FIDA Demonstration Requirements for Assessment, Service Planning and Authorization, and Ongoing Care Management

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, the Interdisciplinary Team (IDT) conducts the person-centered services planning and participates in ongoing care management activities. The IDT also makes coverage determinations, authorizing FIDA Demonstration Covered Services as described in Sections IV.B, VI.C, and VII.

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 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, and the RN may participate on the IDT with the Participant's approval.

C. Timing of Comprehensive Assessment

Upon enrollment in the FIDA Plan, all Participants will receive a Comprehensive Assessment to be completed no later than 60 days from the individual's enrollment effective date for community-based and facility-based individuals who are passively enrolled on or after January 1, 2015. For all other individuals enrolled into the FIDA Demonstration, upon enrollment in the FIDA Plan, Participants will receive a Comprehensive Assessment to be completed no later than 30 days from the individual's enrollment effective date. This initial Assessment must be performed by a FIDA Plan staff or contract Registered Nurse (RN) in the individual's home, hospital, nursing facility, or any other setting using the NYSDOH Approved Assessment.

IV. INTERDISCIPLINARY TEAM

A. Interdisciplinary Team Required

FIDA Plans are required to use an IDT approach to providing each Participant with 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. The FIDA Plan, through the Care Manager and in consultation with the Participant (and/or the Participant's Designee and/or Authorized Representative), must identify the individuals who will be on the Participant's IDT. The IDT members should be identified as soon as possible. For Participants who are passively enrolled after January 1, 2015, IDT members should be identified within 60 days from the individual's enrollment effective date. For all other Participants (i.e. opt-in), the IDT members should be identified no later than 30 days from the individual's enrollment effective date. The Participant's Assessment will occur either 30 or 60 days after enrollment (as per Section III.C), and the IDT then has 30 days from the initial Assessment to develop the Participant's PCSP (as per Section VI.B).

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. 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. Notwithstanding the above, between IDT meetings, the FIDA Plan may authorize services in addition to those included in the PCSP as needed.

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 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. 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;
- Participant's designee(s), if desired by the Participant;
- Primary Care Provider (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the needs 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;
- FIDA Plan Care Manager;
- 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, if the Participant is receiving home care and approves the home care aide/designee's participation on the IDT;
- Participant's nursing facility representative who is a clinical professional, if receiving nursing facility care; and
- Additional individuals including:
    - Other providers either as requested by the Participant or his/her designee; or as recommended by the IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee; or
    - The RN who completed the Participant's Assessment, if approved by the Participant and/or his/her designee.

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.

The IDT must at all times meet the minimum requirements outlined above. Additional clinical staff, such as physician specialists, may be added to the IDT as appropriate. Once added, any member of the IDT may be relieved from the IDT by the Care Manager, unless objected to by the

Participant. IDT members may also be added or dropped from the IDT as the Participant's needs require. An IDT member may drop from the IDT once they no longer have any current goals or objectives related to the Participant. For example, a physical therapist would become part of the IDT if the Participant suffered acute injury requiring rehabilitation. Once treatment is complete, the physical therapist would then be removed from the IDT, because they lack current goals or objectives (assuming no additional social, functional, medical, behavioral, wellness, or prevention need is discovered, or develops, in the meantime).

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

All current IDT members must actively participate in the IDT service planning and care management process. In particular, 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. These IDT members must attend the meeting in person, or via means of real-time, two-way communication (such as by telephone or videoconference).

As described in Section VI.B, the IDT must meet to create the PCSP within 30 days (or sooner if required by the circumstances or clinically indicated) of the initial Assessment. Thereafter, the IDT must meet to evaluate the PCSP no more than 6 months after the IDT's previous meeting. Certain trigger events, as described in Section X, will necessitate a Reassessment, which will require the IDT to reconvene and may require revisions to the PCSP. The Care Manager must reconvene the IDT within 30 days of the 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.

1. Clinical Decisions

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. Where consensus is not possible, the IDT members should strive for workable compromise. 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.

E. Responsibilities of IDT Members

The IDT is responsible for coordinating care for the Participant. This responsibility is continuous and independent from their authorizing authority. It remains applicable even when a different entity is responsible for authorizing particular services, as described in Section VII. The IDT must maintain regular communication as and when required and agreed upon by the other members, and must participate in service planning and oversight.

Each IDT member is responsible for: (1) regularly informing the IDT of the medical, functional, and psychosocial condition of each Participant; (2) remaining alert to pertinent input from other team members, Participants, and caregivers; and (3) documenting changes of a Participant's condition in the Providers' own medical record for the Participant consistent with policies established by the FIDA Plan. These responsibilities are intended to inform the IDT members—individually and collectively—and aide in the continued development of the PCSP. In particular, the Providers' own medical record for the Participant must be considered in developing the PCSP at the next service planning meeting.

Implementation of the PCSP means that the IDT members must either directly deliver (or arrange and confirm delivery of) services required under the PCSP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness.

F. IDT Ongoing Communication

The IDT determines its own methods and processes for candid and complete communication amongst and between its members. The IDT must establish, implement, and maintain documented internal procedures governing the exchange of information between IDT members, providers, and Participants and their caregivers consistent with the requirements for confidentiality (e.g. HIPAA). Each team member is responsible for informing the IDT of the medical, functional, and psychosocial condition of each Participant in an ongoing manner.

When decisions are made by the FIDA Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager and recorded in the shared, accessible Participant record i.e. Comprehensive Participant Health Record and then must be communicated to all IDT members within one business day of the decision.

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.

G. Participant Involvement on IDT

To the extent they are able and willing, Participants shall participate in care planning. Participants must be asked to express their preferences about care, and his or her expression must be

respected and incorporated into care decisions, as appropriate. Providers on the IDT must work with the Participant (and his or her Designee and/or his or her Authorized Representative) and consider his or her preferences in making care decisions.

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.

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. In the event that the Participant refuses to participate in an IDT meeting, the Care Manager should meet (by phone or in-person) with the Participant both before each meeting to identify and ensure Participant input into goals, needs, preferences, etc., and after each meeting to review the proposed PCSP. The IDT may subsequently need to reconvene to incorporate information obtained from the Participant and/or caregiver related to service plan changes requested by the Participant. The Participant must sign a standard written refusal form to participate in each IDT meeting confirming that he/she is choosing not to attend and that his/her non-attendance is not a result of the IDT failing to accommodate the Participant's needs and schedule. If a Participant refuses to participate in the IDT process and also refuses to sign the standard written refusal form to confirm as much, the Care Manager must note the refusal in the Participant's record, along with notes documenting the efforts the Care Manager undertook to include the Participant in the process and to obtain a signed standard written refusal form.

The IDT must keep a record that documents how Participants and families are included in the service planning process, even if they refuse to meet with the IDT.

H. Interdisciplinary Team Member Training

The FIDA Plan will ensure that IDT members have received training on the IDT process. IDT members must agree to participate in approved training on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, independent living and recovery, and wellness principles, along with other required training, as specified by the State. This will include ADA/*Olmstead* requirements.

I. IDT Education and Support of Participant

The IDT must:

- Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in Consumer Directed Personal Assistance Services (CDPAS) as well as their obligations for participation in CDPAS;

- Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or caregiver, and stress Participant-centered collaborative goal setting;
- Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active;
- Establish a set of guidelines or care responsibilities for the entire team and distribute these to Participant;
- Provide education to the Participants and families regarding health and social needs;
- Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs;
- Assess and assist the Participant in identifying and addressing quality of life issues;
- Provide links/coordination/integration with care providers across settings;
- Assist the Participant in accessing reasonable accommodation and accessible providers;
- Provide information about and assist Participant in maintaining and establishing community links;
- Provide information about services available through the Area Agency on Aging to adults age 60 and older;
- Provide information about and assist Participant with housing and transportation issues; and
- 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.

J. 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);
- 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. Again, choice of Care Manager is limited to those Care Managers available within the FIDA Plan care management staff and those that have room in their caseload to handle care management responsibilities for additional Participants. 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

As the lead member of the IDT, the Care Manager has many responsibilities, which can be found throughout this policy document. This subsection describes some of the most important.

During the initial and subsequent IDT meetings, Care Managers must ask each IDT member to give their thoughts on the questions or topics being discussed. This includes the members' preferences or recommendations regarding their preferred course(s) of action. The Care Manager must then summarize and record each member's response into the PCSP.

The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the PCSP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under 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.

For example, in the instance of a Participant that requires x-rays, the IDT members do not simply note that the Participant needs x-rays in the PCSP. Instead, the IDT members are responsible for

all care coordination involved in obtaining the x-rays for the Participant. In this case, the Care Manager (or Care Management team under the direction of the Care Manager) would likely be the one responsible for scheduling the x-rays at the appropriate off-site network provider, arranging the transportation, confirming the appointment, preparing the Participant, ensuring the Participant makes the appointment, ensuring the Participant is transported safely home, following-up to obtain the x-rays and radiology reports, and ensuring that the x-rays and radiology reports make it to the appropriate IDT members for review and discussion. And, the Care Manager must also ensure that all these steps occur in a timely fashion, in accordance with the access standards for the FIDA Demonstration and as dictated by the needs of the Participant.

Any number of these tasks could be delegated to other members of the IDT, if agreed to by the IDT during service planning and recorded in the PCSP. This may be ideal when a Participant has a close friend or family member who has proven reliable in carrying out similar logistical tasks. In that case, the Care Manager would still be responsible for overseeing that the tasks are being accomplished. The Care Manager would have to step-in when the responsible IDT member is no longer able or willing to provide an appropriate level of coordination (i.e. a level of coordination equivalent to what the Care Manager could have provided absent the delegation).

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.

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

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. Person-centered service planning 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 FFS, NHTD Waiver, MLTC or from another FIDA Plan, the Participant will continue to receive services, including any community-based or facility-based LTSS, in their preexisting 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. 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

A Person-Centered Service Plan (PCSP) must be completed for each Participant by and with that Participant's IDT within 30 days of the FIDA Plan completing the Comprehensive Assessment and each Reassessment. The original Assessment must itself occur either 30 or 60 days after enrollment, depending on whether the Participant actively (opt-in) or passively enrolled. Prior to the initial care planning meeting, service authorizations related to new needs for service may be made by, and only 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. Any additional services needed that are not addressed by the PCSP are subject to the FIDA Plan's utilization management process, as more fully described in Section VII.

E. Service Planning Process

The IDT must meet for purposes of developing the initial PCSP and updating the PCSP when a Reassessment has been completed and a PCSP update is indicated. The full IDT should meet in person with the Participant for the development of the initial PCSP development meeting, if and when possible. The IDT lead, who will be the Care Manager, will schedule the meeting at a time convenient to the members of the IDT with current goals and objectives related to the Participant and any proposed changes to the PCSP. The Care Manager should also take into consideration the primary goals of Participant attendance and timeliness of PCSP planning. When in-person meetings are not possible, those IDT members should participate telephonically or by video conference. 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 the service planning meetings, the Care manager will request that each IDT member explicitly communicate his or her thoughts on questions being considered, including his/her recommendations and/or preferred course(s) of action. The Participant always has a right to appeal PCSPs and other service authorization decisions through the FIDA Plan appeal process.

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 with the Participant's religious or cultural beliefs;
- Provide information about the Participant specific to each discipline and expertise;
- Brainstorm approaches to care across all fields (e.g., Social Work suggests a nursing intervention, Nursing suggests an activity intervention, etc.);
- Review the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination;
- Summarize problems, approaches and goals and incorporate into PCSP;
- Specify goals for the six months/duration of the care plan;
- Authorize care/services for the six months/duration of the care plan;
- Identify who is responsible for implementation of each element of the care plan;
- Review advance directives;
- Determine communication plan for IDT members for the six months/duration of the care plan;
- 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 ddiscuss the Participant obligations related to this choice;
- In addition to the above, during service plan meetings, the IDT should also review and discuss:
    - Feedback from each IDT member about how the Participant's needs and preferences are being met under the current service plan and any suggested changes.
    - Evaluate the effectiveness of the current plan of care and implement modifications as needed in collaboration with the Participant and other providers as appropriate.
    - Discuss problems, issues, interventions related to triggers and any other concerns raised at last care planning. If relevant, review previous issues raised at last care planning.
    - Obtain feedback from each team member regarding how the Participant is functioning and suggested interventions for targeted problems; and
- Include anything else appropriate for the needs of the Participant.

F. 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) must each receive a signed written copy (hard copy or electronic) of the final PCSP.

G. 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 staff responsible for conducting the interventions and monitoring the outcomes;
- Reasonable long-term and short-term goals for all problems identified;
- All services authorized and the scope and duration of the services authorized;
- A schedule of preventive service needs or requirements;
- Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines;
- Method and frequency of evaluating progress towards goals and documentation of progress toward the goals including success, barriers, or obstacles;
- 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;
- How frequently specific services will be provided;
- 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.
- The person(s)/providers responsible for specific interventions/services;
- Participant's informal support network and services; and
- 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.

H. 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.G. 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 though there was no need to authorize it, as described in Section VII.B.12.

I. PCSP Monitoring

Monitoring of the PCSP requires that the IDT members must monitor the Participant's medical, functional, social, and cognitive status. IDT members monitor status by direct observation when providing services, informal observation of the Participant, self-report by Participants, feedback from caregivers, reports from network providers, or communication among IDT members. The FIDA Plans will monitor the PCSPs and any gaps in care will be addressed in an integrated manner with the IDT.

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[1] 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. Any items or services

[1] See Exhibit 1

indicated in the most recent version of the PCSP are authorized by virtue of the IDT's agreement to the PCSP. 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. However, between IDT meetings, the FIDA Plan is responsible for authorizing items and services not indicated in the PCSP. 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 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.D.

A. Specificity of the PCSP Service Authorizations

In drafting the PCSP, 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;
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 or the FIDA Plan, 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

As described in Section IV.A, the FIDA Plan must assemble a Participant's IDT as soon as possible but no later than 30 days from the effective date of enrollment of the Participant. Notwithstanding the requirements of this section, in the interim period between the effective date of enrollment and the date upon which the IDT has been assembled, service authorizations related to new needs for service that arise during this time may be made by the FIDA Plan through its utilization management process.

E. Prescription Drugs

IDT approval is not required for drugs, however, the IDT 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) will contact the FIDA Plan to either approve or deny the request.

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 form must 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

A. Care Management Role of IDT

While the Care Manager is the facilitator of the IDT activities, the whole IDT is required to manage care and take all steps necessary to 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

In addition to 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 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).
- Enrollment Agreement.
- Physician orders.
- Discharge summary and disenrollment justification, if applicable.
- Advance directives, if applicable.
- A signed release permitting disclosure of personal information.

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. This information may contain a) subjective information reported by the Participant (e.g., complaints, concerns, effectiveness of ongoing therapy, etc.); b) objective data collected by the provider (e.g., vital signs, weight, examination of body systems, random blood sugar test, etc.); c) assessment (e.g., diagnosis, presumptive condition, etc.); d) treatment plan (e.g., medication, procedure, lifestyle activity, self-management strategy, etc.); and e) education (e.g., demonstration of self-management technique, discussion about disease stages, explanation of medication side effects, etc.).

Notes may also document an exchange between providers (e.g., documentation of a discussion with the physician managing the case of a hospitalized Participant, summary of a meeting with a nursing facility's care planning team for a Participant placed in a skilled nursing facility, description of a home care coordinator's visit to the contracted home care facility to review contractor records, etc.) or between IDT members and the Participant's family or other caregivers (discussion of a proposed change in a Participant's care plan, discussion of a grievance filed by the Participant and/or family, etc.). This information is essential to the IDT care management process. 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. The Care Manager must ensure that a written copy is furnished to the Participant upon such request. The Participant may choose to receive the PCSP 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 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 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 will 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.

B. PCSP Update/Revision Process

As described above in Section VI.E, updates to the PCSP are made through service planning meetings. These meetings should be fully attended in person with the Participant, where possible. Where in-person meetings are not possible, those IDT members should participate telephonically or by video conference.

Updates are made directly to the service plan 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 sign off on the updated or revised 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. While the Participant must physically sign a copy of the IDT, for the remaining members of the IDT, this does not need to be accomplished by obtaining an in-person, ink signature on the PCSP from each IDT member. Instead, IDT member assent or sign-off may be obtained through written signature, through electronic signature, or through email from the IDT member indicating his/her agreement to the PCSP. 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 IN ASSESSMENT, CARE PLANNING, CARE MANAGEMENT, AND IDT PROCESSES

The FIDA Plan will report on specific defined elements related to evaluating the impact of the IDT, how decisions are made, which IDT members supported or opposed particular service authorization decisions, what services prompt differences of opinion, and more. Plans are expected to monitor the quality of the care management services being provided by the Care Manager and any other similar concerns raised by the IDT process. The FIDA Plan will also capture information to monitor and oversee the Assessment, service planning, and care management process. More details about this reporting are forthcoming in the FIDA Plan Reporting Requirements.

The Contract Management Team will closely monitor issues and will be available to address case-by-case problems that cannot be resolved without CMT intervention.

Exhibit 1: FIDA DEMONSTRATION LIST OF COVERED SERVICES (excerpted from Appendix A of the Three-Way Contract)

Abdominal Aortic Aneurism Screening	Medicare Part B Prescription Drugs
Adult Day Health Care	Medicare Part D Prescription Drug Benefit as Approved by CMS
AIDS Adult Day Health Care	Medication Therapy Management
Ambulance	Mobile Mental Health Treatment
Ambulatory Surgical Centers	Moving Assistance
Assertive Community Treatment (ACT)	Non-Emergency Transportation
Assisted Living Program	Nursing Facility (Medicaid)
Assistive Technology (State Plan and Supplemental to State Plan)	Nursing Hotline
Bone Mass Measurement	Nutrition (includes Nutritional Counseling and Educational Services)
Breast Cancer Screening (Mammograms)	NYS Office of Mental Health Licensed Community Residences
Cardiac Rehabilitation Services	Obesity Screening and Therapy to Keep Weight Down
Cardiovascular Disease Risk Reduction Visit (therapy for heart disease)	Opioid Treatment Services – Substance Abuse
Cardiovascular Disease Screening and Testing	Other Health Care Professional Services
Care Management (Service Coordination)	Other Supportive Services the Interdisciplinary Team Determines Necessary
Cervical and Vaginal Cancer Screening	Outpatient Blood Services
Chemotherapy	Outpatient Hospital Services
Chiropractic	Outpatient – Medically Supervised Withdrawal-Substance Abuse
Colorectal Screening	Outpatient Mental Health
Community Integration Counseling	Outpatient Rehabilitation (OT, PT, Speech)
Community Transitional Services	Outpatient Substance Abuse
Consumer Directed Personal Assistance Services	Outpatient Surgery
Continuing Day Treatment	Palliative Care
Day Treatment	Pap Smear and Pelvic Exams
Defibrillator (implantable automatic)	Partial Hospitalization (Medicaid)
Dental	Partial Hospitalization (Medicare)
Depression Screening	PCP Office Visits
Diabetes Monitoring (Self-Management Training)	Peer-Delivered Services
Diabetes Screening	Peer Mentoring
Diabetes Supplies	Personal Care Services
Diabetic Therapeutic Shoes or Inserts	Personal Emergency Response Services (PERS)
Diagnostic Testing	Personalized Recovery Oriented Services (PROS)
Durable Medical Equipment (DME)	Podiatry
Emergency Care	Positive Behavioral Interventions and Support^
Environmental Modifications^	Preventive Services
Family Planning Services	Private Duty Nursing
Freestanding Birth Center Services	Prostate Cancer Screening

Health/Wellness Education	Prosthetics
Hearing Services	
HIV Screening	Pulmonary Rehabilitation Services
Home and Community Support Services	Respiratory Care Services
Home Delivered and Congregate Meals	Respite
Home Health	Routine Physical Exam 1/year
Home Infusion Bundled Services	Sexually Transmitted Infections (STIs) Screening and Counseling
Home Infusion Supplies and Administration and Medicare Part D Home Infusion Drugs	Skilled Nursing Facility
Home Maintenance Services	Smoking and Tobacco Cessation
Home Visits by Medical Personnel	Social and Environmental Supports
Immunizations	Social Day Care
Independent Living Skills and Training	Social Day Care Transportation
Inpatient Hospital Care (including Substance Abuse and Rehabilitation Services)	Specialist Office Visits
Inpatient Mental Healthcare	Structured Day Program
Inpatient Mental Health over 190-day Lifetime Limit	Substance Abuse Program
Intensive Psychiatric Rehabilitation Treatment Programs	Telehealth
Inpatient Services during a Non-covered Inpatient Stay	Transportation
Kidney Disease Services (including ESRD services)	Urgent Care
Mammograms	Vision Care Services
Medicaid Pharmacy Benefits as Allowed by State Law	“Welcome to Medicare” Preventive Visit
Medical Nutrition Therapy	Wellness Counseling
Medical Social Services	