. Facilitate direct communication between the provider and the enrollee;<br>ix. Facilitate enrollee and family education;<br>x. Coordinate and communicate with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative services and supports are provided;<br>xi. Develop, with enrollee and ICT, an IICSP specific to individual needs, and monitor and update the plan at least annually or following a significant change in needs or other factors;<br>xii. Coordinate and make referrals to community resources (e.g., housing, home delivered meals, energy | Care coordination P&P defines the Care Coordinator's responsibilities. |

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| | assistance programs) to meet IICSP goals;<br>xiii. Monitor the implementation of the IICSP with the enrollee, including facilitating the enrollee's evaluation of the process, progress and outcomes, and identifying barriers and facilitating problem resolution and follow-up;<br>xiv. Advocate with or on behalf of the enrollee as needed, to ensure successful implementation of the IICSP;<br>xv. Support transitions in care when the enrollee moves between care settings;<br>xvi. Engage in other activities or services needed to assist the enrollee in optimizing his or her health status, including assisting with self-management skills or techniques; face-to-face annual medication review and enrollee education; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status;<br>xvii. Assure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits;<br>xviii. If the enrollee is receiving services that require meeting the Nursing Facility Level of Care Determination (NFLOCD) standards, assure that the enrollee continues to meet the criteria or transitions to services that do not require NFLOCD standards. ICOs are required to conduct the NFLOCD assessment for Enrollees with identified long-term care needs;<br>xix. Regularly monitor the Integrated Care Bridge Record, utilization data from the MDCH Data Warehouse, and other appropriate information that may reflect the Enrollees' health status; and<br>**xx.** Identify changes in conditions or utilization of services for all Enrollees, including, but not limited to newly-diagnosed acute and chronic conditions, high frequency of emergency department visits, hospitalizations, and LTSS or BH, SUD, and I/DD referrals. | |
| 203 | The ICO will ascertain and adhere to:<br>a. The enrollee's choice with respect the his or her level of participation in the ICT, as well as<br>b. The enrollee's determinations with respect to the involvement of his or her medical providers and caregivers, in accordance with HIPAA, and, for substance use disorder treatment, CFR 42, Part 2. | Care coordination P&P defines the role and responsibilities of the ICT and either this P&P or other P&Ps include the ICT's specified functions. |
| 204 | The ICO Care Coordinator is responsible for assuring ICT activities are conducted. | ICT P&P that demonstrates this requirement. |
| 205 | The ICO ensures that the composition of the ICT will include:<br>a) The enrollee and the enrollee's chosen allies;<br>b) The ICO Care Coordinator;<br>c) The primary care physician or nurse practitioner;<br>d) LTSS Supports Coordinator, as applicable;<br>e) PIHP Supports Coordinator, as applicable; and<br>f) Other persons as needed and available (e.g., family caregivers and natural supports, primary care nurse care manager, specialty providers; paid supports; hospital discharge planner, nursing facility representative). | ICT P&P that demonstrates that the ICO will ensure this ICT composition. |
| 206 | ICT members will:<br>a) Participate in the person-centered planning process at the enrollee's discretion;<br>b) Collaborate with ICT members to ensure the person-centered planning process is maintained;<br>c) Assist the enrollee in meeting his/her goals; | Care coordination P&P defines the role and responsibilities of the ICT and either this P&P or other P&Ps include the ICT's specified functions. |

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| | d) Ensure the team member's part of the IISCP is implemented and monitored in order to meet the enrollee's goals;<br>e) Update the ICBR as needed pertinent to the team member's role on the ICT;<br>f) Review assessment, test results and other pertinent information in the ICBR;<br>g) Address transitions of care when a change between care settings occur;<br>h) Ensure continuity of care; and<br>i) Monitor for issues related to quality of care and quality of life. | |
| 207 | The LTSS Supports Coordinator:<br>a) Will be offered to all Enrollees who have a need for LTSS; and<br>b) Must be a Michigan licensed registered nurse or social worker employed by or contracted with the ICO and have experience with the population. | Care coordination P&P defines the role and responsibilities of the LTSS Supports Coordinator and either this P&P or other P&Ps include the LTSS Supports Coordinator's specified functions. |
| 208 | The ICO will provide, directly or contractually, the following LTSS Supports Coordination services:<br>a) Support an on-going person-centered planning process;<br>b) Assist the enrollee to take a lead role in the process and provide information to the enrollee and ICT;<br>c) Contact and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment;<br>d) Participate in the assessment process as needed, including conducting the Level II Assessment specific to the enrollee's needs;<br>e) Participate on the enrollee's ICT;<br>f) Develop, with the enrollee and the ICT, an IICSP;<br>g) Ensure optimal utilization of information and community supports;<br>h) Arrange services as identified in the IICSP;<br>i) Update the ICBR with current enrollee status information to manage communication and information flow regarding referrals, transitions, and care delivery;<br>j) Monitor service implementation, service outcomes, and the enrollee's satisfaction;<br>k) Collaborate with the ICO Care Coordinator to assist the enrollee during transitions between care settings, including full consideration of all options; and<br>l) Advocate for the enrollee and support self-advocacy by the enrollee. | Care coordination P&P defines the role and responsibilities of the LTSS Supports Coordinator and either this P&P or other P&Ps include the LTSS Supports Coordinator's specified functions. |
| 209 | The ICO contracts with Prepaid Inpatient Health Plans (PIHP) to jointly coordinate and manage care for Enrollees with behavioral health, substance use disorder and/or intellectual/developmental disabilities (BH, SUD, and/or I/DD). | Care Planning P&P demonstrates that the ICO will meet this requirement. |
| | *B. Individual Integrated Care and Supports Plan (IICSP)* | |
| 210 | In consultation with the enrollee and the ICT, the ICO Care Coordinator will develop an Individual Integrated Care and Supports Plan (IICSP) that will focus on supporting the enrollee to achieve personally defined goals in the most integrated setting. | Assessment P&P includes these requirements. |
| 211 | The IICSP will be developed through the person-centered planning process and will include the following essential elements:<br>a) The enrollee's preferences for care, services, and supports;<br>b) The enrollee's prioritized list of concerns, goals and objectives, and strengths; | Care Planning P&P states that ICO assures that these elements are incorporated into the IICSP. |

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| | c) specific providers, services and supports (including community or informal supports needed and desired by the enrollee) including amount, scope, and duration;<br>d) Results of the Initial Screening, Level I Assessment, and Level II Assessment (if performed);<br>e) Summary of the enrollee's health status;<br>f) The plan for addressing concerns or goals and measures for achieving the goals;<br>g) The person(s) responsible for specific interventions, monitoring, and reassessment;<br>h) The due date for the interventions and reassessment;<br>i) Performed in a culturally competent manner; and<br>j) Conducted in (or interpreted into) the enrollee's first language. | |
| 212 | The IICSP will be completed for all Enrollees within 90 calendar days of enrollment. | Care planning P&P includes these timeframes and describes the process for meeting the timeframes. |
| 213 | ICO's policies and procedures outline how it will:<br>a) Develop the IICSP for each enrollee within 90 days of enrollment;<br>b) Define the process for addressing the goals, services, and preferences identified by the enrollee in the IICSP;<br>c) Utilize the ICT to develop a comprehensive plan reflecting the preferences of the individual across domains including physical, long term, and BH;<br>d) Ensure the enrollee and his or her designee(s) and the ICT are working within the same IICSP and share responsibility for their contributions to the IICSP and supporting the enrollee in achieving his or her goals;<br>e) Incorporate the IICSP into the Integrated Care Bridge Record within 90 days of enrollment;<br>f) Make the IICSP available upon request to the enrollee in alternative formats and/or preferred written or spoken language; and<br>g) Ensure that the IICSP reflects assessment results, clinical data, BH, SUD, and I/DD utilization, and other pertinent information, as well as self and provider referrals. | Care planning P&P includes these timeframes and describes the process for meeting the timeframes, as well as the other criterion requirements. |
| 214 | The ICO's policies and procedures demonstrate that it has in place:<br>a) A process for person-centered planning that identifies and honors the enrollee's preferences and choices regarding services and settings that is consistent with the MDCH definition;<br>b) A process for ensuring the provision of person-centered planning and treatment approaches are collaborative and responsive to the enrollee's changing and continuing needs;<br>c) A process for ensuring the participation of the enrollee and any family, friends, and professionals of his or her choosing, in discussions and decisions regarding treatments and services; and<br>d) A process for ensuring that the Enrollee receives all necessary information regarding treatment and service options to make informed choices. | Care planning P&P outlines a process that describes how the ICO will involve the enrollee in developing the plan of care and will use the information gathered from the assessment(s) of the enrollee in developing the plan of care.<br><br>Care planning P&P states that the ICO intends to provide person-centered care to all Enrollees, and describes strategies for assuring this. |
| 215 | The ICO assures that it will:<br>a) Participate in train-the-trainer person-centered planning educational opportunities offered by MDCH;<br>b) Be responsible for training ICO staff and network providers; and<br>c) Report participation in the MDCH and ICO trainings as required. | Care planning P&P demonstrates that the ICO will meet these requirements. |

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| 216 | The ICO's policies and procedures specify mechanisms for Enrollees to access arrangements that support Self-Determination consistent with MDCH requirements and guidance. These policies and procedures will include provisions to:<br>a) Inform the enrollee of his or her right to use arrangements that support Self-Determination and document the enrollee's decisions regarding these arrangements;<br>b) Reflect current statutory, policy and regulatory requirements related to arrangements that support Self-Determination, including the authority to control an individual budget (with the assistance of a fiscal intermediary) and the right to employ (hire, manage, and when necessary fire) workers and/or contract with providers; and<br>c) Make personnel available to help inform, navigate, connect, and refer the Enrollees who are using arrangements that support Self-Determination. | Care planning P&P demonstrates that the ICO will meet these requirements. |
| | *C. Transitions Between Care Settings* | |
| 217 | The ICO's policies and procedures facilitate timely and smooth transitions between care settings and between different providers of the same service. These will include provisions to:<br>a) Inform the enrollee of his or her right to live in the most integrated setting;<br>b) Inform the enrollee of the availability of services necessary to support his or her choices;<br>c) Record the home and community-based options and settings considered by the enrollee; and<br>d) Ensure immediate and continuous discharge planning including, electronic and verbal communication with the enrollee and ICT members following an enrollee's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, services and supports are in place in the community for the enrollee when discharged. This includes scheduling an outpatient appointment, ensuring the enrollee has all necessary medical equipment and supplies, medications or prescriptions upon discharge, and conducting follow-up with the enrollee and/or caregiver. | Care planning P&P demonstrates that the ICO will meet these requirements. |
| | *D. Coordination of Services* | |
| 218 | 1. The ICO has a process to monitor and audit care coordination that includes, at a minimum:<br>a. Documenting evaluations and reports for the care coordination program; and<br>b. Communicating these results and subsequent improvements to ICO advisory councils and/or stakeholders. | Care coordination P&P explains how and when the ICO will evaluate the processes within the care coordination program.<br><br>Care coordination P&P explains how the results of the evaluation will be communicated to ICO advisory councils and/or stakeholders. |
| 219 | The ICO facilitates timely and thorough coordination among the ICO, the primary care provider, and other providers as necessary and appropriate. | Care coordination P&P explains how the ICO facilitates coordination with the necessary providers. . |
| | **Confidentiality** | |
| 301 | The ICO 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 or privacy P&P explains how the ICO will safeguard PHI. |

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| 302 | The ICO provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI. | Sample privacy notice to be sent to providers or privacy P&P explains how the ICO will safeguard PHI and the provider's role in safeguarding PHI. |
| 303 | ICO ensures privacy and security of Enrollee health records and provides for access by Enrollees to such records. | Privacy P&P. |
| 304 | The ICO ensures a written consent is obtained from the Enrollee or Enrollee's responsible party to share PHI consistent with HIPAA requirements. | Sample consent form and P & P for obtaining authorization. |
| | **Enrollee and Provider Communications** | |
| | *A. Enrollee and Provider Communications* | |
| 401 | The ICO maintains and operates a toll-free Enrollee services telephone line call center 8:00 A.M. to 8:00 P.M. Eastern Time, seven days per week. ICO sponsors are permitted to use alternative technologies, which include interactive voice response system or similar technologies, to meet the customer service call center requirements for Saturdays, Sundays, and holidays. Live customer service representatives must be available to answer the phones Monday through Friday from 8:00 A.M. to 8:00 P.M. Eastern Time, excluding holidays. The ICO must have an Enrollee Services line with an automated menu to route the person to the appropriate point of contact. | Enrollee services telephone line P&P confirms that the hotline is toll-free, is available during required times, and have the ability to route persons appropriately. |
| 402 | The ICO or its PBM operates a toll-free call center for coverage determinations (including exceptions and prior authorizations), grievances, and appeals that:<br>a. Is staffed with live customer service representatives available to respond to providers or Enrollees;<br>b. Operates during normal business hours and, at a minimum, from 8:00 A.M. to 6:00 P.M., Monday through Friday, according to the time zones for the regions in which they operate. .<br>This may be a part of the Enrollee Service line, so long as the enrollee service line has an automated menu to route the person to the appropriate point of contact, and the hours are consistent with the customer service call center (i.e., from 8:00 A.M. to 8:00 P.M. Eastern Time) | Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times. |
| 403 | The ICO's customer service department representatives shall, upon request, make available to Enrollees and potential Enrollees information including, but not limited to, the following:<br>a. The identity, locations, qualifications, and availability of providers;<br>b. Enrollees' rights and responsibilities;<br>c. The procedures available to a Enrollee and/ or provider(s) to challenge or appeal the failure of the ICO to provide a covered service and to appeal any adverse actions (denials);<br>d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats;<br>e. How to access the MI Health Link Ombudsman,the Michigan ENROLLS Call Center and 1-800-Medicare;<br>f. Information on all ICO covered services and other available services or resources either offered directly through the ICO or through referral or authorization;<br>g. The procedures for an Enrollee to change ICOs or opt out of the Demonstration and information on how Enrollees can access the Enrollment Broker to effectuate such a change; and<br>h. How to contact the PIHP enrollee Services for behavioral health inquiries/Crisis Line. | Enrollee services telephone line P&P confirms that all of the listed information will be available to customer service department representatives. |

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| 404 | The ICO operates a toll free call in system with appropriately trained and qualified health professionals available to answer care coordination questions 24 hours a day, 7 days a week.<br>a. Call in system staff must, in accordance with HIPAA laws, be able to assess the enrollee's issues and provide an appropriate course of action; and<br>b. If care management needs are identified for an enrollee, the ICO staff person facilitating the enrollee's issue has access to, and is familiar with, the enrollee's plan of care; and<br>c. The ICO must also ensure timely and appropriate follow up from call in system calls to assure the enrollee's health and welfare. | Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times. |
| 405 | The ICO maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency Enrollees. In addition:<br>a. 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; and<br>b. The language line is TDD/TTY accessible. | Contract with language line company or draft contract for language line or existing MLTC language line contract includes these requirements, including mandatory hours of operation. |
| 406 | The ICO ensures that it and its providers are able to communicate with their Enrollees in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for those with cognitive limitations, and interpreters for those who do not speak English. | ICT P&P describes how the ICO will ensure that ICT members and other providers communicate with Enrollees in a manner that accommodates individual needs. |
| 407 | The ICO ensures that the PIHPs maintain and operate a toll free call center and the ICOs have the appropriate scripting to refer enrollees to the PIHP call center when necessary. | |
| | *B: Stakeholder Feedback/ Advisory Council* | |
| 408 | The ICO has policies governing the establishment of at least one advisory council that includes a mix of Enrollees, caregivers, and local representation from key community stakeholders such as advocacy organizations, faith-based organizations, and other community-based organizations, with one third of the advisory council composed of Enrollees. The composition must reflect the diversity of the Demonstration. | The ICO has policies or a charter for its consumer advisory council that meets these requirement |
| 409 | The ICO's Advisory Council policies include a process for that council to provide input to the governing board of the health maintenance organization (HMO). | The ICO has policies or a charter for its consumer advisory council that meets these requirement |
| | *C: Pharmacy Technical Support* | |
| 410 | The ICO or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume resulting from Demonstration enrollments. | The 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. |
| 411 | The ICO ensures that pharmacy technical help desk is available at any time that any of the network's pharmacies are open. | Hours of operation for technical support cover all hours for which any network pharmacy is open. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | **Enrollee Protections** | |
| | *A. Enrollee Rights* | |
| 501 | 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. |
| 502 | The ICO policies articulate that it will notify Enrollees of their rights and protections (including appeal and grievance rights) 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.<br><br>Enrollee rights P&P details how notifications will be adapted based on the Enrollee's condition and ability. |
| 503 | The ICO does not discriminate against Enrollees due to:<br>a. Medical condition (including physical and mental illness);<br>b. Claims experience;<br>c. Receipt of health care;<br>d. Medical history;<br>e. Genetic information;<br>f. Evidence of insurability; or<br>g. Disability.<br>h. Age<br>i. Sexual Orientation<br>j. Religion | Enrollee rights P&P addresses that the ICO will not discriminate and will prohibit its providers from discriminating against Enrollees based on the enumerated reasons.<br><br>Staff training includes discussion of Enrollee rights. |
| 504 | The ICO informs Enrollees that they will not be balanced billed by a provider for the cost of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. This is articulated through policies and procedures and staff and provider training modules. | Enrollee rights P&P explains that the ICO informs Enrollees that they should not be balanced billed for any covered service, any coinsurance, deductibles, financial penalties, or any other amount in full or in part.<br><br>Training materials for providers and staff cover this rule. |
| 505 | The ICO has policies and procedures to ensure that it provides reasonable accommodations. The policies and procedures ensure that the ICO informs Enrollees, in general, of their right to reasonable accommodations and specifies how to obtain reasonable accommodations from the ICO and providers, including the process, who decides whether the accommodations will be provided, and the process for appealing any decisions. | Enrollee rights P&P states that the ICO informs Enrollees of their right to reasonable accommodation and specifies how to obtain reasonable accommodations from the ICO and providers, including the process, who |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | decides, and how to appeal any decisions.<br><br>Enrollee rights P&P ensures that the ICO and its providers are required to provide reasonable accommodations. |
| | *B: Appeals and Grievances* | |
| 506 | The ICO staff receive training on Enrollee protections, including but not limited to:<br>a. The ICO's organization and coverage determination processes; and<br>b. Appeals and grievance processes. | Training materials contain information about the ICO's organization and coverage determination processes and the appeals and grievance processes. |
| 507 | The ICO provides Enrollees with reasonable assistance in filing an appeal or grievance. Any assistance must include information and reminders about the availability of the Enrollee Ombudsman. | Grievances and appeals P&P explains the extent to which the ICO will assist an Enrollee in filing an appeal or grievance and extent to which may and must refer to the Enrollee Ombudsman. |
| 508 | The ICO maintains an established process to track and maintain records on all grievances, received both orally and in writing, including, at a minimum:<br>a. The date of receipt;<br>b. Final disposition of the grievance; and<br>c. The date that the ICO notified the Enrollee of the disposition. | Screenshots of or reports from the tracking system in which Enrollee grievances are kept include these elements.<br><br>Data summaries or reports detail the types of reporting and remediation steps that are taken to ensure grievances are correctly handled.<br><br>Grievances P&P define how staff from the ICO should document grievances within the tracking system. |
| 509 | The ICO's policies and procedures for Enrollee grievances include the following:<br>a. Enrollees are entitled to file grievances directly with the ICO.<br>b. The ICO has processes to ensure that such requests are processed through the appropriate avenues in a timely manner applicable to Medicare and Medicaid rules;<br>c. The ICO tracks and resolves all grievances or reroutes grievances to the coverage decision or appeals process as appropriate;<br>d. The ICO has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals, and has processes to ensure that such requests are processed or rerouted to the appropriate avenues in a timely manner for processing; and<br>e. The ICO will have a process to collect and track grievance data from the PIHP to include in the ICO reporting requirements. | Grievances P&P includes these specifications |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| 510 | The ICO notifies Enrollees of all Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question. | Appeals P&P includes these specifications and how the ICO will monitor compliance with them. |
| 511 | The ICO maintains policies and procedures for Enrollee appeals, in accordance with the requirements specified in the CMS-State MOU. These policies and procedures include the following:<br>a) Enrollees are entitled to file appeals directly with the ICO within 45 days from the date of the action. If the action taken involves a Medicaid service or benefit, Enrollees also have the right to file an appeal through the Medicaid Fair Hearings process. The Medicaid Fair hearing must be requested within 90 days from the date of action. The request for a Medicaid Fair Hearing can be concurrent to filing an internal appeal directly to the ICO.<br>b) The ICO resolves internal appeals:<br>a. For standard appeals, within 30 days of filing; and<br>b. For expedited appeals, within 72 hours of filing or as expeditiously as the Enrollee's condition requires.<br>c) For all non-Part D benefits that the ICO terminates or modifies, the ICO provides continuing Medicare and Medicaid benefits pending an internal ICO appeal or Medicaid Fair Hearing if the request for appeal is received within 12 days of the notice's postmark date or by the intended effective date, whichever is later. This means that such benefits will continue to be provided by providers to Enrollees, and that the ICO continues to pay providers for providing such services pending the outcome of the appeal.<br>d) The ICO will have a process to collect and track hearings data from the PIHP to include in the ICO reporting requirements. | Appeals P&P includes these specifications |
| 512 | The ICO has a process to auto forward adverse decisions related to Medicare services to Independent Review Entity (IRE). | Appeals P&P includes these specifications. |
| | *C: Enrollee Choice of PCP* | |
| 513 | The ICO allows Enrollee to select his or her PCP and the Enrollee's right to select a specialist to act as a PCP. | PCP selection and assignment P&P specifies how an Enrollee can choose and change his/her PCP and how an Enrollee can select a specialist as a PCP. |
| | *D: Emergency Services* | |
| 514 | The ICO has a back-up plan in place in case a community-based or facility-based 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 community-based and facility-based LTSS Enrollees when a community-based or facility-based LTSS provider does not arrive to provide care. |
| 515 | The ICO can connect Enrollees with the appropriate resources or services if an Enrollee calls during a mental health crisis. | Emergency services P&P addresses how the ICO is prepared to provide emergency behavioral health services to Enrollees in crisis. |

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| 516 | The ICO ensures access to emergency care and urgently needed care in accordance with State and Federal requirements. | Emergency services P&P |
| | **Organizational Structure and Staffing** | |
| | *A. Organizational Structure and Staffing* | |
| 601 | The ICO's Quality Improvement (QI) committee includes physicians, psychologists, providers with expertise in community-based and facility-based LTSS, pharmacists, and others, who represent a range of health care services used by Enrollees in the target population. | QI committee members are appropriate based on the target population described in the CMS-state MOU. Note: For ICOs with current QI committees, review will focus on the change in composition to address the new services (e.g., community-based and facility-based LTSS and behavioral health). |
| 602 | The ICO has an individual or committee responsible for provider credentialing who is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical and community-based and facility-based LTSS). | A provider credentialing point of contact or committee is reflected in organizational chart.<br><br>The provider credentialing point of contact is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, community-based and facility-based LTSS, behavioral health, and pharmacy). |
| | *B: Sufficient Staff* | |
| 603 | The ICO demonstrates that it has a rational for sufficient internal and/or contracted staff to complete all levels of Enrollee assessments as required by the MOU, in a timely manner (as defined in the MOU and Readiness Review Criteria for Assessment) for all Enrollees through its staffing plan and explains:<br>a. The ICO's estimate of its enrollment over the enrollment period;<br>b. Which staff position(s) will complete the function;<br>c. How many employees in those staff position(s) the ICO believes will be needed to perform the function:<br>d. How the ICO derived that estimate; and<br>e. In what timeframe the ICO will staff to the level indicated. | The rationale should include any staffing ratios or timeframes for completing assessments. |
| 604 | Care Coordinators who are employed by the ICO staff, contractors, or providers and perform Enrollee comprehensive assessments have the appropriate education and experience for the subpopulations (e.g., experience in community-based and facility-based LTSS, behavioral health). | Job descriptions include relevant educational and experience requirements.<br><br>Resumes for selected staff indicate staff |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | meets job description. |
| 605 | The ICO ensures that the Care Coordinator's caseload is reasonable to provide appropriate care coordination and care management. CMS and the State are not prescribing a specific caseload. Rather, the ICO shall describe its recommended caseload for Care Coordinators and explain why it believes that recommended caseload (i.e., ratio of Care Coordinators to Enrollees) is reasonable to ensure appropriate care coordination and care management. | Care Coordinator qualifications P&P includes those listed.<br><br>The ICO demonstrates reasonable ratios of Care Coordinators to Enrollees to ensure appropriate care coordination and care management. Care Coordinator qualifications P&P describes the number of Enrollees assigned to Care Coordinators (i.e., caseload ratios), including how these caseloads vary by Enrollee risk level |
| 606 | Care Coordinators must be a Michigan licensed registered nurse, nurse practitioner, physician's assistant, or social worker employed or contracted with the ICO. | Job descriptions include relevant educational and experience requirements. |
| 607 | LTSS Supports Coordinators must be a Michigan licensed registered nurse or social worker employed by or contracted with the ICO and have experience with the population. | Job descriptions include relevant educational and experience requirements. |
| 608 | The ICO demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight in a timely manner for all Enrollees through its staffing plan, and explains:<br>a. The ICO's estimate of its enrollment over the enrollment period;<br>b. Which staff position(s) will complete the function;<br>c. How many employees in those staff position(s) the ICO believes will be needed to perform the function:<br>d. How the ICO derived that estimate; and<br>e. In what timeframe the ICO will staff to the level indicated. | The ICO staffing plan demonstrates that it meets the requirements of the criterion and its estimation is reasonable. |
| 609 | The ICO demonstrates that it has a rationale for sufficient internal and/or contracted staff to handle organization and coverage determinations and appeals and grievances, in a timely manner for all Enrollees through its staffing plan, and explains:<br>a. Which staff position(s) will complete the function;<br>b. How many employees in those staff position(s) the ICO believes will be needed to perform the function:<br>c. How the ICO derived that estimate; and<br>d. In what timeframe the ICO will staff to the level indicated. | The ICO staffing plan demonstrates that it meets the requirements of the criterion and its estimation is reasonable. |
| 610 | The ICO demonstrates that it has a rationale for sufficient internal and/or contract staffing to to handle its call center operations, including 1) the general Enrollee services telephone line; 2) the coverage determinations, grievances, and appeals telephone line; 3) the call in system (which must be staffed to respond to Enrollee calls 24 hours a day, seven days a week); and 4) the pharmacy technical help desk, in a timely manner for all Enrollees and explains:<br>a. Which staff position(s) will complete the function;<br>b. How many employees in those staff position(s) the ICO believes will be needed to perform the function: | The ICO staffing plan demonstrates that it meets the requirements of the criterion, its estimation is reasonable and includes how the ICO will ensure ongoing compliance with the staffing plan. The rationale should include any staffing ratios for call center staff. |

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| | c. How the ICO derived that estimate; and<br>d. In what timeframe the ICO will staff to the level indicated. | |
| 611 | The ICO 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.<br><br>Job description for the medical director includes this responsibility. |
| | *C: Staff Training* | |
| 612 | The ICO has a cultural competency and disability training plan that:<br>a. Ensures that all ICO employees and members of the ICT who are not employees deliver culturally-competent services in both oral and written communications with Enrollees;<br>b. Incorporates input from representatives of or advocates for affected populations in the development of training materials; and<br>c. Includes training on:<br>i. Accessibility and accommodations;,<br>ii. Independent living and recovery models:<br>iii. Cultural competency;<br>iv. Wellness philosophies; and<br>v. Olmstead requirements. | The ICO's cultural competency and disability training plan (or training P&P) identifies which staff receive this training and how often, and includes a schedule of training activities for new staff. P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training.<br><br>The ICO's training materials include training on cultural competency and disability. |
| 613 | The ICO staff who have contact with Enrollees is adequately trained to handle critical incident and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect, and exploitation of Enrollees by service providers and/or natural supports providers. | The ICO's P&P and/or training materials include training on critical incident and abuse reporting and include these topics. |
| 614 | The training program for Care Coordinators includes, but is not limited to information detailing:<br>a. Roles and responsibilities;<br>b. Timeframes for all initial contact and continued outreach;<br>c. Needs assessment and care planning;<br>d. Service monitoring;<br>e. Community-based and facility-based LTSS;<br>f. Self-direction of services;<br>g. Person-centered planning;<br>h. Behavioral health and coordinating with PIHPs for behavioral health services (Services including Substance Use, Intellectual Disability, and Development Disability services, as well as those behavioral | The ICO's P&P and/or training materials for Care Coordinators include modules or sections on each of these elements. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | health service traditionally covered by Medicare);<br>i. Medical equipment and supplies;<br>j. Care transitions;<br>k. Skilled nursing needs;<br>l. Abuse and neglect reporting;<br>m. Pharmacy and Part D services;<br>n. Community resources;<br>o. Enrollee rights and responsibilities;<br>p. Independent living philosophy;<br>q. Most integrated/least restrictive setting;<br>r. Dementia and caregiver issues<br>s. How to identify behavioral health and community-based and facility-based LTSS needs; and<br>t. How to obtain services to meet community-based and facility-based LTSS needs;<br>u. How to explain Enrollees' rights to reasonable accommodations and how to assist Enrollees in obtaining reasonable accommodations and handle inquires related to grievances and appeals. | |
| 615 | The ICO's staff is trained on confidentiality guidelines and has received training to meet HIPAA compliance obligations. | The ICO's P&P and/or training materials include training on HIPAA compliance and confidentiality guidelines. |
| 616 | The ICO has scripts for its Enrollee services telephone line call center customer service staff including, but not limited to:<br>a. Request for pre-enrollment information;<br>b. Benefit information;<br>c. Information about the right to reasonable accommodations, how to obtain them, and how to appeal a decision;<br>d. Cost-sharing information;<br>e. Continuity of care requirements;<br>f. Enrollment/disenrollment;<br>g. Formulary information;<br>h. Pharmacy information, including whether an Enrollee's pharmacy is in the ICO's network;<br>i. Provider information, including whether an Enrollee's physician is in the ICO's network;<br>j. Out-of-network coverage;<br>k. Claims submission, processing, and payment;<br>l. Formulary transition process;<br>m. Coverage determination, grievance, and appeals process (including how to address Medicaid drug and Medicare Part D appeals and PIHP grievances and appeals);<br>n. Information on how to contact the ombudsman program;<br>o. Information on how to obtain needed forms;<br>p. Information on replacing an identification card; and<br>q. Service area information. | Copies of Enrollee services telephone line call center customer service staff scripts contain content related to the competencies listed in the criteria. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| 617 | The ICO's training protocols for Enrollee services telephone line staff include following areas:<br>a. Explaining the operation of the ICO and the roles of participating providers;<br>b. Assisting Enrollees in the selection of a primary care provider;<br>c. Assisting Enrollees to obtain services and make appointments; and<br>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 personnel on these topics and specifications on how the ICO will monitor that trainings have been completed. Training P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training.<br><br>Step-by-step procedures or a flow chart showing how staff from the ICO would walk through assisting Enrollees in explaining or selecting services. |
| | **Performance and Quality Improvement** | |
| | *Performance and Quality Improvement* | |
| 701 | The ICO collects and tracks critical incidents and reports of abuse for all Enrollees. The ICO also documents and tracks that Enrollees are advised of their ADA-related rights, to what extent reasonable accommodations are provided, and grievances and appeals related to those rights. | QI program description explains how the ICO tracks incidents and cases of abuse for all Enrollees.<br><br>Sample annual performance report includes the ICO's method of tracking and reporting cases of incidents and abuse.<br><br>The contract between the ICO and PIHP will contain requirements for the PIHP to report critical incidents and abuse to the ICO. |
| 702 | The ICO must report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. The ICO has policies and procedures, a staffing plan, and a staff supervision structure to ensure that it collects and reports all quality measures and fulfills all other reporting requirements. | QI program description includes all these elements. The ICO has policies and procedures, a staffing plan, and a staff supervision structure to ensure that it collects and reports all quality measures and fulfills all other reporting requirements |
| 703 | The ICO must collect, track and report information related to performance measures for the MI Health Link c-waiver | QI program description explains how the ICO collects, tracks and reports data consistent with the approved c-waiver. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | **Provider Credentialing** | |
| 801 | The ICO shall:<br>a. Adhere to managed care standards at 42 CFR §438.214 and 42 CFR §422.204;<br>b. 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;<br>c. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted as appropriate to all providers, following recognized managed care industry standards and relevant State regulations; and<br>d. Maintain a documented re-credentialing process that occurs 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 and any other State requirements; and<br>e. Ensure PIHPs validate proper credentialing of BH, SUD, and I/DD providers. | Provider credentialing P&P includes these requirements. |
| 802 | Prior to contracting with a new provider, the ICO verifies the following:<br>a. A valid license to practice medicine, when applicable;<br>b. A valid Drug Enforcement Act (DEA) certificate, when applicable, by specialty;<br>c. Other education or training, as applicable, by specialty;<br>d. Malpractice insurance coverage, when applicable;<br>e. Work history;<br>f. History of medical license loss;<br>g. History of felony convictions;<br>h. History of limitations of privileges or disciplinary actions;<br>i. Medicare or Medicaid sanctions; and<br>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 and on an ongoing basis to ensure continuous compliance. It specifies what copies the ICO will maintain of which documents.<br><br>Sample initial completed credentialing application instructions. |
| 803 | The ICO requires all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification. | The ICO submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver. |
| 804 | The ICO requires providers to use evidence-based practices. In doing so, the ICO will:<br>a. Develop and employ mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery;<br>b. Have to demonstrate how they will ensure that their providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options;<br>c. Have to identify how they will employ systems to identify and track patients in ways that provide patient-specific and population based support, reminders, data and analysis, and provider feedback; | Provider participation requirement P&P specifies requirements to use best-evidence practices.<br><br>Provider participation requirement P&P specifies how the ICO will educate and support providers in using best-evidence practices and how the ICO will monitor and |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | d. Be required to demonstrate how they will educate their providers and clinical staff about evidence-based best practices and how they will support their providers and clinical staff (through training or consultations) in following evidence-based practices; and<br>e. Be required to demonstrate how they will hold their providers to evidence-based practices specific to their practice areas. | enforce the use of best-evidence practices. |
| | **Provider Network** | |
| | *A: Establishment and Maintenance of Network, including Capacity and Services Offered* | |
| 901 | The ICO outlines a plan to meet the Medicare and Medicaid provider network standards including those specified in the MOU, which takes into account:<br>a. How the ICOs will ensure it meets following standards for its LTSS network:<br>i. at least two available providers with sufficient capacity to accept Enrollees; and<br>ii. allow enrollee choice of providers, including those providing supports coordination (if the ICO cannot assure choice within 30 miles for each enrollee, it may request a rural exception from MDCH).<br>b. The anticipated enrollment;<br>c. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations;<br>d. The numbers and types (e.g., training, experience, specialization ,age, and criminal background check) of providers required to furnish the contracted services, including community-based and facility-based LTSS providers; and<br>e. Whether providers are accepting new Enrollees. | Provider network P&P defines expected number of Demonstration Enrollees and required number of providers. P&P specifies how access standards and network requirements specified in the MOU will be met continuously and how compliance will be measured and monitored.<br><br>Provider network P&P defines specialties covered and how they relate to the specific needs of the target population. |
| 902 | The ICO directly employs or contracts with independent care providers of the enrollee's choice, if the individual meets MDCH qualification requirements, to provide Medicaid Personal Care services.<br>The ICO also allows Enrollees who currently receive personal care services from an independent care provider to elect to continue to use that provider, or select a new provider that meets the state qualifications. | Provider network P&P describes how the ICO will ensure access to independent care providers of Enrollee's choice, and ensure that that Enrollees who currently receive personal care services from an independent care provider will be able to continue to use that provider. |
| 903 | The ICO has a policy and procedure and training materials that demonstrate that the medical, and community-based and facility-based LTSS, provider networks are trained in cultural competency for delivering services to Enrollees. The ICO must ensure the PIHPs have policies and procedures and training materials that demonstrate network providers of BH, SUD and I/DD services are trained in cultural competency for delivering services to Enrollees. | Provider network P&P explains how its primary care, specialty, , behavioral health, and community-based and facility-based LTSS providers are prepared to meet the additional competencies necessary to serve Enrollees within the target population.<br><br>Provider training materials for all of these groups include modules on cultural competency when serving target populations. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | P&P states that ICO ensures that PIHPs have P&Ps and training materials that demonstrate behavioral provider networks are trained in cultural competency for delivering services to enrollees. |
| 904 | 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. | Provider network P&P describes PCP requirements and minimum required numbers of PCPs for counties. |
| 905 | 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 explains how and when services outside of the network may be covered and under what circumstances. |
| 906 | 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 by in-network and out-of-network providers. |
| 907 | 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. This information includes provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations. | Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories). |
| 908 | The ICO ensures that it contracts with or has a payment arrangement with all nursing facilities in which any potential Enrollee resides. | Provider network P&P includes requirements for contracting and/or having a payment arrangement with all nursing facilities. |
| | *B: Accessibility* | |
| 909 | The ICO medical, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities. The ICO must ensure the PIHPs network includes behavioral health providers whose physical locations and diagnostic equipment accommodate individuals with disabilities. | Provider network P&P explains how the ICO alerts its Enrollees of providers able to accommodate Enrollees with disabilities (e.g., ICOs in provider directory, information available upon request). |
| 910 | Medical, community-based and facility-based and LTSS, network providers provide linguistically- and culturally-competent services. The ICO must ensure the PIHPs' behavioral health network providers provide linguistically and culturally-competent services. | Provider network P&P specifies that providers are required to provide linguistically and culturally competent services and training includes training on linguistic and cultural competency. |
| 911 | The ICO ensures all medical, and community-based and facility-based LTSS network providers, and all PIHP behavioral health network providers, receive training in physical accessibility, which is defined in accordance with U.S. Department of Justice ADA guidance for providers, in the following areas:<br>a. Utilizing waiting room and exam room furniture that meet needs of all Enrollees, including those with | Provider network P&P requires providers to meet accessibility requirements (physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | physical and non-physical disabilities.<br>b. Accessibility along public transportation routes and/or provide enough parking;<br>c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities. | equipment must be accessible.) and requires providers to complete training in these areas. Provider training materials detail special needs required by Enrollees and provide suggestions or solutions on how to work with such Enrollees.<br><br>Templates require providers to take these actions as condition for participation. |
| | *C: Provider Training* | |
| 912 | The ICO requires disability training for its medical, behavioral, and community-based and facility-based LTSS providers, including information about the following:<br>a. Various types of chronic conditions prevalent within the target population;<br>b. Awareness of personal prejudices;<br>c. Legal obligations to comply with the ADA requirements;<br>d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;<br>e. Types of barriers encountered by the target population;<br>f. Training on person-centered planning (i.e., Person-Centered Service Plans) and self-determination, the social model of disability, the independent living philosophy, and the recovery model;<br>g. Use of evidence-based practices and specific levels of quality outcomes;<br>h. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment; and<br>i. Reporting abuse, neglect, exploitation and other critical incidents. | Each of the listed elements is included in the provider training curricula.<br><br>Template specifies that completion of these trainings is mandatory. |
| 913 | The ICO's training for all providers and ICT members includes coordinating with behavioral health and LTSS providers, information about accessing LTSS, and lists of community supports available. | Sample training materials for ICT members and potential ICT members include the required topics.<br><br>Provider training P&P states that completion of training of ICT members will be documented and defines the consequences associated with non-completion of ICT trainings. |
| 914 | The ICO provides training to providers that balance billing is prohibited under the Demonstration. | Provider training materials and provider handbook include information informing providers of no balance billing. |
| 915 | 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 community-based and facility-based LTSS providers who are not |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | required to have National Provider Identifiers (NPIs). |
| | *D: Provider Handbook* | |
| 916 | The ICO prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, community-based and facility-based LTSS, and pharmacy providers), which includes the following:<br>a. Updates and revisions;<br>b. Overview and model of care;<br>c. ICO contact information;<br>d. Enrollee information;<br>e. Enrollee benefits;<br>f. Quality improvement for health services programs;<br>g. Enrollee rights and responsibilities; and<br>h. Provider billing and reporting. | Each of the listed elements is included in the provider handbook. |
| 917 | The ICO makes resources available (such as language lines) to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Enrollees that require culturally-, linguistically-, or disability-competent care. | Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on ICO website, information about local organizations serving specific subpopulations of the target population). Information on Section 508 compliance is available at www.section508.gov. |
| | *E: Ongoing Assurance of Network Adequacy Standards* | |
| 918 | The ICO ensures that the hours of operation of all of its network providers, including medical, behavioral, community-based and facility-based LTSS, 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), and that ICO 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. |
| 919 | The ICO has a policy and procedure that states:<br>a. The ICT arranges for necessary specialty care, community-based and facility-based LTSS, and behavioral health; and<br>b. An adequate provider network is available to accommodate this care. | Care coordination P&P states that the ICT arranges for necessary specialty care, community-based and facility-based LTSS, and behavioral health, and the provider network P&P ensures an adequate provider network is available.<br><br>List of network providers includes specialties |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | in all geographic regions for the Demonstration. |
| | **Monitoring of First-Tier, Downstream, and Related Entities** | |
| 1001 | The ICO 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 ICO. The ICO should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities, and 42 CFR §422.504 (i), the Medicare Advantage regulation governing contracts with first tier, downstream, and related entities. | Monitoring plan provides information on how the ICO monitors all first-tier, downstream, and related entities. |
| | **Systems** | |
| | *A: Data Exchange* | |
| 1101 | The ICO is able to electronically exchange the following types of data utilizing industry standard, HIPAA compliant formats and protocols:<br>a. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data;<br>b. Claims data (including paid, denied, and adjustment transactions);<br>c. Financial transaction data (including Medicare C, D, and Medicaid payments);<br>d. Provider data;<br>e. ICBR information;<br>f. Prescription drug event (PDE) data; and<br>g. The ICO is able to electronically exchange the necessary information with the PIHP as required by CMS and the State. | Baseline documentation must illustrate that these types of data can and will be electronically exchanged. Additionally, submit P&Ps for securing, processing, and validating the exchange of data. Supporting documentation must include:<br><br>1. Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports as it relates to enrollment and claims data.<br>2. File layouts for transmitted data illustrating compliance with transmission of each of these required data types. |
| 1102 | The ICO or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator**.** | Baseline documentation must include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. |
| 1103 | The ICO reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website. | Baseline documentation must include the ICO's clinical care quality P&P for reviewing and acting upon the Part D monthly patient safety reports. |
| | *B. Data Security* | |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| 1104 | The ICO has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident. | Baseline documentation must illustrate that the ICO has a disaster recovery and a business continuity plan in place. |
| 1105 | The ICO facilitates the secure, effective transmission of data. | Baseline documentation must include:<br>1. ICO's Data Security and Privacy P&P; and<br>2. ICO's Data Security policies as they relate to remote access such as; laptops, handheld devices, and removable drives.<br>3. Documentation of processes to document a breach in data integrity and any associated corrective actions. |
| 1106 | The ICO maintains a history of changes, adjustments, and audit trails for current and past data systems. | Baseline documentation must include change management P&Ps. |
| 1107 | 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). | Baseline documentation must include:<br>1. ICO P&P noting compliance with NPI standards, specifications, and requirements.<br>2. Screenshot of provider data/records illustrating that the NPI data field is populated in provider system. |
| | *C. Claims Processing* | |
| 1108 | The ICO processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates. This includes a process and timeframe for managing pended claims. | Baseline documentation must include:<br>1. Claims processing P&P that details clean claims processing steps and turnaround timeframes.<br>2. Claims processing P&P that details claims processing steps and turnaround timeframes for pended claims.<br>3. Claims processing P&P that details methods for ensuring claims processing accuracy. |
| 1109 | The ICO processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical, community-based, or facility-based LTSS claims adjustment. | Baseline documentation must include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical, community-based, or facility-based long term |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | services. |
| 1110 | The claims systems have the capacity to process the volume of claims anticipated under the Demonstration. | Baseline documentation must include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation must also include metrics used to monitor and evaluate claims processing performance and capacity. |
| 1111 | The claims system benefit structure and associated fee schedules can support all medical, home and community-based, or facility-based (Acute and LTSS) for all Medicare and Medicaid covered services. | Baseline documentation must illustrate the ICO's expected process and plan for loading and validating these Demonstration benefits and fee schedules upon finalization. |
| 1112 | The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over-the-counter drugs. | Baseline documentation must include:<br><br>1. The ICO's oversight procedures for monitoring pharmacy claims processing including the PBM's plan to configure, test, and implement the benefits and adjudication rules to properly process Medicare Part D and Medicaid prescription and Medicaid over-the-counter drugs for the Demonstration.<br>2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs. |
| | *D. Claims Payment* | |
| 1113 | The ICO pays 95% of "clean medical and LTSS claims" within 30 days of receipt. | Baseline documentation must include:<br><br>1. Claims P&P that describes clean claims payment standards.<br>2. Claims payment report sample that details the average number of days between receipt and payment of current clean |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | claims. |
| 1114 | The ICO's PBM pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims. The ICO's PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims). | Baseline documentation must include:<br>1. PBM claims P&Ps that describe clean claims payment standards.<br>2. PBM P&Ps that define interest payments for clean claims that do not meet the processing timeframe standards. |
| 1115 | The ICO or its PBM assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement. | Baseline documentation must include PBM pharmacy network provider P&Ps that detail the timeframe for submission of ICO sponsor claims from long term care facilities. |
| 1116 | The ICO's claims processing system checks claims pricing and payment logic to identify erroneous payments. | Baseline documentation must include a description of system edits and reports to identify claims processing trends and anomalies used to identify erroneous claims payment. |
| | *E. Provider Systems* | |
| 1117 | The system generates and maintains records on medical provider and facility networks, including:<br>a. Provider type;<br>b. Services offered and availability;<br>c. Licensing information;<br>d. Affiliation;<br>e. Provider location;<br>f. Office hours;<br>g. Language capability;<br>h. Medical specialty, for clinicians;<br>i. Panel size;<br>j. ADA-Accessibility of provider office; and<br>k. Credentialing information | Baseline documentation must include core provider system screen shots highlighting where each of these data elements are captured.<br><br>Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications. |
| | *F. Pharmacy Systems* | |
| 1118 | The ICO generates and maintains or ensures that:<br>a. Its PBM generates and maintains records on the pharmacy network information, including locations and operating hours.<br>b. Its PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies.<br>c. The ICO or its PBM sends out notification to members of no longer participating pharmacies. | Baseline documentation must include:<br>1. The ICO or its PBM's P&Ps for maintaining records on pharmacy network information, including locations, operating hours and no longer participating pharmacies. |

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| | | 2. The pharmacy network website screenshots illustrating that operating hours are displayed for pharmacy locations.<br>The ICO or its PBM's P&Ps for notification of members of no longer participating pharmacies. |
| 1119 | The ICO audits the PBM's pharmacy system on a regular basis. | Baseline documentation must include the ICO's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring. |
| 1120 | The PBM can submit Prescription Drug Event data (PDEs) on a monthly basis. | Baseline documentation must include:<br>1. The PBM P&P that defines the processes and data submission requirements for Part D PDE reporting.<br>2. ICO's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting. |
| 1121 | The PBM ensures that pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and enrollee identifiers. | Baseline documentation must include the PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers. |
| 1122 | The ICO ensures that the PBM's claims adjudication system and processes:<br>a. Distinguishes between filling prescriptions for Part D drugs and non-Part D (Medicaid) drugs;<br>b. Appropriately meets the 90-day Part D and the non-Part D (Medicaid) transitional fill requirements.<br>c. Ensures that all prior approvals for drugs, therapies will be honored 90 days after enrollment and will not be terminated at the end of the 90 days without advance notice to the enrollee and transition to other drugs or therapies, if needed. | Baseline documentation must include:<br>1. The PBM's P&Ps for supporting the transitional fill requirements.<br>2. Evidence of systems capability to support both Part D and non-Part D formularies and transitional fill requirements.<br>3. The PBM's P&Ps for supporting the advance notification and transition to other drugs or therapies. |
| 1123 | 2. The ICO's PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies | Baseline document must include the PBM's |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | can determine drugs that are covered under the Demonstration and ensure continuity of care and access to medication for the Demonstration Enrollees in the event the PBM systems are inaccessible. | disaster recovery and business continuity plan for confirming enrollee benefit coverage, ensuring that contracted pharmacies are able to determine what drugs are covered under the Demonstration, and that Enrollees receive their required medications when pharmacies cannot access the PBM systems. |
| | *G. Enrollment Systems* | |
| 1124 | The ICO receives, processes, and reconciles in an accurate and timely manner:<br>a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and<br>b. The benefit and enrollment maintenance file from the state. | Baseline documentation must include the ICO's P&P on processing and reconciling enrollment files.<br>Documentation must include the ICO's enrollment systems schematic that details the daily enrollment processing capacity. |
| 1125 | If the ICO receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the ICO submits a 4Rx transaction (TC 72) to CMS' enrollment vendor within 72 hours of receipt of the DTRR. The 4Rx data elements are:<br>a. RxBIN – Benefit Identification Number;<br>b. RxPCN – Processor Control Number;<br>c. RxID – Identification Number; and<br>d. RxGRP – Group Number. | Baseline documentation must include the ICO's P&P for creating and submitting 4Rx transaction files including data specifications detailing the listed data elements. |
| 1126 | The ICO's enrollment/member system includes each of the following data elements:<br>a. Name;<br>b. Date of birth;<br>c. Gender;<br>d. Telephone #;<br>e. Permanent residence address;<br>f. Mailing address;<br>g. Medicare and Medicaid numbers ,<br>h. ESRD status;<br>i. Other insurance COB information;<br>j. Language preference and alternative formats;<br>k. Authorized representative contact information;<br>l. Which plan the enrollee is currently a member of and to which ICO the enrollee is changing;<br>m. Release of information; and<br>n. Option to request materials in a language other than English or in alternate formats | Documentation must include screenshots of the ICO's enrollment/member system that confirms each data element listed is available in the system. |
| 1127 | For passive enrollments, the ICO sends the following to the enrollee 30 days prior to the effective date of coverage: | Baseline documentation must include the ICO's P&P detailing the processes and |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | a. A ICO-specific Summary of Benefits;<br>b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the ICO;<br>c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and<br>d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the enrollee may begin using ICO services as of the effective date of enrollment. | timeframes for sending the passive enrollee materials. The ICO must also illustrate how it systematically tracks when these materials are sent. |
| 1128 | For passive enrollments, the ICO sends the following to the enrollee no later than the last calendar day of the month prior to the effective date of coverage:<br>a. A single ID card for accessing all covered services under the ICO; and<br>b. A Member Handbook (Evidence of Coverage). | Baseline documentation must include the ICO's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC) for passive Enrollees. The ICO must also illustrate how it systematically tracks when these materials are sent. |
| 1129 | For voluntary enrollments, the ICO provides the following materials to the enrollee no later than ten days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:<br>a. A comprehensive integrated formulary;<br>b. A combined provider and pharmacy directory;<br>c. A single ID card; and<br>d. A Member Handbook (Evidence of Coverage). | Baseline documentation must include the ICO's P&P detailing the processes and timeframes for sending the voluntary enrollee materials. The ICO must also illustrate how they systematically track when these materials are sent. |
| | *H. Care Coordination and Care Quality Management Systems* | |
| 1130 | The ICO's care coordination system maintains an Integrated Care Bridge Record (ICBR) that includes the following data elements:<br>a. Enrollee demographic data;<br>b. Provider network information;<br>c. Interdisciplinary care team membership for specific Enrollees including contact information;<br>d. Current integrated condition (problem) list;<br>e. Dates of service and servicing providers for most recent provider and service contacts within PIHP and ICO systems.<br>f. Enrollee assessments level 1 and level 2<br>g. Service outcomes, including specialty provider reports, lab results, and ER visits;<br>h. Individual integrated care and supports plan (IISCP);<br>i. Interdisciplinary care team (ICT) documentation regarding referrals, care transitions and care delivery,<br>j. Communication tools to support and track care coordination activities between the ICO, the PCP, PHIP and LTSS supports coordinators and other providers;<br>k. Medication reconciliation information; and<br>l. Historical and current utilization, authorizations, and claims information | Baseline documentation must include:<br><br>1. A process workflow including screenshots of the care coordination system that confirms the ability to capture the required care coordination data elements and functionality as detailed.<br><br>2. Description of enhancements that will be made to customize systems to facilitate the requirements of this criterion and a projected delivery timeframe. |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| 1131 | The ICO maintains the care coordination system and addresses technological issues as they arise. | Baseline documentation must include the ICO's help desk and application support P&Ps for managing issues specific to the care coordination system. |
| 1132 | The ICO verifies the accuracy of the ICBR and amends or corrects inaccuracies. Corrections and amendments must be dated and attributed to the person making the change. | Baseline documentation must include the ICO's P&P for ensuring data quality in the care coordination system. The ICO must provide evidence such as a screenshot that illustrates the audit trail tracking of the date and person making the changes/corrections in the system. |
| 1133 | The ICO ensures that the ICBR system and procedures include:<br>a. The initiation of an ICBR for each enrollee.<br>b. Methods for ensuring HIPAA compliance by all ICT members given access to the ICBR.<br>c. Definitions of roles and responsibilities for granting secure access to the ICBR for the approved ICT members.<br>d. A process for the provision of the ICBR in paper format to the enrollee upon request.<br>e. Electronic transmission of ICBR is not required; however, if the ICO has electronic capability then it must demonstrate that electronic transition of ICBR information meets HIPAA requirements. | Documentation must include:<br>m. The ICO's P&P and systems capabilities descriptions for securing and providing access to the ICBR for authorized ICT members and ensuring HIPAA compliance.<br>n. The ICO's workflow processes for making the paper format of the ICBR available to the enrollee. |
| 1134 | The ICO's care coordination system includes a mechanism to alert the ICT members about an enrollee's ED use or inpatient admission within 24 hours of becoming aware of the event. | Baseline documentation must include the ICO's P&P for tracking ED and inpatient admissions and a description of the mechanism for alerting the ICT. The P&P must indicate the notification timeframe targets for both admission types. |
| | **Utilization Management** | |
| | *A: The ICO has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services* | |
| 1201 | The ICO specifies procedures under which the Enrollee may self-refer services as applicable. | The UM program descriptions for the ICO explains for which services an Enrollee can self-refer.<br><br>The contract between the ICO and PIHP must identify parameters for self-referral of behavioral health therapies. |

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| 1202 | The ICO defines medically necessary services as services that are:<br><br>1) For Medicare services: 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.<br>2) For Medicaid services: services that are medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, the most cost-effective option in the least restrictive environment, and consistent with clinical standards of care. Medical necessity includes those services and supports designed to assist the person to attain or maintain a sufficient level of functioning to enable the person to live in his or her community.<br>3) Where there is overlap between Medicare and Medicaid benefits, coverage and rules will be delineated in the three-way contract; the benefits will maintain coverage to at least the extent provided by Medicare and Michigan Medicaid as outlined in both state and federal rules. ICOs will be required to abide by the more generous of the applicable Medicare and Michigan Medicaid standards. | The ICO's UM program description includes this definition of medically necessary.<br><br>The ICO's ICT P&Ps include this definition of medically necessary.<br><br>The ICO's P&Ps for adjudicating appeals include this definition of medically necessary. |
| 1203 | The ICO defines the review criteria, information sources, and processes that the ICT will use to review and approve the provision of items and services, including prescription drugs. | The UM program description includes a description of the review criteria, information sources, and processes that the ICT will use to review and approve the provision of items and services, including prescription drugs. |
| 1204 | The ICO has policies and systems to detect both under- and over-utilization of items, services, and prescription drugs. | The UM program description for the ICO details how the ICO monitors under –and – overutilization of services (e.g., regular data analysis, periodic review meetings). |
| 1205 | The ICO has a methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage. | The UM program descriptions for the ICO explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines). |
| 1206 | The ICO outlines its process for authorizing out-of-network services; an item that is necessary for an Enrollee is not available within the network, the ICO will make such items and services available. | Out-of-network service authorization P&P explains how an Enrollee or provider may obtain authorization for an item or service being provided by a provider outside of the ICO's network. |
| 1207 | The ICO describes its processes for communicating to all ICTs and service providers which items and services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters). | The UM program description details mechanisms for informing network providers of prior authorization requirements and |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | procedures.<br><br>The ICO's provider materials describe prior authorization requirements and procedures. |
| 1208 | The ICO policies for adoption and dissemination of practice guidelines require that the guidelines:<br>a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;<br>b. Consider the needs of the ICO's members;<br>c. Be adopted in consultation with contracting health care professionals;<br>d. Be reviewed and updated periodically; and<br>e. Provide a basis for utilization decisions and member education. | The ICO's practice guidelines P&P include these requirements. |
| | *B: The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.* | |
| 1209 | 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 describes the type of communications sent to Enrollees by the ICO or the ICT, regarding their receipt or denial of referrals of service authorizations. |
| 1210 | For the processing of requests for initial and continuing authorizations of covered items and services, the ICO shall:<br>a. Have in place and follow written policies and procedures;<br>b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and<br>c. Consult with the requesting provider when appropriate. | The UM program descriptions for the ICT 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. |
| 1211 | The ICO ensures that prior authorization requirements are not applied to the:<br>a. Emergency and post-stabilization services, including emergency; behavioral health care;<br>b. Urgent care;<br>c. Crisis stabilization, including mental health;<br>d. Family planning services;<br>e. Preventive services;<br>f. Communicable disease services, including STI and HIV testing;<br>g. Post-stabilization care services; and<br>h. Out-of-area renal dialysis services. | The UM program descriptions for the ICO and ICT lists those items and services that are not subject to prior authorization and this list is consistent with the required elements. |
| 1212 | Any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested must be made be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment. | The UM program description for the ICO includes this requirement.<br><br>Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply |

| 1. Criteria Number | 2. Criteria Reference | 3. Example Evidence |
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| | | ICO policies equitably.<br><br>Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function. |
| 1213 | The ICO and ICT ensure that a physician and behavioral health provider are available 24 hours a day for timely authorization of medically necessary items and services and coordinate transfer of stabilized Enrollees in the emergency department, if necessary. The ICO must ensure a PIHP provider is available 24 hours a day for timely authorization of medically necessary items and services and coordinate transfer of stabilized Enrollees in the emergency department, if necessary. | The UM program descriptions for the ICO and ICT states that a physician and PIHP provider are available 24 hours a day, seven days a week for timely authorization of medically necessary items and services and to coordinate transfer of stabilized Enrollees in the emergencies. |