FIDA Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management
(Also known as the "IDT Policy")

REVISED: 12/9/15. Effective Immediately.

I. INTRODUCTION

This policy specifies how Assessment, person-centered service planning and authorization, and ongoing care management will work in the FIDA Demonstration. Under the FIDA Demonstration, FIDA Plans are required to use an Interdisciplinary Team (IDT) approach to person-centered services planning and ongoing care management activities. This policy describes the requirements for that IDT Approach.

II. FIDA PLAN RESPONSIBILITIES

The FIDA Plan must establish, implement, and maintain written policies and procedures for operation of Interdisciplinary Teams that meet the requirements of this document. These policies and procedures shall specify, but not be limited to: 1) mechanisms, tools, and timeframes for IDT interactions and 2) any policies and procedures necessary for permitting the exchange of information between the IDT, providers, and Participants and their caregivers in a manner consistent with confidentiality requirements.

III. COMPREHENSIVE ASSESSMENT OF FIDA PARTICIPANTS

A. Comprehensive Assessment Required

Each Participant will receive, and actively participate in, a timely Comprehensive Assessment of their medical, behavioral health, long-term services and supports (LTSS), and social needs. The Assessment shall be completed by an RN on staff, or under contract with, the FIDA Plan.

B. Assessment Tool

The FIDA Plan Registered Nurse (RN) must use the NYSDOH Approved Assessment, which will be the Uniform Assessment System for NY (UAS-NY), to conduct the Assessment. The Assessment must cover at least the following domains: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Participants' preferences, strengths, and goals. The FIDA Plans' Assessment RN shall use relevant and comprehensive data sources when completing the Assessment, including the Participant, providers, and family/caregivers. The Assessment results will be used a) to confirm the appropriate acuity or risk stratification level for the Participant, and b) as the basis for developing the integrated, Person-Centered Service Plan (PCSP). The Assessment RN must be accessible to each Participant's IDT for any follow-up or clarifying questions regarding the Assessment.

C. Timing of Comprehensive Assessment

Participants enrolling from the sister MLTC Plan of the FIDA Plan must be assessed no later than 6 months from the date of their last MLTC assessment (UAS). For these Participants with a pre-FIDA assessment, FIDA Plans must contact Participants and review any available medical record and claims history of that Participant to ensure that there are no changes in the Participant's health status and needs that would trigger the necessity for an updated assessment. All other Participants must be assessed in a timely manner so that their PCSP can be developed and implemented within 90 days following their effective date of enrollment. The FIDA Plan must also perform the UAS at any time upon the request of the Participant. All assessments must be performed by a FIDA Plan staff or contract RN in the individual's home, hospital, nursing facility, or any other setting in which the Participant resides, using the NYSDOH Approved Assessment.

For purposes of Reporting Requirements Core 2.1 and 2.2, FIDA Plans will report prior assessments that were completed prior to FIDA Plan enrollment as having been completed in the first month of FIDA enrollment.

IV. INTERDISCIPLINARY TEAM

A. Interdisciplinary Team Approach

FIDA Plans are required to offer Participants an IDT approach to providing an individualized, comprehensive care planning process in order to maximize and maintain every Participant's functional potential and quality of life.

For each Participant, an individually tailored IDT, led by an accountable Care Manager at the FIDA Plan, will ensure the integration of the Participant's medical, behavioral health, community-based or facility-based LTSS, and social needs. The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. Within 45 days of the Participant's effective date of enrollment in the FIDA Plan, the FIDA Plan Care Manager shall meet with the Participant to learn about the Participant's preferences for an IDT, IDT members, and the IDT members' level of participation. The Care Manager will use this information to tailor an IDT for this Participant.

B. Interdisciplinary Team Authority and Decision-Making Role

Before the initial PCSP is developed by the IDT, service authorizations may be made by the FIDA Plan through the utilization management process. After the PCSP is developed by the IDT, care decisions included therein, act as service authorizations as long as members of the IDT are able to make such authorizations within their scope of practice. Primary care providers may choose not to participate in IDT meetings but, if willing, can review and sign off on the completed PCSP. These service authorizations may not be modified by the FIDA Plan except in cases where the Participant (or providers, designees, and/or representatives on behalf of the Participant) appeals the IDT service authorizations. In these cases, the Plan may modify the service authorizations consistent with the appeal decision. The Participant may appeal any IDT decision, regardless of whether the Participant agreed to the decision. During the meeting, the IDT authorizes both ongoing service plan care and services that must be adhered to by the FIDA Plan. Any services included in the PCSP that

are outside of the scope of practice of the members of the IDT that participated in the PCSP development will be authorized by the plan through the utilization management process.

The IDT must convene routinely, and no more than 6 months from the previous IDT meeting. These meetings may occur more frequently, as the IDT must reconvene after a Comprehensive Reassessment, which may be triggered by certain events, as described in Section X.

Between IDT meetings, the FIDA Plan makes any necessary service authorizations through its utilization management process. In order to ensure that Participants receive timely access to needed services, the FIDA Plan must authorize any services in line with, or in addition to, the services outlined in the current PCSP, except as listed in Section VII.B and VII.C. FIDA Plans must also follow the authorization timeframes set forth in the Three-Way Contract. Both the IDT and the FIDA Plan will make coverage determinations, and render service authorizations, with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

C. Interdisciplinary Team Composition

A Participant's IDT must be comprised of the following individuals:

- Participant and/or, in the case of incapacity, an authorized representative; and
- The FIDA Plan Care Manager.

At the Participant's choice, the Participant may have the FIDA Plan Care Manager invite the following additional individuals to participate in any or all of their IDT meetings or to review and approve the PCSP:

- Participant's designee(s);
- Primary Care Provider (PCP) (as defined in the Three-Way Contract) or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant. Where a Specialist has been designated as the PCP through the Participant's PCSP in accordance with the Three-Way Contract, this Specialist may serve as PCP on the IDT. The designee can be a Physician extender who is defined in the Three-way Contract as:
    - A Nurse Practitioner licensed by the State of New York or a Physician Assistant who is licensed by State Education Department, Office of the Professions; or
    - A Registered Nurse, if the RN has clinical knowledge of the Participant.
- Behavioral Health Professional, if there is one, or a designee with clinical experience from the Behavioral Health Professional's practice who has knowledge of the needs of the Participant;
- Participant's home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of the needs of the Participant;
- Participant's nursing facility representative who is a clinical professional, if receiving nursing facility care; and
- Other providers either as requested by the Participant who may be recommended by other IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee, such as the RN who completed the assessment.

The FIDA Plan Care Manager is the IDT lead and facilitates all IDT activities. The Care Manager may request information from the Plan's Utilization Management (UM) staff, such as information about medical necessity, clinical guidelines, or evidence-based best practices. The UM staff, however, may not participate in IDT meetings, and should not be deemed members of the IDT.

Participation in each IDT meeting should reflect the needs, wishes, and goals of the Participant.

D. IDT Meetings, the Decision-Making Process, and Standards of Practice

When meeting for the purpose of creating or revising the PCSP, the Care Manager is responsible for scheduling the IDT meeting at a time convenient to all IDT members with current goals and objectives related to the Participant and any proposed changes to the PCSP.

The IDT must create the PCSP within 90 days of enrollment. The IDT shall evaluate the PCSP no more than 6 months after the IDT's previous meeting and within 30 days of any Comprehensive Reassessment. Note that if the IDT is required to convene sooner than 6 months due to a trigger event, the IDT meeting schedule will reset and the next routine IDT meeting will not need to occur until 6 months from the date of that meeting or until another trigger event, whichever is sooner.

IDT members must operate within their professional scope of practice, appropriate for responding to and meeting the Participant's needs, and complying with the State's licensure/credentialing requirements. Each member of the IDT must meet the applicable state, federal, or other requirements for his/her profession. The IDT is highly encouraged to work collaboratively, soliciting input from all members and reaching consensus regarding specific treatment decisions that consider the Participant's specific preferences and needs across multiple domains. When a care decision is required to be made by a provider with a certain licensure and/or certification under the applicable laws and regulations of New York State, the ultimate decision always rests with the appropriately licensed and/or certified treating member(s) of the IDT or with the FIDA Plan via its UM process if such a provider is not participating in the IDT meeting in which the decision is proposed.

E. IDT Ongoing Communication

Each Participant's IDT determines its own methods and processes for candid and complete communication amongst and between its members. Plans are responsible for effective and efficient information-sharing among providers even when they do not participate in the IDT or in a given meeting of the IDT, including sharing any revisions to the PCSP. Participants and their designated family members/caregivers (who are current IDT members) must be provided with contact information (which is regularly updated) for all other members of the IDT. FIDA Plans must share Care Manager contact information with primary care providers and other key providers for Participants.

F. Participant Involvement on IDT

To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the PCSP must clearly outline which services the

Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are obtained as called for in the PCSP.

To the extent that the Participant is able, willing, and agreeable to participate in IDT meetings, in scheduling and arranging meetings for the IDT members, the Care Manager and other IDT members must reasonably accommodate the needs and schedule of the Participant (and home care aide(s)) to help ensure that he/she can be available to attend PSCP meetings.

G. Interdisciplinary Team Member Training

FIDA Plans must encourage IDT members to participate in the approved training on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles. The training is voluntary and available through the following link: https://www.resourcesforintegratedcare.com/sites/default/files/FIDA-Provider-Training-QA.pdf.

H. IDT Coordination of FIDA Plan and Other Available Services for Participant

As appropriate, the IDT shall coordinate care for Participants with:

- the court system (for court ordered evaluations and treatment outside the FIDA Plan's Covered Items and Services, see Section 1.44 of the Three-Way Contract);
- specialized providers of health care for the homeless (if the Participant is homeless or has become homeless and this is necessary while the IDT is working to help the Participant secure housing), and other providers of services for victims of domestic violence;
- family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers;
- WIC;
- programs funded through the Ryan White CARE Act;
- other pertinent entities that provide services out of network; local governmental units responsible for public health, mental health, mental retardation or Chemical Dependence Services; and
- local government Adult Protective Services and Child Protective Services programs.

Coordination may involve mechanisms to ensure coordinated care for Participants, such as protocols for reciprocal referral and communication of data and clinical information on Participants.

V. Care Manager

A. Care Manager Selection

During the enrollment process, Participants with existing Care Managers (from MLTC, for example) may select the same Care Managers to be their FIDA Plan Care Managers and to the extent that the Care Manager is also available in the FIDA Plan and that the Care Manager's caseload permits, the FIDA Plan must honor that Care Manager request. Participants that do not indicate a choice of Care

Manager will be assigned a FIDA Plan staff or contract Care Manager who has the appropriate experience and qualifications to address the Participant's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers). A Participant has the right to choose a different Care Manager and change her/his Care Manager at any time. At all times, the FIDA Plan must ensure that the Care Manager's caseload is reasonable to provide appropriate care coordination and care management.

B. Care Manager Qualifications

Care Managers must have knowledge of physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS), frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.

C. Care Manager Responsibilities

The Care Manager is responsible for leading and coordinating the efforts of the IDT, for coordination the care of the Participant, and for overseeing the development and implementation of the PCSP. The precise tasks involved with carrying out the PCSP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager.

Upon the occurrence of a trigger event, as described in Section X, the Care Manager must notify the IDT, and ensure that a Comprehensive Reassessment will be conducted within the appropriate timeframe.

D. Care Manager Education and Support of Participant

The IDT must:

- Educate, empower and facilitate the Participant to make choices and to exercise his or her rights and responsibilities, including the opportunity to participate in Consumer Directed Personal Assistance Services (CDPAS);
- Ensure that the Participant is provided the right to transition from an inpatient setting to the least restrictive setting as appropriate;
- Provide information and explanation using plain language understandable to the Participant and/or caregiver;
- Provide the supports necessary for the Participant to keep doing things he or she enjoys and remain engaged in his/her community;
- Provide education to the Participants and families regarding health and social needs such as housing, nutrition and transportation;
- Assess and assist Participants in identifying and addressing quality of life issues;
- Provide links/coordination/integration with care providers and community organizations across settings;
- Assist Participants in accessing reasonable accommodation and accessible providers;

- Assist the Participant and/or designated representative in understanding the disease process, chronic illness, and/or disability and realizing his/her role as the daily self-manager.

VI. INITIAL SERVICE PLAN

A. Person-Centered Service Plan Required

Person-centered service planning is the process of creating and implementing a written Person-Centered Service Plan (PCSP) with and for the Participant. It includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. PCSPs must contain measureable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences.

B. Transition to FIDA PCSP

During a Participant's transition to a FIDA Plan, whether from Medicaid Fee-For-Service (FFS), NHTD Waiver, MLTC, Medicare FFS, Medicare Advantage plan, Part D plan or from another FIDA Plan, the Participant will continue to receive services, including any community-based or facility-based LTSS, in their pre-existing service plan (the service plan in place prior to enrollment in the FIDA Plan). The Participant's pre-existing service plan must be honored, as written, for 90 days or until the PCSP is finalized and implemented, whichever is later. For Participants who reside in a Nursing Facility, the FIDA Plan must allow him or her to maintain his or her current Nursing Facility Provider for the duration of the Demonstration. In addition, the FIDA Plan shall allow Participants who are receiving Behavioral Health Services to maintain current Behavioral Health Service Providers (i.e., Participating and Non-Participating) for the current Episode of Care. (See Section 1.62 of the Three-Way Contract for the definition of Episode of Care.) The IDT (if it includes members with the appropriate scope of practice) or the FIDA Plan (if the IDT does not include the appropriate scope of practice) may review a current Episode of Care to determine whether it needs to be continued with the Behavioral Health Service Provider that was providing services before the Participant's Enrollment in the FIDA Plan. This requirement will be in place for a period not to exceed two (2) years from the date of a Participant's Effective Date of Enrollment and applies only to Episodes of Care that were ongoing during the transition period from FFS to Enrollment in a FIDA Plan.

During this transition, the FIDA Plan will adhere to all transition requirements for services outlined in the Three-Way Contract.

C. Timing of Person-Centered Service Plan

The PCSP must be completed for each Participant by and with that Participant's IDT within 30 days of the FIDA Plan completing an initial Comprehensive Assessment and each Reassessment. For Participants enrolling in the FIDA Plan from a sister MLTC Plan, the PCSP must be completed within

90 days of the effective date of enrollment. Prior to the initial care planning meeting, service authorizations related to new needs for service shall be made by the FIDA Plan.

D. The PCSP as Authorization

Once a service or treatment has been agreed to, and entered into the PCSP, that service or treatment is authorized for six months and/or the duration of the care plan. The FIDA Plan may not disallow any service or treatment authorized in the PCSP. The FIDA plan may not deny items in the PCSP for lack of a PCP's order accompanying the PCSP. The FIDA Plan must have an appropriately licensed UM staff physician perform the UM review and provide the requested order, modify, or deny it. Any additional services needed that are not addressed by the IDT members who meet to develop the PCSP are subject to the FIDA Plan's utilization management process, as more fully described in Section VII. If a particular licensed professional is required to approve a service or treatment and none of the individuals who participated in the PCSP development process have such licensure, those services or treatments must be authorized through the FIDA Plan's utilization management process.

E. Service Planning Process

The IDT meeting should be conducted in person if and when possible. The Care Manager will schedule the meeting at a time agreeable to the participant and convenient to the members of the IDT. When in-person meetings are not possible, those IDT members should participate telephonically or by video conference. In instances when all members of the IDT cannot meet at the same time and the Participant does not request that all IDT members meet at the same time, the Care Manager can meet separately with the IDT members and ensure the PCSP is shared with all IDT members for review and approval. The PCSP is to be drafted by the IDT members through the IDT meeting process. The Care Manager shall come prepared to present information he/she has available about prior service plans, current needs, and more, but shall not come to the meetings with a proposed or draft PCSP to present to the IDT members for their review.

During each PCSP planning meeting, the IDT should:

- Review the purpose of the meeting;
- Review and discuss the most recent Assessment, EHR/medical records/progress notes, and existing service plan;
- Identify Participant requests, including those that accord religious or cultural beliefs;
- Provide information about the Participant specific to each discipline and expertise;
- Review the medication plan, including existing prescriptions, for polypharmacy and opportunities for medication dosage reduction and/or elimination;
- Identify who is responsible for implementation of each element of the care plan;
- Review advance directives;
- When a Participant is determined to be likely to require a level of care provided in a nursing facility (i.e., nursing home level of care), inform the Participant and/or his/her designee of any feasible alternatives and offer the choice of either institutional or home and community-based services;

- Discuss with the Participant his/her choice to direct their own services through the consumer-directed personal assistance option and how this could work and if Participant has chosen to self-direct discuss the Participant obligations related to this choice; and
- Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the Participant and other providers as appropriate.

The Participant always has a right to appeal PCSPs and other service authorization decisions through the FIDA Plan appeal process.

F. Coordination with Conditions of Participation

For Participants who are receiving facility-based LTSS (such as in a nursing facility), the service planning process must be coordinated with the existing service planning processes within the facility. The FIDA IDT and PCSP processes do not supplant the facility's pre-existing responsibilities around service planning and care management, however, the pre-existing responsibilities do not negate the requirement for the IDT and PCSP processes to occur for all FIDA Participants. The Care Manager will be the accountable lead on coordinating the activities around the facility and FIDA requirements.

The Care Manager must also work with other certified providers whose conditions of participation require service planning and must ensure that these activities are coordinated with the FIDA required service planning activities.

G. PCSP Form

The FIDA Plan must develop a PCSP form to be used by all IDTs in developing a Participant's PCSP. The form must include a space for the IDT members to sign and date the PCSP and must include language clearly specifying the following:

1. The right of the Participant to appeal a PCSP,
2. That signing the PCSP does not preclude appeal, and
3. Instructions for requesting an appeal.

Each member of the IDT, including the Participant and designee(s) should approve the PCSP. Acceptable methods of approvals from IDT members, including the Participant, are (1) verbal, but noted in the PCSP with the date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person, or (4) wet signature on the PCSP. In addition, each member of the IDT shall receive a written copy (hard copy or electronic) of the final PCSP.

H. PCSP Content

The PCSP must specify the care and services needed to meet the Participant's known and anticipated medical, functional, social, and cognitive needs identified in the initial Comprehensive

Assessment. The PCSP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA Plan. The PCSP must specify:

- All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions;
- All current medications taken by the Participant;
- For each need identified, the PCSP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the individual responsible for conducting the interventions and monitoring the outcomes;
- All services authorized and the frequency and duration of the services authorized including any services that were authorized by the FIDA Plan since the last PCSP was finalized and that need to be authorized moving forward;
- A schedule of preventive service needs or requirements;
- Participant's long and short-term goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines; and method and frequency of evaluating progress toward goals;
- Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's highest feasible level of well-being;
- Participant decisions around self-directed care and whether the Participant is participating in CDPAS;
- Communications plan for IDT members for the six months/duration of the care plan;
- How technology and telehealth will be used;
- Known needed physical and behavioral health care and services;
- Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.);
- Right of the Participant to appeal a PCSP, including the steps for how to request an appeal;
- The Participant's consent to Money Follows the Person participation;
- Participant choice of service providers;
- Individualized back-up plans;
- Participant's informal support network and services;
- Participant's need for and plan to access community resources and non-covered services, including any reasonable accommodations; and anything else appropriate for the needs of the Participant; and
- Participant's goals for the least restrictive setting possible, if they are being discharged or transitioned from an inpatient setting.

I. PCSP Documentation

The PCSP is a comprehensive care plan. For this reason, the IDT should include items and services in the PCSP as noted in Section VI.H. above, as well as any appropriate items and services listed in section VII.B and/or VII.C, even though these items and services do not require authorization. For example, if the IDT determines that the Participant should receive a regimen of daily low dose aspirin, that regimen should be recorded in the PCSP, even if authorization is not required.

VII. AUTHORIZATION OF FIDA COVERED ITEMS AND SERVICES

The Covered Items and Services listed in Section VII.B are items and services that require neither IDT authorization, FIDA Plan authorization, nor authorization from any other providers.

The Covered Items and Services listed in Section VII.C are items and services that do not require IDT or FIDA Plan authorization but do require authorization by a specialist.

Other than the services listed in VII.B and VII.C, all items and services must be authorized by either the IDT or the FIDA Plan. As indicated above in Sections IV.B and VI.C, the IDT is able to authorize items and services through the PCSP development process up to the limits of the scope of practice of the professionals who participate. Any items or services indicated in the most recent version of the PCSP are authorized by virtue of the IDT's agreement to the PCSP, if the services are within the scope of practice of the IDT members participating in the PCSP development. The services will remain authorized until the IDT changes the PCSP so that those services are no longer indicated. There shall be no additional internal or external review of the PCSP within the FIDA Plan. If the PCP or other treating physicians do not participate in the IDT or review and approval of the PCSP, physician ordered services must be authorized by the FIDA Plan through their utilization management process. These services become part of the Participant's PCSP. In addition, between IDT meetings, the FIDA Plan is responsible for authorizing items and services not indicated in the PCSP. These services become part of the Participant's comprehensive health record and are added to the current PCSP. The FIDA Plan must designate in the PCSP which services were authorized via the IDT versus the utilization management process. All service authorizations shall be made with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

In the event that the need for services is a change of condition that would prompt a Comprehensive Reassessment in accordance with Section X below, the Comprehensive Reassessment and PCSP update/revision process will begin immediately and will take place in accordance with the timeframes outlined in Sections X.A. and XI.A.

A. Specificity of the PCSP Service Authorizations

In drafting the PCSP for services within the scope of practice of IDT members, the IDT should consider the following: The PCSP should specify amounts or durations of services. For example, if the Participant is in need of personal care, the number of hours during which a personal care attendant will stay with the Participant each day should be specified. However, not all authorizations have to be as precise. The IDT may provide non-specific authorizations as appropriate. An example might be that the IDT authorizes the Participant to receive transportation to medical appointments. The IDT might authorize the nature of the transportation or the need for an aide during transportation but, the IDT would not need to specify the precise number of trips ahead of time, when the precise number of medical appointments during the PCSP period is likely unknown.

B. Items and Services That A Participant May Access Directly (and Without Prior Authorization or Approval)

The following items and services may be directly accessed and obtained by the FIDA Participant without review and without prior authorization or approval:

1) Emergency or Urgently Needed Care, including emergency behavioral health care;
2) Out-Of-Network Dialysis when the Participant is out of the service area;
3) Primary Care Doctor visits;
4) Family planning and Women's Health specialists' services;
5) For any Participant that is an Indian eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services;
6) Public health agency facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB/DOT);
7) Immunizations;
8) Palliative Care;
9) Other Preventive Services;
10) Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services;
11) Dental Services through Article 28 Clinics Operated by Academic Dental Centers;
12) Cardiac Rehabilitation, first course of treatment (a physician or RN authorization for subsequent courses of treatment);
13) Supplemental Education, Wellness, and Health Management Services; and
14) Prescription drugs:
    a. which are on the formulary, or
    b. which are not on the formulary, but where a refill request is made for an existing prescription within the 90-day transitional period.

Specialists' visits themselves may be prior authorized by the IDT (if within the IDT members' scope of practice) or the FIDA Plan (if outside the IDT members' scope of practice), as appropriate for the Participant's condition, but in multiple visit authorizations and not in single visit increments. FIDA Plans may not require authorization for single visits to specialists due to the special needs of FIDA Participants. Instead, access to specialists should be authorized by the IDT or the FIDA Plan through standing authorization or through pre-approval of a fixed number of visits to the specialist.

C. Services that Must Be Authorized by a Specialist (not the IDT or FIDA Plan)

The following items and services must be authorized by the specialist indicated and cannot be authorized by the IDT or the FIDA Plan. These items and services do not need to be included in the PCSP.

(1) Preventive Dental X-Rays – These require Dentist authorization.
(2) Comprehensive Dental – These services require Dentist authorization.
(3) Eye Wear – These require Optometrist or ophthalmologist authorization.
(4) Hearing Aids – These require Audiologist authorization.

D. Before Assembly of the IDT Team

Within 45 days of the Participant's effective date of enrollment in the FIDA Plan, the FIDA Plan Care Manager shall meet with the Participant to learn about the Participant's preferences for an IDT, IDT members, and the IDT members' level of participation. The Care Manager will use this information to tailor an IDT for this Participant.

E. Prescription Drugs

IDT approval is not required for drugs, however, the IDT (if within IDT members' scope of practice) may authorize drugs as part of the PCSP development process and, at a minimum, is required to discuss and incorporate a list of medications in use by the Participant within the PCSP. Whether during transition to a FIDA Plan or otherwise, if a Participant goes to the pharmacy with a drug prescription and the drug appears on the formulary and no prior authorization is required, the prescription should be filled. If the drug requires a prior authorization and one is on file, the prescription should be filled. If the drug requires an authorization and no authorization is on file, the Pharmacy Benefit Manager (PBM) can provide authorization.

In the case where a request for a non-formulary drug occurs during the transition period as described in Section VI.B, and the request is for a refill of an existing prescription, the FIDA Plan must authorize the request.

VIII. RIGHT TO APPEAL

To the extent that the Participant does not agree with the PCSP or any coverage determination the Participant may appeal in accordance with the appeal process outlined in the Three-Way Contract. The PCSP must always be issued with either Integrated Coverage Denial Notice (ICDN) model #1 or ICDN model #2 which include language clearly specifying the right of the Participant to appeal a PCSP, including the steps for how to request an appeal.

IX. CARE MANAGEMENT AND SERVICE DELIVERY OVERSIGHT

A. Care Management Role of IDT

The Care Manager must ensure that the Participant receives the items and services the Participant needs, including those called for in his/her PCSP. The care management system includes processes for:

- Sharing clinical and treatment plan information;
- Obtaining consent to share confidential medical and treatment plan information among providers consistent with all applicable state and federal law and regulation;
- Providing Participants with written notification of authorized services;
- Enlisting the involvement of community organizations that are not providing covered items and services, but are otherwise important to the health and well-being of Participants; and
- Assuring that the organization of and documentation included in the care management record meet all applicable professional standards.

B. Documenting Care Needs and Service Delivery

Separate from the PCSP, the Care Manager on behalf of the FIDA Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members:

- Appropriate identifying information.
- Documentation of all services furnished, including the following:
- A summary of emergency care and other inpatient or long-term care services.
- Items and services furnished by Network and Out-Of-Network providers.
- Current and past Comprehensive Assessments, Reassessments, PCSPs, and any file notes that include the Participant's response to treatment.
- Laboratory, radiological and other diagnostic test reports.
- Medication records.
- Skilled nursing facility / nursing facility to hospital transfer forms, if applicable.
- Hospital discharge summaries, if applicable.
- Reports of contact with informal support (for example, caregiver, legal guardian, or next of kin).
- Physician orders.
- Discharge summary and disenrollment justification, if applicable.
- Advance directives, if applicable.

The FIDA Plan shall establish, maintain, and require its providers to maintain a medical record for each member that is consistent with current professional standards and shall use this to document all care provided. At a minimum, the providers should maintain accessible notes, charts, and records of the items and services provided. Notes included in shared electronic health records should detail the care delivered by providers throughout the period covered by the PCSP.

The notes should give sufficient information to enable other providers to know what care has been given to the Participant. The notes should also explain the details of the encounter and the clinical judgment applied so that subsequent care enhances therapy without redundancy or contravention and inform the IDT's patient-centered care planning.

At any time, the Participant may request a copy of the current PCSP or comprehensive health record. The Care Manager must ensure that a written copy of the current PCSP and/or comprehensive health record is furnished to the Participant upon such request. The Participant may choose to receive the PCSP and/or comprehensive health record electronically or by mail.

X. COMPREHENSIVE REASSESSMENT

A. Timing of Comprehensive Reassessments

The FIDA Plan must conduct a Comprehensive Reassessment at least once within every six (6) month period after the initial Assessment. A Comprehensive Reassessment must be performed no more than 30 days after a request (verbally or in writing) of the Care Manager by the Participant, his/her Designee or Authorized Representative, or his/her Provider. Lastly, the FIDA Plan must ensure that, upon the occurrence of any of the trigger events listed below, a Comprehensive Reassessment is performed as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, and in no case more than 30 days after the occurrence of any of the following:

- A change in health status or needs of the Participant due to:
    - A hospital admission;
    - Transition between care settings;
        - For example, when Participants are in a hospital awaiting discharge because of a need for nursing facility placement authorization, the IDT or FIDA Plan shall provide any prior authorizations for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery;
    - Change in functional status;
    - Loss of a caregiver;
    - Change in diagnosis; OR

- As requested by a member of the IDT who observes a change in functional status including one observed by a member of the IDT.

In situations where a transition between care settings is to occur, a Comprehensive Reassessment may be conducted within a 48-hour period before the transition or within 30-day period after the discharge.

For purposes of the Comprehensive Reassessment of Participants in this Demonstration, a "change in diagnosis" occurs when a Participant is diagnosed with a health condition that is not a self-limiting, temporary health condition, or a condition that will not normally resolve with standard medical attention within a one to two week period. In the event of a temporary health condition, the Participant is expected to return to baseline within this short one to two week period of time and, thus, a Comprehensive Reassessment is not required unless the temporary health condition has not resolved as it should have by the end of the two weeks. One example would be a sinus infection. In the event of a Participant getting a sinus infection, the PCSP is not required to be updated to reflect the several days use of prescription medication. On the other hand, if a Participant was hospitalized for a decubitus ulcer it is expected that the PCSP would be updated to monitor for and prevent against decubiti.

The Comprehensive Reassessment must be performed by an Assessment RN who is not the Participant's Care Manager. Upon the occurrence of a Comprehensive Reassessment, the IDT must meet and make any necessary updates to the PCSP within 30 days or as soon as required by the circumstances or as soon as clinically indicated.

XI. PERSON-CENTERED SERVICE PLAN (PCSP) REVISIONS AND UPDATES

A. PCSP Updates

PCSP updates must occur within 6 months of the previous PCSP authorization or sooner in accordance with the timeframes outlined above in Section X. The Participant's IDT may meet in person, telephonically, or by video-conference to discuss and review the Participant's status, existing Person-Centered Service Plan, and Comprehensive Reassessment and, if necessary, will revise the Participant's PCSP. In instances where all members of the IDT cannot meet at the same time, the Care Manager may have a separate meeting with that individual(s) and ensure the PCSP is shared with all IDT members for review.

B. PCSP Update/Revision Process

As described above in Section XI.A, updates to the PCSP are made through IDT meetings. If the Participant chooses, these meetings should be in person. Where in-person meetings are not used, those IDT members should participate telephonically or by video conference.

Updates are made directly to the PCSP in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems should be retained for monitoring. The rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the PCSP.

The PCSP is routinely updated as the IDT monitors the Participant's health status. The IDT members meet for updates and revisions and complete service planning steps as outlined above.

When a Participant is determined to be likely to require a level of care provided in a nursing facility (i.e., nursing home level of care), the Care Manager and/or IDT informs the Participant and/or his/her representative of any feasible alternatives and offers the choice of either institutional or home and community-based services.

C. PCSP Update/Revision Form

The IDT must generate a new printable PCSP, or update an existing one (as long as the final form will be an easily readable, understandable document), for any PCSP update or revision. Each IDT member (including the Participant) must approve the updated or revised PCSP. Acceptable methods of approvals from IDT members for an update or revision to a PCSP, including the Participant, are (1) verbal, but noted in the PCSP with a date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person or (4) wet signature on the PCSP. The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not necessarily that they agreed with the ultimate care plan that was reached. In addition, the Care Manager must document and attest that the final PCSP accurately reflects the scope of what the IDT members approved. The updated or revised PCSP must be printed and provided to the Participant and his/her designee along with language clearly specifying the right of the Participant to appeal a PCSP update or revision, including the steps for how to request an appeal.

XII. QUALITY OF THE IDT PROCESSES AND ONGOING MONITORING

The New York State Department of Health and CMS will assess the performance of the FIDA Plan's IDT model against the following existing measures:

a. In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers? (Source: CAHPS, Item OHP3)
b. How satisfied are you with the help you received to coordinate your care in the last 12 months? (Source: CAHPS, Item OHP5)
c. Percent of Participants discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason (Source: NCQA/HEDIS)
d. Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented. (Source: NCQA/HEDIS)
e. Percent of all Participants who saw their primary care doctor during the year (Source: HEDIS)
f. Follow-up After Hospitalization for Mental Illness (Source: NCQA/HEDIS)
g. Reporting of the number of nursing home certifiable Participants who lived outside the nursing facility (NF) during the current measurement year as a proportion of the nursing home certifiable Participants who lived outside the NF during the previous year (Source: NYSDOH)
h. Percent of Participants in the FIDA Demonstration who reside in a nursing facility, wish to return to the community, and were referred to preadmission screening teams or the Money Follows the Person Program (Source: NYSDOH)

The FIDA Plan Contract Management Team will also continue to monitor IDT operations.

The FIDA Plan must continue to meet the Medicare-Medicaid Plan Model of Care elements and follow the existing process for updating their Models of Care to reflect changes to the IDT Policy.