NORC at the UNIVERSITY of CHICAGO

4350 East-West Highway
8th Floor
Bethesda MD 20814
office (301) 634-9300
fax (301) 634-9301
www.norc.org

South Carolina Readiness Review Tool

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	Assessment	
	A. Transition to New CICO and Continuity of Care	
101	The Coordinated and Integrated Care Organization (CICO) ensures that: a. The enrollee may maintain his or her current providers for 180 days from the effective date of enrollment. b. During the 180-day transition period, the CICO may change an enrollee's existing PCP only under the following circumstances: i. The CICO consulted with, and assigned the enrollee to, a new medical home that it has determined is accessible, competent, and can appropriately meet the enrollee's needs; ii. A health screening and/or a comprehensive assessment is complete; iii. A transition plan is documented in the Individualized Care Plan (to be updated and agreed to with the new PCP, as necessary); and iv. The enrollee agrees to the transition and transition plan prior to the expiration of the 180-day transition period. c. During the 180-day transition period, the CICO may change an enrollee's existing network specialist or LTSS provider only under the following circumstances: i. A health screening and/or a comprehensive assessment is complete; ii. A transition plan is documented in the individualized care plan (to be updated and agreed to with the new PCP, as necessary); and iii. The enrollee agrees to the transition and transition plan prior to the expiration of the 180-day transition period.	Continuity of care plan includes these provisions.
102	The CICO assures that it maintains current service authorization levels for all direct care waiver services during the 180-day transition period unless: a. A significant change has occurred; and b. The change is documented during the Long Term Care Level of Care assessment and/or reassessment.	Continuity of care plan includes these provisions.
103	During the 180-day transition period, the CICO reimburses an out-of-network provider of emergent or urgent care, as defined by 42 CFR §424.101 and 42 CFR §405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service, or as otherwise required under Medicare Advantage rules for Medicare services.	Continuity of care plan should include these provisions**.**
104	The CICO assures that, with the exception of Part D drugs, all prior approvals for drugs, therapies, or other services existing under Medicare or Medicaid at the time of enrollment: a. Will be honored for 180 days after enrollment; and	Continuity of care plan includes these provisions.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	b. Will not be terminated at the end of the 180-day transition period without advance notice to the enrollee and transition to other services, if needed.	
105	The CICO assures that, within the first 90 days of coverage, it will provide a temporary supply of drugs when the enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug (including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules).	P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on re-fills of non-formulary drugs that otherwise meet the definition of a Part D drug.
106	The CICO assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 30-day supply, unless the prescription is written by a prescriber for less than 30 days.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
107	The CICO 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 CICO provides written notice to each enrollee, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary.	Transition plan P&P defines a time period (within 3 business days) when it must provide enrollees with notice about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary.
	B. Assessment	
109	Unless the CICO completes the comprehensive assessment within 60 days, the CICO will administer a universal initial health screen to all enrollees: a. Within 30 days of enrollment; and b. That it will use to identify potential LTSS needs and determine the necessity of a Long Term Care Level of Care assessment.	Health screen P&P includes these requirements.
110	The CICO stratifies enrollees into one of the following three levels: a. Low-risk; b. Moderate-risk; or c. High-risk.	Risk stratification P&P includes these requirements.
111	The CICO provides a description of how it will stratify enrollees into the three risk categories, which, at a minimum, must include consideration of an enrollee's:	Risk stratification P&P includes these requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	a. Demographics; b. Medical condition; c. Functional status; d. Care patterns; e. Resource utilization; and f. Risk scores (e.g., HCC, CRG, etc.).	
112	The CICO adheres to the following timeframes for administering a comprehensive assessment: a. For enrollees stratified to low-risk levels: within 90 days of enrollment; and b. For enrollees stratified as moderate- or high-risk levels: within 60 days of enrollment.	Assessment P&P outlines the process by which the CICO will administer the initial assessment. At a minimum, the process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment within 90 days.
113	The CICO has a process to refer enrollees to State staff for the Long Term Care Level of Care Assessment under the following circumstances: a. If the enrollee is identified as high-risk during the assessment process; or b. If the enrollee or enrollee's caregiver requests the assessment for the enrollee.	Assessment P&P includes these requirements pertaining to the Long Term Care Level of Care Assessment.
114	For enrollees receiving HCBS or residing in a nursing facility, the CICO completes a face-to-face Long Term Care reassessment beginning in phase II of the HCBS transition: a. At a minimum annually; b. When there is a significant change in the enrollees condition, status, or a significant health care event occurs; or c. If the enrollee, his or her caregiver or provider requests reassessment.	Assessment P&P includes these requirements concerning the Long Term Care reassessment.
115	The CICO assures that comprehensive assessments are completed by qualified, trained health professionals who: a. Possess an appropriate professional scope of practice, licensure, and/or credentials for the part of the assessment they are completing; and b. Are appropriate for responding to or managing the enrollee's needs; c. Are one of the following: i. Registered nurse; ii. Licensed practical nurse (under supervision of a registered nurse); iii. Social worker; iv. Medicaid case manager; v. Certified geriatric care manager; vi. Certified community health worker; or vii. An appropriately credentialed individual who has demonstrated competency training in	Assessment P&P includes these requirements concerning qualifications of individuals performing comprehensive assessments.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	assessment related functions in caring for this target population.	
116	The CICO ensures that it has the capacity to administer assessments and reassessments in a format suitable to the enrollee's preferences and abilities.	Assessment P&P explains how the CICO will adapt its risk assessment tool, including format, language, and mode of communication, etc. to the specific needs of the target population. Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current enrollees.
117	The CICO has policies for staff to follow up and to document when an enrollee refuses to participate in a comprehensive assessment.	Assessment P&P explains how staff from the CICO will respond to those enrollees who decline to participate in a comprehensive assessment. Assessment P&P describes how the CICO staff will assist enrollees who require additional prompting/guidance about participating in the assessment (e.g., enrollees with co-morbidities such as mental health and substance abuse issues along with physical disabilities). Assessment P&P explains how the CICO will monitor those enrollees who decline to participate in the risk assessment process.
	Care Coordination	
	A. Care Management and Multidisciplinary Team (MT)	
201	The CICO assures that every enrollee has a Care Coordinator and a Multidisciplinary Team (MT).	
202	Care Coordination provided to enrollees includes, at a minimum: a. Access to a single, toll-free point of contact for all questions; b. Development of an Individualized Care Plan that is periodically reviewed and updated; c. Disease self-management and coaching;	Care Coordination P&P includes these requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	d. Medication review, including reconciliation during transitions of care setting; e. Periodic monitoring of health, functional and mental status along with pain and fall screening; f. Provision of services in the least restrictive setting and transition support across and between specialties and care settings; g. Connecting enrollees to services that promote community living and help to delay or avoid nursing facility placement; h. Coordinating with social service agencies (e.g., local departments of health, social services and community based organizations) and referring enrollees to State, local and/or other community resources; and i. Collaboration with nursing facilities to promote adoption of evidence-based interventions to: i. Reduce avoidable hospitalization: ii. Manage chronic conditions; iii. Optimize medications; iv. Prevent falls and pressure ulcers; and v. Coordinate services beyond the scope of the nursing facility benefit.	
203	The CICO provides more intensive care coordination to enrollees identified as high or moderate risk, as needed.	Care Coordination P&P includes this provision.
204	For enrollees assessed for, or receiving, waiver services, the CICO ensures that the waiver care plan is fully integrated into a single, overall care plan.	Care planning P&P includes this provision.
205	The MT should: a. Be person-centered; b. Be led by the Care Coordinator; c. Include the waiver case manager, if applicable; d. Ensure the integration of medical, behavioral health, HCBS, and nursing facility services; e. Be built on the enrollee's specific preferences and needs; and f. Deliver services with transparency, respect, linguistic and cultural competence, and dignity.	MT P&P requires each of these requirements.
206	The CICO assures that the care coordinator it assigns to an enrollee has the appropriate qualifications and training to meet that enrollee's needs.	Care coordination P&P requires each enrollee to be assigned a care coordinator based on his or her risk level and/or individual needs and outlines the process for assigning such care coordinators. CICO describes reasonable measures taken to ensure that expertise of Care Coordinator aligns with the needs of individuals who meet the CICO definition of

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		high, medium, and low risk enrollees.
207	The CICO describes: a. The process by which the Care Coordinator identifies who is appropriate to include in the MT (e.g., waiver case manager, nursing facility staff); and b. How the enrollee and/or his or her caregiver are involved in determining the MT.	Care coordination P&P defines how an MT is formed for each enrollee and how the enrollee and/or his or her caregiver are involved in determining the MT.
208	The CICO: a. Conducts training for MT members initially and on an annual basis on: i. The person-centered planning processes; ii. Cultural competence; iii. Accessibility and accommodations; iv. Dementia and other cognitive impairments; v. Independent living and recovery; vi. Dementia and related training; vii. ADA/Olmstead requirements; and viii. Wellness principles; b. Has a policy for documenting completion of training by all MT members, including both employed and contracted personnel, and has specific policies to address non-completion.	P&P noting training will be required for MT members and potential MT members on the required topics. Care coordination P&P states that completion of training of MT members will be documented and defines the consequences associated with non-completion of MT trainings.
	B. ICP / Service Plan	
209	The CICO will develop an Individualized Care Plan (ICP) that is: a. Person-centered and individualized; b. Developed by the enrollee's Care Coordinator with the enrollee, his/her family supports and providers; and c. Addresses all of the clinical and non-clinical needs of the enrollee, as identified in the comprehensive assessment.	Care planning P&P outlines a process that describes how the CICO will involve the enrollee in developing the ICP and will use the information gathered from the assessment(s) of the enrollee in developing the ICP. Care planning P&P states that the CICO intends to provide person-centered care to all enrollees, and describes strategies for assuring this.
210	The CICO ensures that ICPs are: a. Completed within 90 days of enrollment; and	Care planning P&P includes these timeframes and describes the

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	b. Updated at a minimum annually.	process for meeting the timeframes.
211	The CICO ensures that ICPs are reviewed within the following timeframes: a. For high-risk enrollees, at least every 30 days; b. For moderate-risk enrollees, at least every 90 days; and c. For low-risk enrollees, at least every 120 days.	Care planning P&P describes the timeframes for review of ICPs.
212	The CICO will ensure that the enrollee receives: a. Any necessary assistance and accommodations to prepare for and fully participate in the care planning process; and b. Clear information about: i. The enrollee's health conditions and functional limitations; ii. How family members and social supports can be involved in the care planning as the enrollee chooses; iii. Opportunities for educational and vocational activities; and iv. Available treatment options, supports and/or alternative courses of care.	Care planning P&P describes how the CICO will ensure that the enrollee receives necessary assistance and the types of information specified.
213	The CICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.	Care planning P&P states that the CICO accommodates enrollees' religious or cultural beliefs and basic enrollee rights in developing the ICP.
214	The CICO describes its process for addressing health, safety (including minimizing risk), and welfare of the enrollee in the ICP. The ICP will contain the following: a. Prioritized list of enrollee's concerns, needs, and strengths; b. Attainable goals, outcome measures, and target dates selected by the enrollee and/or caregiver; c. Strategies and actions, including interventions and services to be implemented and the person(s)/providers responsible for specific interventions/services and their frequency; d. Progress noting success, barriers or obstacles; e. Enrollee's informal support network and services; f. Determined need and plan to access community resources and non-covered services; g. Enrollee choice of services (including consumer-direction) and service providers.	
	C. Self-Direction	
215	CICOs ensure that enrollees are supported in directing their own care and ICP development. In addition, the CICO ensures that: a. During Phase III of the transition of HCBS authority, it will subcontract with the State's contractor, University of South Carolina's Center for Disability Resources (CDR), to: i. Ensure waiver enrollees receive services from qualified attendants; and	Care planning P&P describing how the CICO supports self-direction, and how it will ensure additional MOU HCBS transition requirements are in place.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	ii. Are capable of supervising the care or has someone who can do that on their behalf.	
	D. Coordination of Services	
216	The CICO has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting evaluations and reports for the care coordination program; and b. Communicating these results and subsequent improvements to CICO advisory boards and/or stakeholders.	Care coordination P&P explains how and when the CICO will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to CICO advisory boards and/or stakeholders.
217	The CICO facilitates timely and thorough coordination among the CICO, the primary care provider, and other providers, including but not limited to hospitals, nursing facilities, and HCBS providers, as necessary and appropriate.	Care coordination P&P outlines how coordination between the parties will occur; including the mechanism by which information will be shared and how the CICO will facilitate the coordination.
218	The CICO has identified appropriate staff to receive and act upon notifications and HCBS claims via the *Phoenix/Care Call* system. a. Notifications include but are not limited to the following: i. Service requests; ii. Complaints; iii. Reports of abuse; iv. Sentinel events; v. Change in cares setting; and vi. Assessments/Reassessments that are due or overdue. b. Procedures must also indicate: i. How and when notifications trigger updates to the ICP; ii. How different types of notifications will be handed in terms of review and response; and iii. How the CICO defines emergent and non-emergent notifications.	P&P outlining process and planning for using the *Phoenix/Care Call* system. P&P outlining detail of review and response protocol based type of notification. P&P outlining process by which notifications trigger updates to ICP.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	E. Transitions between Care Settings	
219	For individuals in a nursing facility who have resided in a nursing facility for greater than 90 days prior to transition from the nursing home and wish to move to the community, the CICO will refer them to preadmission screening teams if the level of care and care plan indicates need for waiver services or Money Follows the Person (Home Again) is indicated.	Sample communications the CICO plans to send to enrollees living in institutional settings contain information related to accessing community supports.
220	The CICO has a policy and procedure for monitoring transfers and minimizing unnecessary complications related to care setting transitions and hospital re-admissions through pre- and post-discharge planning. The procedure should include: a. Documenting transition plans in the ICP through the MT process; and b. Reviewing patient medical records for indications that an assessment and transition may be appropriate.	Care setting transitions P&P explains how the CICO and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the CICO monitors transfers and hospital readmissions, including documenting transition plans and reviewing medical records for potential assessment needs. Draft model data sharing agreements between hospitals and the CICO. Sample report(s) from the CICO describe how it tracks enrollee transfers and admissions. Care coordination P&P describes the role of the Care Coordinator in monitoring care setting transitions.
221	The CICO's protocols for care setting transition planning ensure that: a. An assessment of whether an enrollee has a place to live is completed; b. All community supports are in place prior to the enrollee's move; and c. Providers are fully knowledgeable and prepared to support the enrollee, including interfacing and coordinating with and among clinical services and LTSS, if appropriate.	Care setting transitions P&P explains how the CICO ensures that community supports are available prior to an enrollee's move. Care setting transitions P&P explains how the CICO assesses the qualifications of those providers charged with caring for an enrollee after his or her move. Sample care setting transition plan(s) detail the steps the CICO

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		takes to ensure continuity of care for an enrollee changing care settings.
222	The CICO helps enrollees transition to another provider if their provider leaves the CICO's network, as appropriate to the enrollee's preference.	Care coordination P&P and/or provider handbook includes this policy.
223	The CICO transitions enrollees to new providers, if needed, once the ICP is completed and signed by the enrollee or their authorized representative.	Care coordination P&P and/or provider handbook includes this policy.
	Confidentiality	
301	The CICO provides a privacy notice to enrollees: a. Which explains the policies and procedures for the use and protection of protected health information (PHI); and b. Is written at a literacy level appropriate for the target audience, no higher than a 7th grade education.	Sample privacy notice to be sent to enrollees explains how the CICO will safeguard PHI.
302	The CICO provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers explains how the CICO will safeguard PHI and the provider's role in safeguarding PHI.
	Enrollee and Provider Communications	
	A. General Customer Service & Coverage Determination Hotlines	
401	**General Customer Service Hotline:** The CICO maintains and operates a toll-free call center that operates seven days a week at least from 8:00 A.M. to 8:00 P.M. according to the time zones for the regions in which they operate.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, LTSS, and drugs. An automated voice response system would meet the definition of an "alternative technology" to meet customer call center requirements on the weekends.
402	The CICO's customer service department representatives shall, upon request, make available to enrollees and potential enrollees information including, but not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Enrollees' rights and responsibilities; c. The procedures available to an enrollee and/or provider(s) to formally dispute or appeal the failure of the CICO to provide a covered service and to appeal any adverse actions (denials);	P&P includes these requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. Information on all CICO covered services and other available services or resources (e.g., State agency services) either directly or through referral or authorization; and f. The procedures for an enrollee to change CICOs or to opt out of the Demonstration.	
403	**Coverage Determination Hotline:** The CICO operates a toll-free call center with live customer service representatives available to respond to providers or enrollees with information related to coverage determinations (including exceptions and prior authorizations), and appeals. The call center must meet all requirements in CMS Marketing Guidelines Appendix 5, including that it must operate during normal business hours and never less than from 8:00 A.M. to 6:00 P.M., Monday through Friday according to the time zones for the regions in which they operate.	Enrollee services telephone line P&P confirms that the hotline is toll-free and available during required times.
404	The CICO maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency enrollees. In addition: a. The hours of operation for the CICO'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 b. The language line is TDD/TTY accessible.	Contract with language line company includes these requirements, including mandatory hours of operation.
405	The CICO must employ enrollee service representatives (ESR) who are: a. Trained to answer enrollee inquiries and concerns from enrollees and prospective enrollees using appropriate cultural competencies; b. Trained in the use of TTY, video relay services, remote interpreting services, and how to provide accessible PDF materials, and other alternative formats; c. Trained to work with enrollees with dementia and other cognitive impairments; and d. Capable of speaking directly with, or arranging for someone else to speak with, enrollees in their primary language, including American Sign Language, or through an alternative language device or telephone translation service.	ESR P&P includes these elements. Training materials for ESRs includes these elements.
	B. Pharmacy Technical Support Hotline	
406	The CICO 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 CICO (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.
407	The CICO ensures that pharmacy technical support is available at any time that any of the network’s pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.
	Enrollee Protections	

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	A. Enrollee Rights	
501	The CICO has established enrollee rights and protections and assures that the enrollee is free to exercise those rights without negative consequences.	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 CICO policies articulate that it will notify enrollees of their rights and protections at least annually, in a manner appropriate to their condition and ability to understand.	P&P provides a timeline for updating enrollees about changes or updates to their rights and protections. Enrollee rights P&P details how notifications will be adapted based on the enrollee's condition and ability.
503	The CICO does not discriminate against enrollees due to: a. Medical condition (including physical and mental illness); b. Claims experience; c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; g. Age; or h. Disability.	P&P addresses that the CICO will not discriminate against enrollees based on the enumerated reasons. Staff training includes discussion of enrollee rights.
504	The CICO informs providers and the appropriate staff (i.e., claims processing, member services, and billing staff) on the prohibition on balance billing. This is articulated through: a. Policies and procedures; b. Staff training modules; and c. Provider training modules.	P&P explains that the CICO informs beneficiaries that they should not be balanced billed. Training materials for providers and staff cover this rule.
505	The CICO has policies and procedures to inform enrollees of their right to reasonable accommodation.	P&P states that the CICO informs enrollees of their right to reasonable accommodation.
	B. Appeals and Grievances	
506	The CICO notifies enrollees at least annually about their grievances and appeals rights.	Enrollee rights P&P with a timeline for updating enrollees about

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		changes or updates to their rights and protections.
507	The CICO staff receives training on enrollee protections, including but not limited to: a. The CICO's organization and coverage determination; and b. The CICO's appeals and grievance processes.	P&P noting that CICO training will include information about the CICO's organization and coverage determination processes and the appeals and grievance processes.
508	The CICO provides enrollees with reasonable assistance in filing appeals and grievances.	Grievances and appeals P&P explains to the extent to which the CICO will assist an enrollee in filing an appeal or grievance.
509	The CICO must: a. During the internal CICO appeal process: i. For prior-approved Medicare Parts A and B, and non-Part D benefits, continue to pay providers pending the resolution of the internal CICO appeal process; and ii. For Medicaid-only and Medicare-Medicaid overlap services appeals, pay providers for prior-approved services pending the resolution of the internal CICO appeal process if the request for an appeal is filed with the CICO within 10 calendar days of the Notice of Action. b. For appeals of CICO decisions concerning Medicaid-only services, if the enrollee files an appeal with the State Fair Hearing Agency within 10 calendar days of the Notice of Disposition from the CICO, continue to pay for services pending the resolution of the State Fair Hearing Appeal process. c. For appeals of CICO decisions concerning Medicare-Medicaid overlap services: i. If the appeal is forwarded to the IRE, continue to pay for services pending resolution by the IRE. ii. If the resolution of the IRE is not wholly in favor of the enrollee, continue to pay services for services pending resolution of the State Fair Hearing Appeal process if the enrollee files an Appeal with the State Fair Hearing Agency within 10 calendar days of the Notice of Disposition from the IRE.	Grievances and appeals P&P confirm that the CICO meets these continuation of benefits requirements.
510	The CICO maintains an established process to track and maintain records on all grievances, received both orally and in writing. Records must include, at a minimum, the date of receipt, final disposition of the grievance, and the date that the CICO notified the enrollee of the disposition.	Screenshots of or reports from the tracking system in which enrollee grievances are kept that include these elements. Data summaries or reports that detail the types of reporting and remediation steps that are taken to ensure grievances are correctly handled. Grievances P&P that define how

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		staff from the CICO should document grievances within the tracking system.
511	The CICO maintains policies and procedures for addressing enrollee grievances, including following: a. Enrollees are entitled to file grievances directly with the CICO; b. The CICO tracks and resolves all grievances, or reroutes grievances to the coverage decision or appeals process as appropriate; and c. The CICO has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals; and d. The CICO has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.	Grievances P&P that includes these specifications.
512	The CICO resolves internal appeals: a. For standard appeals, within 15 days calendar days of filing; and b. For expedited appeals, within 72 hours of filing or as expeditiously as the enrollee's condition requires.	Appeals P&P that includes these specifications.
513	The CICO's Part D appeals process under the Demonstration is consistent with the requirements under 42 CFR § 423 Subpart M.	Part D appeals P&P that include these requirements for processing appeals.
	C. Enrollee Choice of PCP	
514	The CICO notifies enrollees about the process for choosing their PCP, including the enrollee's right to select his or her PCP and the ability to select a specialist who performs primary care functions as a PCP.	PCP selection and assignment P&P explains how and when an enrollee may elect a new PCP. PCP selection and assignment P&P explains how PCPs are assigned to enrollees who do not elect a provider and/or who are not capable of selecting a provider.
	D. Emergency Services	
515	The CICO has ensured that HCBS providers have a back-up plan in place in case a personal care related service provider does not arrive as scheduled to provide assistance with activities of daily living.	Emergency services P&P explains how the CICO is ensures the provision of care to HCBS enrollees when a personal care related service provider does not arrive to provide care.
516	The CICO develops an individualized disaster preparedness plan for all LTSS enrollees, as well as enrollees residing in assisted living facilities. a. CICO updates the plan regularly; and b. Integrates the plan into the overall ICP.	P&P addresses disaster preparedness plan, including updates and integration into overall ICP.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
517	The CICO can connect enrollees with emergency behavioral health services, when applicable.	Emergency services P&P addresses how the CICO is prepared to provide emergency behavioral health services to enrollees in crisis.
	Organizational Structure and Staffing	
	A. Organizational Structure and Staffing	
601	The CICO must establish at least one consumer advisory committee and a process for that committee to provide input to the governing board. The CICO must demonstrate the participation of consumers with disabilities, including enrollees, within the governance structure of the CICO.	Bylaws governing the CICO's consumer advisory committee state that consumers with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the CICO), and that the committee has a process for providing input to the CICO's governing board.
602	The CICO's Quality Improvement (QI) committee includes physicians, behavioral health providers, providers with expertise in LTSS, and others, who represent a range of health care services used by enrollees in the target population.	QI committee members are appropriate based on the target population described in the CMS-South Carolina MOU. Note: For CICOs with current QI committees, review will focus on the change in composition to address the new services (e.g., LTSS and behavioral health).
603	The CICO has an individual or committee responsible for provider credentialing who is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, LTSS, behavioral health, and pharmacy).	A provider credentialing point of contact or committee is reflected in an organizational chart. The provider credentialing point of contact is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, LTSS, behavioral health, and pharmacy).

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	B. Sufficient Staff	
604	The CICO demonstrates that it has sufficient employees and/or contractors to complete enrollee assessments and reassessments, including the initial health screen and comprehensive assessment for all enrollees within required timeframes through its staffing plan. The staffing plan must explain: a. The CICO's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the CICO believes will be needed to perform the function; d. How the CICO derived that estimate; and e. In what timeframe the CICO will staff to the level indicated.	The CICO demonstrates that it meets the requirements of the criterion.
605	The CICO staff, contractors, and providers performing enrollee-assessments have the appropriate education and experience for the subpopulations (e.g., experience in LTSS or behavioral health).	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description requirements.
606	The CICO demonstrates that it has sufficient employees and/or contractor staff to meet the care coordination needs of the target population through its staffing plan. The staffing plan must explain: a. The CICO's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the CICO believes will be needed to perform the function; d. How the CICO derived that estimate; e. How the CICO will make caseload determinations based on risk stratification; f. How the CICO's caseload protocol will promote quality care outcomes; g. In what timeframe the CICO will staff to the level indicated; and h. Include a comprehensive list of elements that impact caseload determination in diverse care settings.	The CICO demonstrates that it meets the requirements of the criterion.
607	The qualifications for a care coordinator meet the requirements of the Demonstration. These requirements include the following: a. Must have a bachelor's degree with demonstrated ability to communicate with members who have medical needs and may have communication barriers; and b. Experience navigating resources and computer systems to access information.	Care coordinator qualifications P&P includes those listed. Education and experience must be appropriate for coordinating care for the Demonstration population.
608	The CICO demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight through its staffing plans. The staffing plan must explain: a. The CICO's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the CICO believes will be needed to perform the function; d. How the CICO derived that estimate; and	The CICO demonstrates that it meets the requirements of the criterion.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	e. In what timeframe the CICO will staff to the level indicated.	
609	The CICO demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances through its staffing plan. The staffing plan must explain: a. The CICO's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the CICO believes will be needed to perform the function; d. How the CICO derived that estimate; and e. In what timeframe the CICO will staff to the level indicated.	The CICO demonstrates that it meets the requirements of the criterion.
610	The CICO demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations, including care management hotline through its staffing plan. The staffing plan must explain: a. The CICO's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the CICO believes will be needed to perform the function; d. How the CICO derived that estimate; and e. In what timeframe the CICO will staff to the level indicated.	The CICO demonstrates that it meets the requirements of the criterion.
611	The CICO Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that the medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. Job description for the medical director includes this responsibility.
612	The CICO Medical Director has experience in geriatrics or adult medicine and has experience and/or training with coordinating care for adults with multiple chronic conditions.	Job description for the medication director that includes this experience.
	C. Staff Training	
613	The CICO has a cultural competency and disability training plan to ensure that staff delivers culturally-competent services, in both oral and written enrollee communications (e.g., person-first language, target population competencies).	The CICO's cultural competency and disability training plan (or P&P) identifies which staff receive this training and how often, and includes a schedule of training activities for new staff.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		P&P noting that CICO's training program will require training on cultural competency and disability.
614	The CICO staff is adequately trained to handle critical incident and abuse reporting. Training includes, among other things: a. Ways to detect and report instances of abuse, neglect, and exploitation of enrollees by service providers and/or natural supports providers; b. South Carolina State law requirements for mandatory reporters; and c. The Omnibus Adult Protection Act.	P&P noting that CICO's training program will require training on critical incident and abuse reporting, South Carolina state law requirements for mandatory reporters and the Omnibus Adult Protection Act.
615	The training program for care coordinators includes, but is not limited to: a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. LTSS and process; f. Self-direction of services (as authorized by the State); g. Behavioral health (including addictive disorders) and processes; h. Care transitions; i. Skilled nursing needs/NF processes; j. Abuse and neglect reporting; k. Pharmacy and Part D services; l. Community resources; m. Enrollee rights and responsibilities; n. Independent living philosophy; o. Most integrated/least restrictive setting; p. How to identify behavioral health and LTSS needs; q. How to obtain services to meet behavioral health and LTSS needs; r. Role of enrollment broker. s. Advance Care Planning; t. Person-centeredness; and u. Patient activation/engagement.	P&P noting that the CICO's training program for care coordinators will include modules or sections on each of these elements.
616	The CICO conducts training for MT members on dementia and related training includes the following on: a. Introduction to Dementia (Diagnosis, Prognosis, Treatment); b. Communication and Feelings; c. Depression; d. Repetitive Behaviors, Paranoia, Hallucinations, Wandering, Hoarding, Aggressive Behaviors; e. Catastrophic Reactions; f. Intimacy & Sexuality;	

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	g. Dementia and Driving; h. Activities; i. Staff and Family Support; j. Recognizing Abuse and Neglect in the Home; k. Diversity and Cultural Competency; and l. Spiritual Care and End of Life Issues.	
617	The CICO's staff is trained on HIPAA compliance obligations and the CICO's confidentiality guidelines.	The CICO's training materials include training on HIPAA compliance and confidentiality guidelines.
618	The CICO or PBM has scripts for its general customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment; f. Formulary information; g. Pharmacy information, including whether an enrollee's pharmacy is in the CICO's network; h. Provider information, including whether an enrollee's physician is in the CICO's network; i. Out-of-network coverage; j. Claims submission, processing, and payment; k. Formulary transition process; l. Grievance, coverage determination, and appeals process (including how to address Medicaid drug appeals); m. Information on how to obtain needed forms; n. Information on replacing an identification card; and o. Service area information.	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See SC MOU for details)
619	The CICO has protocols or staff training modules to train enrollee services telephone line staff in the following areas: a. Explaining the operation of the CICO and the roles of participating providers; b. Assisting enrollees in the selection of a primary care provider; c. Knowledge of services available through the CICO including HCBS waiver services, behavioral health and nursing facility services; d. Assisting enrollees to obtain services and make appointments; and e. Handling or directing enrollee inquiries or grievances.	P&P noting that CICO will require training for its enrollee services telephone line staff personnel on these topics. Step-by-step procedures or a flow chart showing how staff from the CICO would walk through assisting enrollees in explaining or selecting services.
	Performance and Quality Improvement	

1. Criteria Number	2. Criteria Reference	3. Example Evidence
701	The CICO collects and tracks reports of critical incidents and abuse of enrollees receiving LTSS in a home and community-based long-term care service delivery setting, including: adult day care centers; other HCBS provider sites; and an enrollee's residence, if the incident is related to the provision of covered HCBS.	QI program description explains how the CICO tracks incidents and cases of abuse for enrollees receiving LTSS. Sample annual performance report includes the CICO's method of tracking and reporting cases of incidents and abuse.
702	The CICO collects prescription drug quality measures consistent with Medicare Part D requirements and has established quality assurance measures and systems to reduce medication errors and adverse drug interactions and improve medication use.	QI program description explains the CICO's means of collecting and reviewing drug quality measures. Sample annual performance report includes the CICO's method of reporting these measures.
	Provider Credentialing	
801	The CICO: a. Adheres to standards for provider credentialing under 42 CFR § 438.214 and 42 CFR § 422.204; b. Is accredited by NCQA and follows NCQA procedural requirements for standards for credentialing and re-credentialing; and c. Follows the State Medicaid requirements and guidance.	Provider credentialing P&P includes these requirements.
802	Prior to contracting with a new provider, the CICO considers and/or verifies the following information for the provider: a. The provider has a valid professional license for their field of practice, when applicable; b. The provider has a valid DEA certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. The provider has malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss, when applicable; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions, when applicable; i. Medicare or Medicaid sanctions; and j. Malpractice history, when applicable.	Provider credentialing P&P states that the CICO will review these documents and this information, as applicable, prior to contracting with a provider. Sample initial completed credentialing application instructions.
803	The CICO requires that all contracted laboratory testing sites maintain certification under the Clinical Laboratory	The CICO submits a copy of its

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	Improvement Amendments (CLIA) or have a waiver of CLIA certification.	contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.
804	The CICO has processes in place: a. To facilitate medical homes advancing toward National Committee for Quality Assurance (NCQA) certification; and b. To offer financial incentives to providers that achieve NCQA medical home certification. This includes quarterly per member per month payments to providers in the following four payment levels. CICOs must make payment to qualifying practices within 30 days of the CICO's receipt of the quarterly payment from SCDHHS. i. Application Period: $.50 ii. Level I Certification: $1.00 iii. Level II Certification: $1.50 iv. Level III Certification: $2.00	P&P describes CICO's process to facilitate medical home providers advancing toward NCQA accreditation and offer financial incentives for this purpose.
	Provider Network	
901	The CICO has a set of procedures that govern participation in the medical, behavioral, and LTSS provider networks, including written rules of participation that cover: a. Terms of payment; b. Credentialing; and c. Other rules directly related to participation decisions.	The CICO's rules for participation for medical, behavioral, and LTSS provider networks include all necessary items and specify that written notice of material changes in the rules will be submitted to CMS and the State prior to changes taking effect.
902	The CICO has a clear plan to meet the Medicare and Medicaid provider network standards, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; and c. Whether providers are accepting new enrollees.	Provider network P&P defines expected number of Demonstration enrollees and required number of providers. Provider network P&P defines specialties covered and how they relate to the specific needs of the target population.
903	The CICO has a policy and procedure that Medical Homes: a. Are available to enrollees for primary care; b. In the network will provide evidence-based primary care services, acute care, behavioral health care (where appropriate), chronic health condition management, and referrals for specialty care and LTSS; c. In the network will be supported by health information technology (HIT); and	Provider network P&P describes how it will ensure Medical Home inclusion in the network that meets MOU requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	d. Be a part of the MT (care team) to assist in coordinating care across the full spectrum of available services, including behavioral health care, and managing transitions between levels of care.	
904	The CICO has a policy and procedure and training materials that demonstrate that the medical, behavioral, LTSS, and pharmacy provider networks are trained in cultural competency (including language,) for delivering services target populations in the Demonstration.	Provider network P&P explains how its primary care, specialty, behavioral health, and LTSS, providers are prepared to meet the additional competencies necessary to serve enrollees within the target population. Provider training materials for all of these groups include modules on cultural competency when serving target populations.
905	The CICO has a policy and procedure that states that it establishes a panel of PCPs from which enrollees may select a PCP.	P&P describes PCP requirements and minimum required numbers of PCPs for counties or other plan areas and for sub-populations of enrollees if applicable.
906	The CICO 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.
907	The CICO 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.
908	The CICO ensures that enrollees have access to the most current and accurate information by updating its online provider directory on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).
	B. Accessibility	
909	The CICO medical, behavioral, and LTSS networks include providers whose physical locations and diagnostic equipment accommodate individuals with disabilities.	Provider network P&P explains how the CICO alerts its enrollees of providers able to accommodate enrollees with disabilities (e.g., CICOs in provider directory, information available upon

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		request).
910	Medical, behavioral, and LTSS, network providers provide linguistically- and culturally-competent services.	Provider training includes training on cultural competency.
911	Providers receive training in the following areas: a. Utilizing office furniture that meet needs of all enrollees, including those with physical and non-physical disabilities; b. Accessibility along public transportation routes, and/or providing enough parking; and c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities.	Provider training materials detail special needs required by enrollees and provide suggestions or solutions on how to work with such enrollees. Templates require providers to take these actions as a condition for participation.
	C. Provider Training	
912	The CICO requires disability literacy training for its medical, behavioral, and LTSS providers, including information about the following: a. Various types of chronic conditions prevalent within the target population; b. Awareness of personal prejudices; c. Legal obligations to comply with the ADA requirements; d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; e. Types of barriers encountered by the target population; f. Training on person-centered planning and self-determination, the social model of disability, the independent living philosophy, and the recovery model; g. Use of evidence-based practices and specific levels of quality outcomes; and h. Working with enrollees with mental health and addictive disorders diagnoses, including crisis prevention and treatment.	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.
913	The CICO's training for all providers and MT members includes coordinating with behavioral health and LTSS providers, information about accessing behavioral health and LTSS, and lists of community supports available.	Provider training materials include modules on coordination of care, behavioral health services, LTSS, and community supports (see also care coordinator training in the care coordination section).
914	The CICO provides training to providers, explaining that their contracts require there be no balance billing under the Demonstration.	Provider training materials and provider handbook include information informing providers of no balance billing.
915	The CICO has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	Data systems management guidelines for LTSS providers

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		address LTSS providers who are not required to have National Provider Identifiers (NPIs).
916	The training program for primary care providers includes: a. How to identify behavioral health needs; and b. How to identify LTSS needs.	The CICO's training materials for PCPs include modules or sections on behavioral health needs and services.
	D. Provider Handbook	
917	The CICO prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. CICO contact information; d. Enrollee information; e. Enrollee benefits; f. Quality improvement or health services programs; g. Enrollee rights and responsibilities; h. South Carolina's Omnibus Adult Protection Act; i. Provider billing and reporting; j. Role of the Enrollment Broker; k. Fraud, Waste and Abuse; and l. Marketing Guidelines.	Each of the listed elements is included in the provider handbook.
918	The CICO makes resources available (such as language lines) to medical, behavioral, LTSS, and pharmacy providers who work with enrollees that require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on CICO website, information about local organizations serving specific subpopulations of the target population).
	E. Ongoing Assurance of Network Adequacy Standards	
919	The CICO ensures that the hours of operation of all of its network providers, including medical, behavioral, and LTSS, are convenient to the population served and do not discriminate against CICO enrollees (e.g. hours of operation may	Network provider P&Ps and/or contract templates that include

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	be no less than those for commercially insured or public fee-for-service insured individuals), and that plan services are available 24 hours a day, 7 days a week, when medically necessary.	these provisions.
920	The CICO has a policy and procedure that states that it arranges for necessary specialty care, LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care. List of network providers includes specialties in all geographic regions.
	Monitoring of First-Tier, Downstream, and Related Entities	
1001	The CICO 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 CICO. The plan should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities, and 42 CFR §422.504 (i), the Medicare Advantage regulation governing contracts with **first tier, downstream, and related entities.**	Monitoring plan provides information on how the CICO monitors all first-tier, downstream, and related entities.
	Systems	
	A. Data Exchange	
1101	The CICO is able to electronically exchange the following types of data: a. Person centered Individualized Care Plan b. Assessments; c. Enrollee benefit plan enrollment, disenrollment, and enrollment-related data; d. Claims data (including paid, denied, and adjustment transactions); e. Financial transaction data (including Medicare C, D, and Medicaid payments); f. Third-party coverage data; g. Enrollee demographic information; h. Provider data; and i. Prescription drug event (PDE) data.	Baseline documentation should illustrate the types of data that can and will be electronically exchanged along with policies and procedures for securing, processing, and validating the exchange of data including EDI system specifications for transmitting ANSI compliant file formats—e.g., 834, 835, 837 transactions. Supporting documentation should include: 1) Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports. 2) Documentation of rejection thresholds and data reconciliation processes. 3) File layouts for transmitted

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		data illustrating compliance with transmission of required data elements (e.g., Items 2a-2i). 4) Documentation of CICOs transaction sets with CMS, the State, and other third party vendors, including where transaction are compliant with HIPAA versioning standards—e.g., HIPAA Version 5010.
1102	The CICO or its contracted PBM is able to exchange Part D data with the TrOOP Facilitator.	Baseline documentation should include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. Supporting documentation should include transaction facilitator certification documentation for its FIR.
1103	The CICO reviews Medicare Part D monthly Patient Safety Reports, via the Patient Safety Analysis website.	Baseline documentation should include the CICO's quality of care policies and procedures for reviewing and acting upon the Part D monthly patient safety reports.
1104	The CICO ensures that health information technologies and related processes support national, state, and regional standards for health information exchange and interoperability.	Baseline documentation should include policies and procedures for monitoring the standards for health information exchange and interoperability. The CICO should highlight any HIEs networks in which they currently or are preparing to participate.
	B. Data Security	
1105	The CICO has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation should include a copy of the CICO's disaster recovery and business continuity plan and an inventory of

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		the core systems specifically used to operate this Demonstration. 1. Supplemental documentation may include proof of disaster recovery plan validation and testing.
1106	The CICO facilitates the secure, effective transmission of data.	Baseline documentation should include: 2. CICO's Data Security and Privacy P&P; and 3. CICO's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. 4. Documentation of processes to document a breach in data integrity and any associated corrective actions.
1107	The CICO maintains a history of changes, adjustments, and audit trails for current and past data systems.	Baseline documentation should include Change Management P&Ps.
1108	The CICO complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	Baseline documentation should include: 1. CICO P&P noting compliance with NPI standards, specifications, and requirements. 2. Screenshot of provider data/records illustrating that the NPI data field is populated in provider system.
	C. Claims Processing	
1109	The CICO 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 should include: 1. Claims processing P&P

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		that details claims processing turnaround timeframes, steps for managing pended claims, including turnaround times, and methods for ensuring claims processing accuracy. 2. Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.).
1110	The CICO processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and community-based or facility-based LTSS claims adjustment.	Baseline documentation should include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and community-based or facility-based long term services.
1111	The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation should include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the demonstration. Documentation should highlight the basis for CICO estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by CICO staff without affecting performance standards. Supplemental documentation may include statistics on average claims

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		processed per processor, annual average of claims per enrollee (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity.
1112	The claims system fee schedule includes all medical, community-based or facility-based LTSS, HCBS, Medicare and Medicaid services.	Baseline documentation should illustrate the following: 1. CICO's process and plan for loading and validating the Demonstration fee schedules. 2. Screen shots of the modules where the fee schedules will be configured and identify how medical, community-based or facility-based LTSS and HCBS Medicare, and Medicaid services are captured within the system.
1113	The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over the counter drugs.	Baseline documentation should include: 1. The CICO'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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		and Medicaid over-the-counter drugs for the Demonstration. 2. The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs. 3. Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs.
1114	The CICO's claims processing system applies logic edits to identify erroneous claims.	Baseline documentation should include a description of claims system edits as well as proscriptive and retrospective reporting to identify claims processing trends and anomalies used to identify erroneous claims. Note: If this validation is performed outside of the CICO, please provide evidence of the contract with the external vendor, as well as oversight P&Ps.
	D. Claims Payment	
1115	The CICO pays 90% of "clean medical and LTSS claims" within 30 days of receipt, and 100% attendant care providers (HCBS clean claims) within 7 days of receipt.	Baseline documentation should include: 1. Claims P&P that describes clean claims payment

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		standards. 2. Claims payment report sample that details the average number of days between receipt and payment of current clean claims.
1116	The CICO or its PBM pays Part D 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 CICO pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	Baseline documentation should include: 1. PBM claims P&Ps that describe clean claims payment standards. 2. PBM P&Ps that define interest payments for clean claims that do not meet the processing timeframe standards.
1117	The CICO 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 should include PBM pharmacy network provider P&Ps that detail the timeframe for submission of CICO sponsor claims from long term care facilities.
1118	The CICO's claims processing system checks for pricing errors to prevent erroneous payments.	Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous payments. CICOs should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits. Note: If this validation is performed outside of the CICO, please provide evidence of the contract with the external vendor,

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		as well as oversight P&P.
	E. Provider Systems	
1119	The system generates and maintains records on medical provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. ADA-Accessibility of provider office; and k. Credentialing information.	Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots illustrating where these data elements are captured. Note: if all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications.
	F. Pharmacy Systems	
1120	The CICO or its PBM generates and maintains or ensures that its PBM generates and maintains records on the pharmacy networks, including locations and operating hours where the CICO subcontracts the maintenance of the pharmacy network.	Baseline documentation should include: 1. The CICO or its PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours. 2. A screenshot or sample of how this information is collected, maintained, and made accessible to enrollees.
1121	The CICO or its PBM updates records of pharmacy providers and deletes records of no longer participating pharmacies. The CICO ensures that the PBM performs this function in those instances where the CICO subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the PBM's P&P for updating/maintaining pharmacy provider network information.
1122	The CICO audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a	Baseline documentation should

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	regular basis in those instances where the CICO subcontracts the maintenance of the pharmacy network.	include the CICO's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring.
1123	The PBM can submit Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation should include: 1. The PBM P&P that defines the processes and data submission requirements for Part D PDE reporting. 2. CICO's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.
1124	The PBM ensures that pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits by utilizing unique routing identifiers and enrollee identifiers.	Baseline documentation should include the PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers.
1125	The CICO ensures that the PBM's claims adjudication system: a. Distinguishes between filling prescriptions for Part D drugs and non-Part D drugs; and b. Appropriately meets the 90-day Part D and the non-Part D transitional fill requirements.	Baseline documentation should include: 1. The PBM's P&Ps for supporting the transitional fill requirements. 2. Evidence of systems capability to support both Part D and non-Part D formularies and transitional fill requirements. 3. The CICO's P&P for oversight of the PBM performance on transitional fills.
1126	The CICO's PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can	Baseline document should include

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	the PBM's 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.
	G. Enrollment and Membership Tracking Systems	
1127	The CICO receives, processes, and reconciles in an accurate and timely manner: a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and b. The benefit and enrollment maintenance file from the State.	Baseline documentation should include the CICO's P&P on processing and reconciling enrollment files. Documentation should also include the CICO's enrollment systems schematic that details the daily enrollment processing capacity.
1128	If the CICO receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the CICO submits a 4Rx transaction (TC 72) to CMS' enrollment vendor within 72 hours of receipt of the DTRR. The 4Rx data elements are: a. RxBIN – Benefit Identification Number; b. RxPCN – Processor Control Number; c. RxID – Identification Number; and d. RxGRP – Group Number.	Baseline documentation should include the CICO's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.
1129	The CICO's enrollment/member system includes each of the following data elements: a. Name; b. Date of birth; c. Gender; d. Telephone #; e. Permanent residence address; f. Mailing address; g. Medicare #; h. ESRD status; i. Other insurance COB information; j. Language preference and alternative formats; k. Authorized representative contact information; l. Employer or union name and group number;	Documentation should include screenshots of the CICO's enrollment/member system that confirms each data element listed is available in the system.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	m. Which plan the enrollee is currently a member of and to which CICO the enrollee is changing; n. Option to request materials in a language other than English or in alternate formats; and o. Medicaid #.	
1130	For passive enrollments, the CICO sends the following to the enrollee 30 days prior to the effective date of coverage: a. A CICO-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the CICO; c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the enrollee may begin using CICO services as of the effective date of enrollment.	Baseline documentation should include the CICO's P&P detailing the processes and timeframes for sending the enrollee materials. The CICO should also illustrate how it systematically tracks when these materials are sent, if applicable.
1131	For passive enrollments, the CICO sends the following to the enrollee no later than the last calendar day of the month prior to the effective date of coverage: a. A single ID card for accessing all covered services under the CICO; and b. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the CICO's P&P detailing the processes and timeframes for the single ID card and the Member Handbook (EOC). The CICO should also illustrate how it systematically tracks when these materials are sent, if applicable.
1132	For voluntary enrollments, the CICO provides the following materials to the enrollee no later than ten days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later: a. A comprehensive integrated formulary; b. A combined provider and pharmacy directory; c. A single ID card; and d. A Member Handbook (Evidence of Coverage).	Baseline documentation should include the CICO's P&P detailing the processes and timeframes for sending the enrollee materials. The CICO should also illustrate how they systematically track when these materials are sent.
1133	The CICO maintains a system for tracking and maintaining records on all grievances and appeals, received both orally and in writing, including at a minimum, the date of receipt, final disposition of the grievance, personnel assigned to grievance or appeal, and the date the CICO notified the enrollee of the disposition,	Baseline documentation should include an overview of the membership tracking system used to maintain grievance and appeals and screen shots of the system that identifies the fields for date of receipt, final disposition of the grievance and date the enrollee is notified of the disposition.
	H. Care Coordination and Care Quality Management Systems	
1134	The CICO has appropriate connectivity to *Phoenix,* the State's Case Management System to ensure designated staff can coordinate care for all enrollees.	Baseline documentation should include appropriate steps taken by CICO to coordinate with State to

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		ensure appropriate level of access for designated CICO staff to ensure appropriate coordination of care.
1135	The CICO plan has appropriate connectivity with the State's *Phoenix* system for prior authorization of services, service documentation, service monitoring, web-based reporting, and billing for the State's four waiver programs.	Baseline documentation should include appropriate steps taken by CICO to coordinate with State to support service authorizations, documentation, monitoring and reporting for the State's four waiver programs.
1136	1. The system generates and maintains records necessary for care coordination, including: a. Enrollee data (from the enrollment system); b. Enrollee Waiver status (if applicable); c. Provider network; d. MT membership for specific enrollees; e. Enrollee assessments; f. Individualized Care Plan; g. MT case notes; h. Claims information; i. Grievances and appeals; j. Health record, including medication list; k. Advanced Directives; and l. LTSS back-up or emergency plan, with acuity score.	1. An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements. 2. Description of software solutions (e.g., care management solutions) that will be used to support the systems infrastructure of the care coordination process. This includes documentation of enhancements made to customize systems to facilitate management of the Demonstration population. 3.Screen shots of the application(s) / modules(s) that capture the required data elements (1a.-1k.). 4.Description of processes used to profile, measure and monitor enrollee profiles.
1137	The CICO care coordination/management systems have the capability to print the enrollee's health information and medication list.	Sample print-out of the enrollee's health information and medication list.
1138	The CICO maintains its care coordination system and addresses technological issues as they arise. The CICO must maintain a protocol by which to notify the State of any issues related to *Phoenix.*	Baseline documentation should include the CICO's help desk and application support P&Ps for managing issues related to the care coordination system. Policies should include a protocol by which

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		to notify the State of any issues related to *Phoenix*.
1139	The CICO verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include the CICO's P&P for ensuring data quality in the care coordination system.
1140	The enrollee assessments and plans of care are available to enrollee MT members and any of the enrollee's other providers.	Documentation should include: m. The CICO's P&P for securing and providing access to the care coordination system. n. The CICO's workflow processes for making enrollee assessment and plans of care information available to the enrollee's providers.
1141	The care coordination system includes a mechanism to alert MT members, including the enrollee's PCP, of ED use or inpatient admissions.	Baseline documentation should the CICO's P&P for tracking ED and inpatient admissions and the notification timeframe for alerting the multidisciplinary care team about ED and IP admissions. CICO should include a P&P for ensuring the PCP receives copies of discharge records.
	Utilization Management	
1201	The CICO specifies procedures under which the enrollee may self-refer services.	The UM program descriptions for the CICO explains for which services an enrollee can self-refer.
1202	The CICO defines medically necessary services as services that are: a. For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395y;	The CICO's UM program description includes these definitions of medical necessity.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	i. Are essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity of an enrollee; ii. Are provided at an appropriate facility and at the appropriate level of care for the treatment of the enrollee's medical condition; and iii. Are provided in accordance with generally accepted standards of medical practice. Where there is an overlap between Medicare and Medicaid benefits (e.g., durable medical equipment services), the CICO will apply the definition of medical necessity that is the more generous to the enrollee of the applicable Medicare and South Carolina's Medicaid standards.	
1203	The CICO defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.	The UM program description for the CICO defines the review criteria, information sources, and processes used to review and approve the provision of services and prescription drugs.
1204	The CICO has policies and systems to detect both under- and over-utilization of services and prescription drugs. Systems should include, among other elements: a. A polypharmacy component; and b. A medication reconciliation component.	The UM program description for the CICO includes these elements for the CICO and the CICO's PBM.
1205	The CICO 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 CICO 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 CICO: a. Outlines its process for authorizing out-of-network services; and b. If specialties necessary for enrollees are not available within the network, the CICO will make such services available out-of-network.	Out-of-network service authorization P&P explains how an enrollee or provider may obtain authorization for a service being provided by a provider outside of the CICO's network.
1207	The CICO describes its processes for communicating to all providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		authorization requirements and procedures. The CICO's provider materials describe prior authorization requirements and procedures.
1208	The CICO policies for adoption and dissemination of practice guidelines require that the guidelines: a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the CICO's members; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and member education and service coverage.	The CICO's practice guidelines P&P include these requirements.
1209	The CICO 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 CICO's UM program describes the type of communications sent to enrollees, regarding their receipt or denial of referrals of service authorizations.
1210	For the processing of requests for initial and continuing authorizations of covered services, the CICO shall: a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consult with the requesting provider when appropriate.	The UM program descriptions for the CICO 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 CICO ensures that prior authorization requirements are not applied to: a. Emergency services, including emergency; behavioral health care; b. Urgent care; c. Crisis stabilization, including mental health; d. Family planning services; e. Preventive services; f. Communicable disease services, including STI and HIV testing; and g. Out-of-area renal dialysis services.	The UM program descriptions for the CICO lists those services that are not subject to prior authorization and this list is consistent with the required elements.
1212	The CICO follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §422.568, 422.570 and 422.572.	The UM program description for the CICO includes these

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	For overlap services, the CICO follows the three-way contract.	requirements.
1213	Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's medical condition, performing the procedure, or providing the treatment.	The UM program description for the CICO includes this requirement. Resumes for staff who review coverage decisions show that these staff have appropriate competencies to apply CICO policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate training and experience caring for older adults to conduct this function.
1214	The CICO ensures that a physician and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees out of the emergency department, if necessary.	The UM program description for the CICO states that a physician and behavioral health provider are available 24 hours a day, seven days a week for timely authorization of medically necessary services and to coordinate transfer of stabilized enrollees in emergencies.