Section	Topic	Policy language	Suggestion/comment/question
IV. 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."	Who serves as the "FIDA Plan" in this instance? Is this the UM team? The Care Manager? Please define. At the least, a Care Manager should be assigned before the PCSP is developed, and the Care Manager must be included in these conversations.
IV. B	Interdisciplinary Team Authority and Decision-Making Role	"Between IDT meetings, the FIDA Plan makes any necessary service authorizations."	Again, who is the "FIDA Plan"? The Participant should have a Care Manager assigned by this point, and that Care Manager along with the Participant must be included in making necessary service authorizations between IDT meetings.
IV. C	Interdisciplinary Team Composition	"A Participant's IDT must be comprised of the following individuals: Participant's designee(s), if desired by the Participant;"	We would like to thank the State for acknowledging our 12/13/13 request that "a Participant should be able to assign a caregiver/family member to participant on the IDT in his or stead, should that be the Participant's desire."
IV. F	IDT Ongoing Communication	"Participants and their designated family members/caregivers must be provided with contact information (which is regularly updated) for all members of the IDT."	We would like to thank the State for acknowledging our 12/13/13 request that "Participants and their designated family members/caregivers should also be provided with updated contact information for all members of the IDT."
IV. G	Participant Involvement on IDT	"To the extent they are able, Participants shall participate in care planning."	Participants should participate in care planning to the extent they are able *and* willing.
IV. G	Participant Involvement on IDT	"The Participant must sign a written refusal to participate in the service planning 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.'	The written refusal must be standardized and conssitent across all FIDA Plans. In addition, the Participant must be given the option to sign the written refusal for each and every service planning meeting.

IV. H	Interdisciplinary Team Member Training	"The FIDA Plan will provide training to all members of the IDT on the IDT process."	What entity is responsible for creating this training? The State should have a role in developing these trainings.
IV. H	Interdisciplinary Team Member Training	"The FIDA Plan will provide training to all members of the IDT on the IDT process."	This training should also include a focus on self-direction and principles of gerontology and geriatric case management.
IV. I	IDT Education and Support of Participant	"The IDT must establish a set of guidelines or care responsbilities for the entire team and distribute these to the Participant."	This language should be updated as follows: "The IDT must establish a set of guidelines or care responsibilities for the entire team and distribute these to the Participant in a format he/she wishes and in a format that is most accommodating to the Participant."
IV. I	IDT Education and Support of Participant	"The IDT must…"	A bullet should be added as follows: "Provide the Participant with a specific description of reasonable accommodations and modifications of policies and procedures that must be made by the FIDA Plan and providers. This description should be provided in a format that is most accommodating to the Participant."
IV. I	IDT Education and Support of Participant	"The IDT must provide information about services available through the Area Agency on Aging to adults 60 and older;"	We would like to thank the State for acknowledging our 12/13/13 request that "The IDT should also provide education and support to Participants over the age of 60 to include services offered through the Area Agency on Aging."

V. A	Care Manager Selection	"A Participant has the right to choose a different Care manager and change her/his Care Manager at any time."	We would like to thank the State for acknowledging our 12/13/13 request that "…should a Participant be less than satisfied with care management under the IDT or Care Manger, the policies and procedures should outline how the Participant can go about requesting a new IDT or Care Manager for the FIDA Plan." We would like to stress that the Participant receive information on how to request a different Care manger in writing.
V. A	Care Manager Selection	"At all times, the FIDA Plan must ensure that the Care Mangager's caseload is reasonable to provide appropriate care coordination and care management."	The State should specify a particular maximum Participant-to-Care Manager ratio. Please see our comments from 12/13/13 that give specific examples of criteria other states have used to develop these ratios.
V. 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."	The draft policies and procedures fall short of outlining specific qualifications of the Care Manager, including licensure and credentialing requirements and necessary education. Please see our comments from 12/13/13 that give specific examples of other states' stricter requirements for individuals serving as Care Managers or related positions.
VI. B	Transition to FIDA PCSP	"During a Participant's transition to a FIDA Plan, whether from MLTC or from another FIDA Plan, the Participant will continue to receive any community-based or facility-based LTSS in their preexisting service plan (the service plan in place prior to enrollment in the FIDA Plan)."	We would like to thank the State for acknowledging our 12/13/13 request that services should be continued and "include any transition from one FIDA Plan to another." However, a Participant should continue to receive not only LTSS, but also any other health service in his/her preexisting service plan.
VI. E	Service Planning Process	"The Participant always has a right to appeal PCSPs and other service authorization decisions thorugh the FIDA Plan appeal process."	We would like to thank the State for acknowledging our 12/13/13 request that "To the extent it does nto involve 'action' by the plan, the PCSP should be subject to filing of a grievance" or other the appeals process.

VI. E	Service Planning Process	"During each PCSP planning meeting, the IDT should review the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination;"	This should only take place when the prescribing physician, pharmacist, or other IDT member with appropriate clinical expertise and qualifications is present at the PCSP planning meeting.
VI. F	PCSP Form	"The form must include a space for the IDT members to sign the PCSP and must include language clearly specifying the following: (1) The right of the Participant to appeal a PCSP, (2) That signing of the PCSP does not preclude appeal, and (3) Instructions for requesting an appeal."	We would like to thank the State for answering questions in our comments dated 12/13/13 related to how Participants will receive instructions on how to initiate an appeal of the PCSP. We stress that these instructions must be provided in a format that is most accommodating to the Participant.
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 nor authorization from any other providers."	We would like to thank the State for supporting our opposition to requiring IDT involvement for routine medical treatment, as noted in our comments dated 12/13/13.
IX. B	Documenting Care Needs and Service Delivery	"In addition to the PCSP, the FIDA Plan must maintain a single, comprehensive medical record for each Participant in accordance with accepted professional standards. At a minimum, the medical 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:"	As the central member of the IDT, the Participant must also receive access to his/her medical record. This should be mentioned explicitly in the policies and procedures.
X. A	Timing of Comprehensive Reassessments	"The FIDA Plan must ensure that a Comprehensive Reassessment is performed as expeditiously as possible but no later than within 30 days (or as soon as required by the circumstances or as clinically indicated) from the date of any of the following triggering events: as requested (verbally or in writing) of the Care Manager by the Participant, his/her caregiver, or his/her provider;"	We would like to thank the State for answering questions in our comments dated 12/13/13 related to how Participants can go about requesting a comprehensive reassessment.
XII.	QUALITY IN ASSESSMENT, CARE PLANNING, CARE MANAGEMENT, AND IDT PROCESSES	"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."	We would like to thank the State for acknowledging our 12/13/13 comment that "the draft policies and procedures do not delineate the entity that monitors the IDT." We look forward to reviewing additional information about what checks and balances will be put in place to ensure the IDT is coordinating the Participant's care and is accountable to the Participant.