Coalition to Protect the Rights of New York's Dually Eligible

September 6, 2013

Mr. Mark Kissinger
New York State Department of Health
Empire State Plaza, Corning Tower, 14th Floor
Albany, New York 12237

Ms. Melissa Seeley
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21214

Dear Mr. Kissinger and Ms. Seeley,

We appreciate the opportunity to comment on New York's draft plan readiness review tool. However, we are troubled by not being afforded as much time as the plans to review and submit feedback. Additionally, we are concerned that we initially received this draft indirectly, and then were given only three days to respond. As the three days did fall on the Jewish holidays, many members of the Steering Committee were unable to provide comments on this draft. Thus, the absence of comments on any section should not be interpreted to mean that the Coalition has no comment, but rather that there was not enough time for all of the Steering Committee members to address each and every issue.

Overall, we are concerned that plan readiness in the draft tool is confirmed merely by existence of certain provisions in plan policies and procedures, rather than by verification that the required policies and procedures either have been or are ready to be implemented. Some systems and procedures must be tested in order to verify readiness, or be verified through more tangible means. California's readiness tool, for example, requires screenshots or website mock-ups where the website is not yet live, specifications or workflow diagrams, samples of how processes work, such as how information on provider networks is collected, maintained, and made accessible to enrollees, and lists of members of

consumer stakeholder groups and schedules of meetings, etc.[1] Such verification is only sporadically evident in this draft.

Additionally, while this tool is intended to assess plan readiness, we are also concerned about readiness of other systems, policies and procedures—those administered by DOH, by HRA and the other local districts, and by Maximus. Examples are numerous. First, the roll-out of MLTC revealed the many WMS coding issues we have discussed, which should have been identified before implementation so that they could be fixed or so that workarounds could be developed. These problems remain as significant barriers to access and will remain for FIDA. Second, the lack of consistent model consumer communications and notice templates, which should be developed by DOH and CMS with consumer stakeholder involvement, has deprived many MLTC members of vital information about their rights. The harm will only multiply with FIDA. Third, systems needed for transitions depend not only on plan readiness but also on the local districts, Maximus, and DOH's WMS system to relay on a timely basis plans of care, shift enrollment between plans, etc. These are just a few examples. We would like to know if a readiness tool is also being developed for these players.

Please find additional comments on the draft readiness review criteria below. We look forward to engaging you further as this tool is developed.

Sincerely,

The Coalition to Protect the Rights of New York's Dually Eligible

cc: Edo Banach

[1] California Financial Alignment Readiness Review Document, posted at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf. We have not had the time to compare every part of the California tool to the comparable part of New York's to make specific recommendations, but generally note more robust requirements for enrollee and provider communications, including plan websites, at pages 19-21

I. Assessment Processes

A. <u>Transition to New FIDA Plan and Continuity of Care</u>

i. **Re: A(1):** We recommend that New York adopt at least the 180 day timeframe for allowing Participants to continue to receive services at the time of enrollment. This 180-day time frame was used in the Virginia, Illinois and California MOUs. The communications and processes that will take place during the transition period will take more time than the 90 day transition period affords.

ii. **TESTING OF CONTINUITY PROCESSES.** In the initial transition to MLTC, because of partial capitation, continuity for many people involved only one or two providers. Now that all primary, acute and emergency care is involved, the continuity policy will apply to multiple providers for each member, putting more demand on the plans' systems for ensuring that members' treatment by out-of-network providers is not disrupted during the 90-day transition period, and that the plan reaches out to and informs these providers of how to join the network. Even treatment by in-network providers is at risk of being disrupted if it would now require prior authorization by the plan. Members-- especially those passively enrolled and who may have no understanding of the network requirements--will also have to be educated about the new system, assisted with identifying in-network providers with capacity, and also informed of their right to disenroll and return to Original Medicare or their former Medicare Advantage plan. All of these communications and processes will take time, and we are doubtful they can be effectively done within the short 90-day transition period, which we note is half the length of the 6-month periods in Virginia, Illinois, and in California for Medicare and services, and far less than the One Year period used in California for Medicaid services. Because of this time constraint, it is imperative that the plans demonstrate that the care continuity processes have been tested. The existence of processes is not enough; they must be tested to ensure they are operational.

iii. In addition to contacting out-of-network providers to join the network, the plan must inform in-network providers of any requirements that ongoing treatment

provided prior to enrollment must now be approved by the plan under a prior authorization system. This must be done in time for prior authorization to be submitted and processed to ensure that care is not disrupted.

iv. Re: A(3): Evidence of readiness should include a random sampling of actual policies and procedures, not just contractual provisions referencing said procedures.

v. Re. A(6)&(7): Add to suggested evidence proof in the plan's P&P that an extension of the applicable transition period will automatically be granted if a decision on any pending exception request or appeal has not been issued at the expiration of the applicable transition period.

    1. Evidence of readiness for criteria number 6, which requires that temporary fills of non-formulary drugs should contain at least a 90 day supply, should include a definition of transition supplies of at least 90, not 30 days.

vi. Re. A(8): Add to suggested evidence a copy of an actual pharmacy transition fill notice, to ensure compliance with CMS Prescription Drug Manual, Chap. 6 §30.4.10 at pp.40-41 (February 19, 2010), available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

vii. Re: A(2)&(8): Evidence of readiness to comply with criteria numbered 2 and 8 in this section should include random sampling of actual notices plans will provide to members [regarding use of out of network care (#2) and temporary fills (#8)], not just contractual provisions referencing such communications.

B. <u>Assessment</u>

i. Assessment of the need for modification of policies and procedures and for reasonable accommodations in order to access services should be a part of creation of a FIDA Plan and clearly indicated in B.

ii. It should be indicated that a change in the Person-Centered Service Plan should trigger a review of modifications and reasonable accommodations to ensure that these are current.

iii. Evidence of compliance with assessment of need for reasonable accommodation should include a plan for training staff on how to identify patients needing accommodation and the range of possibilities for accommodating a variety of disabilities.

iv. Re: B(2): While we support the requirement that plans must conduct assessments in the assisted living facility or nursing home if that is the Participant's home, it should require plans to conduct the assessments in a hospital or rehabilitation facility, if the client is temporarily receiving care in such facilities. In MLTC, we have seen plans refuse to assess prospective members in these settings, delaying their ability to return home with the necessary home care services.

v. Re: B(2): We understand the MOU requires assessments be conducted within 30 days, and staffing should be sufficient to meet this timeline. However, that timeline proved unrealistic for MLTC, and it was extended to 90 days. We believe the 30-day requirement will also be unrealistic in the FIDA program. If the transition period was extended to 180 days, plans could have 90 days to assess Participants. a more realistic time period given MLTC track record. This will protect consumers by ensuring that prior services continue.

II. Care Coordination

A. Care Management and Interdisciplinary Team (IDT)

i. The FIDA Plan's policies should be clearly stated to include policies concerning modification of policies and procedures and reasonable accommodations, including specific procedures for doing so. The FIDA Plan should include notation of what reasonable accommodations and modification of policies are required and provided.

ii. Re: A(7)&(8): Evidence of readiness to assign appropriate care managers includes reference to "reasonable measures" to ensure an appropriate staff-participant match. Evidence of readiness on this measure and the IDT providing appropriate supports should be described more specifically to include a feedback loop for participants to provide comment regarding whether the

match is appropriate and whether the IDT is able to meet the participant's needs.

B. Person Centered Service Plan

   i. In developing the plan, the IDT should be required to consider reasonable accommodations and modifications of policies and procedures that must be made by the plan and providers.

   ii. The person-centered plan should contain a specific description of reasonable accommodations and modifications of policies and procedures that must be made by the plan and providers.

C. Self-Directed Services: Consumer Direction

D. Coordination of Services

   i. The process for monitoring and auditing care coordination must contain a process for auditing whether reasonable accommodations and modifications of policies and procedures have been offered and are delivered and what these are.

   ii. Evidence of readiness to monitor and audit care coordination should call for specific plans regarding communication the results to advisory boards and consumer stakeholders. For example, plans should be required to specify the types of documents that will be produced and the frequency with which these documents will be provided to consumer stakeholders. Plans should also be required to contemplate scheduling time to discuss and react to findings in order to achieve meaningful program adjustment and improvement.

E. Transitions Between Care Settings.

   i. Re:E(2): The sole requirement for FIDA plans to assist members who want to transition to the community from nursing homes is a referral to Pre-Admission Screening and Resident Review (PASRR) evaluations or the Money Follows the Person (MFP) program. This is inadequate. PASRR evaluates solely persons known to have or suspected of having mental illness, TBI, or dual diagnoses of MI with TBI or DD.[2] While this screening is required and helpful, it will not

[2] See description of program generally -- http://www.health.ny.gov/funding/rfp/inactive/1001061024/1001061024.pdf.

screen people who do not have these diagnoses for possible discharge into the community. Nor is MFP program sufficient—while it is a worthwhile program, it has very limited capacity to assess potential for transition to community living to all institutionalized members of FIDA plans. Also, we understand that this program is being diverted to the DD population, so it will be even less of a resource. **RECOMMENDATION:** Since FIDA plans are responsible for assessing and authorizing a wide range of community-based long-term care services, and for providing person-centered case management, the FIDA plans should be required to do essentially what the MFP contractors do, PLUS assess eligibility for all CB-LTC services and for identifying, applying for and securing housing options where needed.

ii. Re: E(3): Requiring FIDA plans to track the number of members wanting to move to the community as referred to PASSR or MFP is not enough. FIDA Plans should report the number of residents the plan *independently assessed* for potential discharge and eligibility for community-based care, number found to need affordable and accessible housing that is not available, and number found to need affordable and accessible housing that is available, and of those, number found eligible/ not eligible for community-based care. For those found not eligible for community-based care despite access to housing, plan should report reasons for ineligibility. For those found eligible, plan should report length of time from initial assessment for discharge to actual discharge to community.

    1. This type of participant transition data should be reported to the Participant Ombudsman as well as the state.

F. <u>Participant Ombudsman</u>

i. The Ombudsman must provide reasonable accommodations and be trained to and assist in negotiating these as required.

ii. The Ombudsman must routinely receive and have access to data that the plans report to the State or CMS, and must have authority to ask questions of the plans about participants regardless of whether a particular participant has provided authorization, and about procedures, systems, and data. This is necessary for the Ombudsman to investigate systemic issues and not only

troubleshoot individual cases. The Ombudsman's contract with the State can make provisions for Confidentiality, which will ensure that the Ombudsman will not disclose any confidential information to third parties without an individual participant's permission. The Ombudsman's effectiveness will be significantly compromised if access and information is restricted to individual participants who individually provide authorization.

iii. Re: F(2): These duties should include ensuring that reports on the number of participants wishing to leave nursing facilities, as well as other data relevant to the trend monitoring function of the PO, are made available within reasonable time frames.

G. Confidentiality

III. **Participant and Provider Communications**

A. Participant and Provider Communications

i. The customer service department should make information available about the availability of reasonable accommodations and modifications of policies and procedures and should describe how these may be arranged and provided.

ii. What are cognitively accessible formats?

iii. All materials must be made available in alternate formats (describe) and should be readily understandable by individuals with limited literacy.

iv. The FIDA Plan toll-free call center with live customer service representatives must be able to respond to TTY and videophone inquiries.

v. The FIDA Plan must provide its vital documents in alternate formats for individuals who are blind or have limited vision.

vi. Plans must demonstrate that toll-free call centers – and the plan departments to which calls are transferred -- have capacity to handle the anticipated number of calls within a specified maximum "hold" time. Testing should be done not only in readiness review but at regular intervals to ensure this capacity.

vii. Re: A(6): It is not enough for the plan to describe how it will ensure that vital documents are translated. Actual translations should be reviewed and tested.

viii. The State should review and adopt criteria from California's Readiness Review Document regarding participant and provider communications including the requirements for the plan website.[3]

ix. Additional criteria should be added to ensure that Plans transmit information for posting on Medicare's Plan Finder and/or include information from the Medicare Plan Finder on their own websites, allowing Participants to receive information about covered drugs from both FIDA and Medicare. See, for example, California's Readiness Review Document.

B. Stakeholder Feedback

i. The FIDA Plan Participant Advisory Committee (PAC) must provide reasonable accommodations to ensure full and equal access to participation in the PAC for individuals with disabilities.

C. Pharmacy Technical Support

IV. **Participant Protections**

A. Participant Rights

i. The FIDA Plan should have policies and procedures to ensure that it provides reasonable accommodations and that it informs participants of their right to reasonable accommodations. The evidence should show not only that individuals are informed in general, but specifically about how to obtain accommodations from the plan and its providers (what process, who decides, how to appeal).

ii. The Plan informs enrollees that they will not be balance billed by a provider for any service; this is articulated through policies and procedures and staff and provider training modules.

B. Appeals and Grievances

i. FIDA Plan Staff training for those handling grievances and appeals should include training on participant rights pursuant to the ADA, and their own obligation to provide these as well as to address complaints related to failure to provide effective accommodations.

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf, Table 5 (Pages 19 and 20), Sections 4 and 5.

ii. The FIDA Plan should show evidence that it provides notice to enrollees of the right to complain to the HHS, OCR concerning plan or provider failure to provide effective reasonable accommodations.

iii. Re: B(2): This section states that CMS and DOH will jointly provide FIDA plans with a template Notice of Denial of Medical coverage, but there is no other mention elsewhere in Section **B** of notice templates for the multiple other notices: Notices of Reduction or Termination of medical coverage, Notices of internal appeal decisions, Notices of appeal rights, etc. We strongly recommend that these various template notices be developed prior to implementation, with consumer stakeholder involvement. In the MLTC roll-out, the inadequacy of these notices has been striking – plans use a mere "plan of care" instead of a notice that includes appeal rights, and plans use notices that lack critical appeal information. Notice requirements for Medicaid services are specified in various state regulations and other guidance and must be adhered to by the plans. Having consistent notices across plans can only be achieved by a uniform Template.

iv. Re: B(3): Evidence of readiness for criteria #3 should include sample written information and designation of the contact person in the staffing plan. Additionally, this section requires the FIDA plan to provide participants with reasonable assistance in filing an appeal or grievance – including information and reminders about the PO. These criteria should be more specific to include:

    1. Information regarding the time frame for plan response;
    2. A contact person at the plan, with phone number, who will be able to provide assistance over the phone;
    3. The SDOH complaint hotline so that participant problems can be reported to the state as well as the plan.
    4. An additional criterion should be added to this section requiring the FIDA plans to track grievances and appeals in order to monitor outcomes and compliance with required time frames. These data should be reported to both the state and the PO.

v. Re: B(7): The FIDA Plan's policy and procedure must include notification of participant of the right to present evidence and examine her/his case file during appeal. The FIDA Plan must also provide participant with the evidence that upon which the Plan will rely during the appeals process.

C. Participant Choice of PCP

i. This should make reference not only to the right to select a specialist as PCP, but also of the right to a standing referral, out-of-network referral, and other provider access rights pursuant to the State's Managed Care Bill of Rights.

D. Emergency Services

V. **Organizational Structure and Staffing**

A. Organizational structure and staffing

i. This should include and give evidence that there is a specific person responsible for ensuring that reasonable accommodations and modifications of policies and procedures are made.

B. Sufficient Staff

i. Care managers and nurses conducting Participant assessments must have knowledge of the ADA and their obligation to provide and assist enrollees in obtaining reasonable accommodations and modifications of policies and procedures.

ii. Plans must be able to demonstrate that a sufficient number of nurses conducting participant assessments are able to conduct the assessments in participants' languages or that interpreters are available, and that assessments and all case management services can otherwise be conducted in a linguistically and culturally appropriate manner.

C. Staff Training

i. The FIDA Plan has a disability *literacy* training plan and the training plan includes training on the plan's policies and procedures for providing, obtaining, documenting, and appealing reasonable accommodations. This section is fairly well done.

ii. The FIDA plan informational scripts should include information about the right to reasonable accommodations, how to obtain them and appealing their denial

or inadequacy. This should be included in the competencies that the plan must demonstrate.

iii. Re: C(3)&(5): Training program for care managers and scripts for customer service staff should also include information on how members or their representatives or providers may request new services or increases in the amount of existing services, and the time frames and procedures for processing these requests. In MLTC, we have seen that many plan staff are poorly informed of these procedures, with the result that members cannot obtain necessary services.

D. Readiness Review Criteria

i. The step by step flow chart that shows how staff assists participants should include how it assists participants in understanding their rights, obtaining accommodations, handling inquiries or grievances or appeals related to these.

VI. **Performance and Quality Improvement**

A. Performance and Quality Improvement

i. Quality reports should include a process for documenting and tracking that participants are advised of their ADA-related rights, reasonable accommodations are being made, and any inquiries, complaints and appeals related to those rights.

ii. It is concerning that the Tool suggests that each plan will develop its own quality measures that it will collect and report on. We presume that the State will create a reporting system based on the quality measures specified in the MOU as the basis for Quality Withholds. We did not have the opportunity to comment on the measures used for Quality Withholds but have previously made recommendations to the State on quality measures in long-term care.[4]

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[4] See, eg. ***Incentives for Community-Based Services and Supports in Medicaid Managed Long TermCare: Consumer Advocate Recommendations for New York State*** **(March 2012)** posted at http://wnylc.com/health/download/304/; *New York's 2012 Managed Long Term Care Report: An Incomplete Picture* (*Coalition to Protect the Rights of New York's Dually Eligible, April 2013), posted at* http://www.wnylc.com/health/download/401/.

Many national organizations have compiled recommendations for monitoring quality in LTSS, given that traditional outcome measures through HEDIS and other protocols focus on primary and acute care.[5] Some particular concerns, include:

1. MOU Figure 6-4, p. 51 – DOMAIN: Reducing the Risk of Falling. MEASURE: Percent of participants with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year. COMMENT: While this measure may be relevant, it is equally important that among those whose treatment did not eliminate the risk of falling, the percent of participants with a problem falling, walking or balancing who were provided with home care services to assist with walking and transfer and whether, among this group, the incidence of falling was reduced.
2. MOU Figure 6-4, p. 51 – DOMAIN: Improvement/Stability in ADLs. MEASURE: Participants who remained stable or improved in ADL functioning since last assessment. COMMENT: In a population that, by definition, has chronic conditions that cause the need for long-term care, the improvement or even stability of ADLs cannot be expected, except perhaps after acute episodes such as hip fractures. This measure would be more appropriate for a different population, where recovery of ADL ability could be expected and achieved. Alternate measures have been suggested in the resources referenced in the footnotes.
3. Measurement of Impact of Transition -- The Kaiser report (see fn 5) stresses the importance of measuring the impact of the transition to managed care from Fee for Service, which would be especially important since this is a demonstration program. While most FIDA

[5] See, e.g. *Identifying and Selecting Long-Term Services and Supports Outcome Measures,* (Disability Rights Education and Defense Fund (DREDF) and Natl. Senior Citizens Law Center, January 2013), posted at *http://www.nsclc.org/wp-content/uploads/2013/02/Guide-LTSS-Outcome-Measures-Final.pdf; Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs (Kaiser Commission, April 2013), posted at http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8433.pdf.*

members will have been in a managed care plan (MLTC) for some services, they still received other Medicaid services and all Medicare services Fee for Service. Table 2 of the Kaiser report has specific suggested measures, and is attached hereto. While all of these may not apply to the FIDA program, and there are other measures not listed, this Table presents a valuable base.

4. Report measures by population as well as region and plan – To be most useful, data can be analyzed and measures reported by population, region, and plan. Ideally, for example, it should be possible to examine data for people with disabilities and for subgroups with particular types of disabilities. Kaiser Report at 23-24. "Drilling down" to differentiate between subgroups will compare apples to apples. For example, people assessed as bedbound, who use wheelchairs for all mobility, would not be expected to show improvement in mobility, but may in other measures (prevention of bedsores, avoiding use of catheter), while for other groups a higher percentage of people using wheelchairs for indoor ambulation relative to the percentage using canes, walkers or no devices, compared to the prior assessment, could show diminishment of ADLs. The State's 2012 Report on Managed Long Term Care failed in this regard in one way, by combining fully capitated and partially capitated plans in one group for comparison.

B. <u>Provider Credentialing</u>

i. Provider credentialing should include an examination of whether the provider is ADA compliant and review of provider information includes an audit process for verifying that the provider is in compliance.

VII. **Provider Network**

A. <u>Establishment and Maintenance of Network, including Capacity and Services Offered</u>

i. The FIDA Plan ensures that participants have current and accurate information on provider compliance with the ADA—not only in terms of physical and communications accessibility for people who are Blind or Deaf, but also provisions of other reasonable accommodations.

ii. While the standards for network sufficiency in Number A(1) are satisfactory, the criteria for readiness review are not. Passing a rigorous network review should include not only Polices & Procedures that state the expected number of beneficiaries and of providers, including specialists, specialty facilities and the various types of Long Term Care providers, but should verify how these numbers were calculated based on available Medicare and Medicaid usage data. Network review should include:

   1. Verification of geographic and disability access – simply including a policy to ensure access is not enough without verification.
   2. Verification of how many providers are actually accepting new patients,
   3. Verification of the ability and willingness of the network to engage in the care coordination process.

iii. Re: A(1): Suggested evidence should include a contracting log documenting the plan's or contracted PBM's efforts to provide standard terms and conditions to prospective network pharmacies as well as any contracting negotiations, pursuant to CMS Prescription Drug Benefit Manual, Chap. 5, § 50, at p.36 (September 20, 2011) available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf. In addition, plan must provide proof that pharmacy network complies with the minimum access criteria of §§50.1–50.6. Id.

iv. Re: A(4): Out of Network Providers --The network review should also identify key providers within the community that are not part of the plan's network and ensure that steps have been taken to handle access issues for dual eligibles that rely on those providers, regardless of proximity of network providers.

v. Re: A(6): This section calls for timely updating of online provider directories and search functionality; these time frames should be specific. Plans should be required to update directories and search functionality on a monthly basis. Evidence of readiness should include a plan for ensuring that directories are up to date through regular sampling of plan directories.

B. Accessibility

i. This section should require that provider physical accessibility be defined by reference to the DOJ guidance for providers. Providers should also be trained concerning their obligation to provide reasonable accommodations to those with hearing, vision, cognitive and psychiatric disabilities. Providers must meet these accessibility requirements as well.

C. Provider training

i. This section is good. However, it should be clear that providers not only receive training, but also prove knowledge of content on which they were trained.

D. Provider Handbook

i. The provider handbook includes information about the obligation to be ADA compliant.

ii. The FIDA Plan resources are available in alternate formats as well as available through a 508 complaint web site.

E. Ongoing Assurance of Network Adequacy Standards

i. The provider contract must not only ensure "non-discrimination" but also the affirmative obligation of providers to reasonably accommodate all participants with disabilities.

ii. The list of providers includes not only their geographic region served but information sufficient to determine that there is a choice of ADA complaint providers in all regions.

iii. This section should include criteria to specifically address access to services (i.e. behavioral health services) known by the state to be in short supply in various geographic areas. Plans should be required to have contracts with relevant providers in these areas and/or describe their plans for assisting participants with accessing out of network care for these services [this is referenced in criteria #6 in the Utilization Management section, but more detail should be required on how the plans will *assist* participants who need out of network care].

VIII. Monitoring of First-Tier, Downstream, and Related Entities

IX. Systems

A. Data Exchange

i. A requirement is needed for the Plan or its contracted Pharmacy Systems Contractor (PBM) to make timely and accurate submissions of Part D pricing data for posting on the Medicare Plan Finder. Baseline documentation should include P&Ps that detail the processes and data requirements to ensure timely and accurate submission of pricing data for posting on the Medicare Plan Finder. Supporting documentation should include screenshots or other demonstrations of successful transmission of data to the Medicare Plan Finder. (See California readiness tool, p. 43)

B. Claims Processing

i. Re: B(5): Suggested evidence should include proof that the plan or contracted PBM complies with the electronic transaction standards contained in CMS Prescription Drug Benefit Manual, Chap. 5, §90 *et seq.* at pp.66-71 (September 20, 2011), available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/MemoPDBManualChapter5_093011.pdf.

C. Claims Payment

D. Provider Systems

i. This section should include not only the physical accessibility of the provider office, but also its communications accessibility and the accessibility of its systems for those who are blind, Deaf, have cognitive and psychiatric disabilities.

E. Pharmacy Systems

F. Care Coordination and Care Quality Management Systems

Records necessary for care coordination include evidence that participants are informed of their ADA rights, how to obtain reasonable accommodations and how to complain.

G. Health Information Technology and Integrated Records

X. Utilization Management

A. FIDA has a UM Program to Process Requests for Initial and Continuing Authorizations of Covered Services

i. The reference to Olmstead and compliance with the ADA is appreciated, but evidence should be required to show that FIDA Plans are in compliance.
ii. Re: A(2): Evidence of readiness to comply with these criteria should include a plan to ensure compliance with this standard, including staff training since the Medicaid definition is different than that utilized by many commercial plans.
iii. Re: A(6): Evidence of readiness should require explanation of not just how a participant "may obtain authorization" but how the participant will be *assisted*, not just in obtaining authorization but in locating the necessary services.

B. The UM program has timeliness, notification, communication, and staffing requirements in place.

i. The FIDA plan must have strategies for informing participants "with communication barriers." This should explicitly include alternate formats and other reasonable accommodations that may be needed in order to communicate with people with any disabilities.
ii. Additional criteria should be added to this section calling upon plans to communicate prior authorization requirements to participants and provide participants with notice of decisions on requests for prior authorization.