Draft New York Readiness Review Tool

Assessment Processes	
Readiness Review Criteria	**Suggested Evidence**
A. Transition to New FIDA Plan and Continuity of Care	
1. The Fully Integrated Duals Advantage (FIDA) Plan allows Participants receiving any service at the time of enrollment other than nursing facility services to maintain current providers and service levels until the later of: a. For at least 90 days after enrollment, or b. Until a comprehensive assessment has been completed by the FIDA Plan.	Continuity of care plan includes these provisions.
2. During the transition period, FIDA Plans will advise Participants and providers if and when they have received care that would not otherwise be covered at an in-network level. On an **ongoing** basis, and as appropriate, FIDA Plans must also contact providers not already members of their network with information on becoming credentialed as in-network providers.	Continuity of care plan includes these provisions, including information on how the FIDA Plan will advise participants and providers that the beneficiary received care out of network, and frequency by which FIDA Plans will contact providers not already members of their network with information on becoming credentialed as in-network providers.
3. The FIDA Plan has policies and procedures to accept and honor established service plans provided on paper or electronically transferred from FFS or prior plans when Participants transition with service plans in place. FIDA Plans must also have policies and procedures in place to ensure timely transfer of Person-Centered Service Plans to other FIDA Plans or other plans when a FIDA Participant is disenrolling from the FIDA Plan.	Continuity of care plan includes these provisions.
4. The FIDA Plan allows Participants who reside in nursing facilities to maintain current nursing facility providers for the duration of the Demonstration.	Continuity of care plan includes these provisions.
5. The FIDA Plan assures that, within the first 90 days of coverage, it will provide a) a temporary supply of drugs when the Participant requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug and b) a 90-day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.	Transition plan P&P allows and defines a time period (at least within the first 90 days of coverage) when it will provide temporary fills on refills of non-formulary drugs that otherwise meet the definition of a Part D drug and non-Part D drugs that are covered by Medicaid.
6. The FIDA Plan assures that, in outpatient settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D and non-Part D drugs that are covered by Medicaid contain at least a 90-day supply.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 30 days.
7. The FIDA Plan assures that, in long-term care settings, temporary fills of non-formulary drugs that otherwise meet the definition of a Part D drug contain at least a 91-day supply, unless a lesser amount is requested by the prescriber.	Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in long term care settings to be at least 91 days.
8. The FIDA Plan provides written notice to each Participant, within 3 business days after the temporary fill of a Part D drug, if his or her prescription is not part of the formulary.	Transition plan P&P defines a time period (within 3 business days) when it must provide Participant with notice about temporary fills and their ability to file an exception or consult with prescriber to find alternative equivalent drugs on the formulary.
B. Assessment	
1. The FIDA Plan ensures that each Participant receives and actively participates in a timely comprehensive assessment completed by the Interdisciplinary Team (IDT). Assessment domains must include following (the FIDA plan may include additional domains: a. Social; b. Functional;	The FIDA Plan shall submit their Assessment P&P, including any updates that will need to be made to this P&P to reflect use of the NYSDOH Approved Assessment Tool rather than the Semi-Annual Assessment of Members (SAAM).

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c. Medical; d. Behavioral; e. Community-based or facility-based or facility-based long-term services and supports (LTSS) needs; f. Wellness and prevention; g. Caregiver status and capabilities; and h. The Participants' preferences, strengths, and goals.	
2. The Plan ensures that: a. All Participants receive a comprehensive assessment within 30 days of enrollment; b. The assessment is performed using the NYSDOH Approved Assessment Tool; c. The assessment is performed in and in the Participant's home, which includes an assisted living or nursing facility; and d. The assessment is performed by a Registered Nurse (RN).	The FIDA Plan shall submit their Assessment P&P with timeline for fulfilling 30-day requirement, including any updates that will need to be made to this P&P to reflect use of the NYSDOH Approved Assessment Tool rather than the Semi-Annual Assessment of Members (SAAM). The process should include these requirements, but it should further outline the process for identifying, contacting, and conducting the assessment.
3. The FIDA Plan uses the results of the comprehensive assessment to: a. Confirm the appropriate acuity; and b. As the basis for developing the integrated, Person-Centered Service Plan.	Assessment P&P outlines the process by which the FIDA Plan will administer the initial assessment.
4. The FIDA Plan ensures that a comprehensive re-assessment and a Person-Centered Service Plan (PCSP) update are performed as warranted by the Participant's conditions but: a. At least once every six (6) months after the initial assessment completion date; b. When there is a change in the Participant's health status or needs; c. As requested by the Participant, his/her caregiver, or his/her provider; and d. Upon any of the following triggering events: i. A hospital admission; ii. Transition between care settings; iii. Change in functional status; iv. Loss of a caregiver; v. Change in diagnosis; vi. As requested by a member of the Interdisciplinary Team who observes a change that requires further investigation. e. By a Registered Nurse (RN) in the individual's home, which includes an assisted living facility or nursing facility, using the NYSDOH Approved Assessment Tool.	Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current Participants. Staffing plan
5. The FIDA Plan has policies for staff to follow up and to document when a Participant refuses to participate in a comprehensive assessment or re-assessment.	Assessment P&P explains how staff from the FIDA Plan will respond to those Participants who decline to participate in a comprehensive assessment or re-assessment.

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Care Coordination	
Readiness Review Criteria	**Suggested Evidence**
A: Care Management and Interdisciplinary Team (IDT)	
1. The FIDA Plan has a process to ensure that every Participant is offered an Interdisciplinary Team (IDT), which is led by a care manager.	Care coordination P&P discusses the process of offering IDTs to beneficiaries
2. The FIDA Plan's policies: a. Permit IDT's decisions to serve as coverage determinations and service authorizations; and b. State that these coverage determinations and service authorizations may not be modified by the FIDA Plan outside the IDT and are appealable by the Participant.	Care coordination P&P states that the IDT decisions serve as service authorizations and describes a process for resolving any disagreements among IDT.
3. The IDT should: a. Be person-centered; b. Be built on the enrollee's specific preferences and needs; and c. Deliver services with transparency, individualization, accessibility, linguistic and cultural competence, and dignity.	Care coordination P&Ps include these requirements of the IDT
4. The FIDA Plan ensures that the composition of the team will include: a. The Participant and/or his/her designee; b. The designated care manager; c. The primary care physician; d. Behavioral health professional; e. Home care aide; and f. Other providers either as requested by the Participant or his/her designee or as recommended by the care manager or primary care physician and approved by the Participant.	The care coordination or IDT P&P includes a description of how the FIDA Plan will compose the IDT and determine the team members.
5. Key care management and service planning functions of the IDT include: a. Establishing and implementing of a written Person-Centered Service Care Plan (PCSP) for the Participant; and b. Assisting each Participant in accessing services called for under the PCSP.	The IDT P&P includes these IDT functions.
6. The FIDA Plan ensures that staff team members who are performing care management activities are: a. Operating within their professional scope of practice; b. Appropriately qualified to meet the Participant's needs; and c. In compliance with the State's licensure/credentialing requirements.	The care coordination or IDT P&P describes how the FIDA Plan will ensure that staff team members are operating within their professional scope of practice and complying with the State's licensure/credentialing requirements.

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7. The FIDA Plan provides person-centered care management functions to all Participants. This includes making the following supports available, depending on the Participant's needs and preferences: a. A single, toll-free point of contact for all of the Participant's questions; b. Ability to develop, maintain and monitor the PCSP; c. Assurance that referrals result in timely appointments; d. Communication and education regarding available services and community resources; e. Assistance developing self-management skills to effectively access and use services. f. Assurance that the Participant receives needed medical and behavioral health services, preventative services, medications, community-based or facility-based LTSS, social services and enhanced benefits; this includes: i. Setting up appointments, ii. In-person contacts as appropriate; iii. Strong working relationships between care managers and physicians; iv. Evidence-based Participant education programs; and v. Arranging transportation as needed; g. Continuous monitoring of functional and health status; and h. Seamless transitions of care across specialties and settings.	Care coordination P&P defines the role and responsibilities of the IDT and either this P&P or other P&Ps include the IDT's specified functions.
8. The FIDA Plan has a process for assigning to each Participant a care manager with the appropriate experience and qualifications based on a Participant's individual needs (e.g., communication, cognitive, or other barriers). The process includes mechanisms to guarantee the right of each Participant to choose and change his/her care manager at any time.	Care coordination P&P requires each Participant to have a care manager based on his or her risk level and/or individual needs and outlines the process for assigning such care manager. FIDA Plan describes reasonable measures taken to ensure that staff and Participants are matched based on their expertise and special needs.
9. The FIDA Plan ensures that a Participant and/or his or her caregiver are able to request a change in the Participant's care manager.	Care coordination P&P describes the process by which a Participant may request a change in his or her care manager (as applicable).
10. The FIDA plan has a process that 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.	Care coordination P&P describes the process, including the timing and manner, by which the care manager and/or the 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.
B. Person-Centered Service Plan (PCSP)	
1. The FIDA plan ensures that every Participant has a PCSP developed by the Participant's IDT.	Care planning P&P states that the FIDA Plan intends to provide person-centered care to all Participants, and describes strategies for assuring this.
2. In developing the PCSP, the IDT considers: a. The Participant's current psychosocial and medical needs, functional and behavioral health needs, language and culture, and history of the Participants; b. Information on the Participant's functional level and support systems; c. Measureable goals, interventions, and expected outcomes with completion timeframes; d. Involvement of the Participant and caregivers; and e. Requirements that services must be provided in the least restrictive community setting; f. The Participant's wishes in determining the place of service; and g. The Participant's needs for assistance in accessing services.	Care Planning P&P states that the FIDA Plan assures that these elements are incorporated into the PCSP.

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3. The FIDA Plan ensures that the IDT completes the PCSP for all Participants within 30 days of conducting a comprehensive assessment and that the process for completing the PCSP is culturally competent.	Care planning P&P includes these timeframes and describes the process for meeting the timeframes.
4. The FIDA Plan ensures that the Participant receives: a. Any necessary assistance and accommodations to prepare for and fully participates in the care planning process; and b. Information about: i. His or her health conditions and functional limitations; ii. How family members and social supports can be involved in the care planning as the Participant chooses; iii. Self-directed care options and assistance available to self-direct care; iv. Opportunities for educational and vocational activities; and v. Available treatment options, supports and/or alternative courses of care.	Care planning P&P describes how the FIDA Plan will ensure that the Participant receives necessary assistance accurate information and the type specified.
5. The Person-Centered Service Plan contains the following: a. Prioritized list of Participant's concerns, needs, and strengths; b. Attainable goals and outcome measures, c. Target dates for meeting the goals and outcome measures selected by the Participant and/or caregiver; d. Strategies and actions, including interventions and services to be implemented specifying: i. The person(s)/providers responsible for specific interventions/services; and ii. The frequency of the intervention/service; e. Progress towards the goals noting successes, barriers or obstacles; f. Participant's informal support network and services; g. Participant's need for and plan to access community resources and non-covered services; h. Participant choice of services (including self-direction); i. Participant choice of service providers; j. IDT service planning, coverage determinations, care coordination and care management are delineated; and k. Individualized back-up plans.	Care planning P&P states that the FIDA Plan assures that these elements are incorporated into the Person-Centered Service Plan.
6. The FIDA Plan has a process to: a) Monitor the PCSP to identify any gaps in care; b) Address any gaps in an integrated manner through the IDT, including any necessary revisions to the PCSP; c) Update the PCSP in the same time frames articulated in Assessment Criterion #4.	Care planning P&P describes the process by which the FIDA Plan monitors PCSPs, including which FIDA Plan staff and/or IDT members conduct the monitoring and the frequency of the monitoring. Care planning P&P also specifies the process by which any gaps in care will be addressed in an integrated manner by the IDT and be incorporated into the PCSP.
7. The FIDA Plan accommodates Participants' religious or cultural beliefs and basic Participant rights articulated in the Demonstration proposal in developing the Person-Centered Service Plan.	Care planning P&P states that the FIDA Plan accommodates Participants' religious or cultural beliefs and basic Participant rights in developing the Person-Centered Service Plan.
C. Self-Directed Services: Consumer Direction	
1. The FIDA plan assures that all Participants have the opportunity to direct their own services through the consumer-directed personal assistance option. This includes both employer and budget authority.	FIDA Plan P&Ps on self-direction include this requirement
2. FIDA Plan informs Participants of the option to self-direct their own services at initial and annual care planning meetings.	FIDA Plan P&Ps on self-direction include this requirement.
3. The FIDA Plan has policies to provide the Participant the following information: a. An explanation that self-direction of services is voluntary, and that the extent to which Participants would like to self-direct is the Participant's choice;	Sample Participant communications demonstrating that the FIDA Plan has provided the information contained within this criterion to all Participants.

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b. An explanation of the options to select self-directed supports or services; and c. An overview of the supports and resources available to assist Participants to participate to the extent desired in self-direction.	
4. The FIDA Plan's policies regarding self-direction conform to the State requirements. The FIDA plan must: a. Describe how it will educate consumers and informal caregivers on self-directed (consumer-directed) options b. Describe how it will monitor the education efforts c. Describe how it will evaluate the self-directed (consumer-directed) services d. Describe how it will monitor and evaluate the percentage of consumers that use the self-directed (consumer-directed) option	Personal care service P&Ps describe how the FIDA Plan will meet the State self-direction requirements.
D. Coordination of Services-	
1. The FIDA Plan has a process to monitor and audit care coordination that includes, at a minimum: a. Documenting and preserving evaluations and reports of the care coordination program; b. Ensuring that care coordination is provided in a culturally competent way; c. Ensuring that care coordination is comprehensive and encompasses all services needed by the Participant and outlined in the PCSP, including non-covered services as well as those Medicaid services not included in the capitation payment (Medicare and Medicaid Hospice services, Out of Network Family Planning services, Directly Observed Therapy for Tuberculosis, and Methadone Maintenance Treatment); d. Reviewing information from electronic PCSPs to evaluate utilization, preferences, needs, and any other data trends; and e. Communicating these results and subsequent improvements to FIDA Plan advisory boards and/or stakeholders.	Care coordination P&P explains how and when the FIDA Plan will evaluate the processes within the care coordination program. Care coordination P&P explains how the results of the evaluation will be communicated to FIDA Plan advisory boards and/or stakeholders.
2. The FIDA plan describes how the IDT facilitates timely and thorough coordination between the FIDA Plan, the IDT, the primary care provider, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, community-based and facility-based LTSS, etc.).	Care coordination P&P outlines how coordination between the parties will occur, including the mechanism by which information will be shared and how the FIDA Plan will facilitate the coordination.
E. Transitions Between Care Settings	
1. FIDA plan has a policy and procedure for insuring that the hospitals and nursing homes are not imposing a requirement for a 3-day hospital stay prior to covering a skilled nursing facility stay.	Policies and Procedures prohibit imposing a minimum 3-day hospital stay prior to covering a skilled nursing facility stay.
2. For individuals in a nursing facility who wish to move to the community, the FIDA Plan will refer them to preadmission screening teams or the Money Follows the Person (MFP) Program.	Sample communications the FIDA Plan plans to send to Participants living in institutional settings contain information related to accessing community supports.
3. FIDA Plan tracks the number of Participants who wish to move to the community and are referred to preadmission screening teams or the MFP Program and reports this information to the State.	Sample report(s) from the FIDA Plan describes how it tracks Participant referrals to preadmission screening teams and MFP Program.
4. FIDA Plan has policies and procedures to ensure that when patients are in a hospital awaiting discharge because of a need for nursing facility placement or community-based services authorization, IDTs provide any prior authorizations within 48 hours of readiness for discharge.	Care setting transitions P&P describes how IDTs will be informed of an impending hospital discharge and the process IDTs will use to provide any prior authorization within 48 hours.
5. The FIDA Plan has a policy and procedure for monitoring transfers to minimize unnecessary complications during care setting transitions	Care setting transitions P&P explains how the FIDA Plan and providers work together to minimize

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and hospital re-admissions.	unnecessary complications related to care setting transitions and hospital readmissions and how the FIDA Plan monitors transfers and hospital readmissions.
6. The FIDA Plan has policies and procedures to reduce preventable injuries in hospitals, nursing facilities, and during transfers between settings.	Policies and procedures establish requirements around reducing preventable injuries in hospitals, nursing facilities, and during transfers between settings
7. The FIDA Plan's protocols for care setting transition planning ensure that: a. All community supports, including housing, are in place prior to the Participant's move; and b. Providers are knowledgeable and prepared to support the Participant, including interfacing and coordinating with and among clinical services and community-based LTSS.	Care setting transitions P&P explains how the FIDA Plan ensures that community supports are available prior to a Participant's move. Sample care setting transition plan(s) detail the steps the FIDA Plan takes to ensure continuity of care for a Participant changing care settings.
8. The FIDA Plan helps Participants transition to another provider if their provider leaves the FIDA Plan's network.	Care coordination P&P and/or provider handbook includes this policy.
9. The FIDA Plan transitions Participants to new providers, if needed, once the PCSP is completed.	Care coordination P&P and/or provider handbook includes policy.
F. Participant Ombudsman	
1. The FIDA Plan collaborates with the Participant Ombudsman (PO) as required by the terms of the Three-way Contract related to program access and service coordination.	The FIDA Plan will have a PO P&P that describes the working relationship between the FIDA Plan, PO, and FIDA Demonstration Participants.
2. FIDA Plan policies and procedures must require staff to cooperate with the PO as follows: a. Designate a staff liaison or supervisor responsible for overseeing and ensuring cooperation with the PO. b. Answer questions raised by the PO on behalf of a specific Participant: i. Within reasonable timeframes. ii. Upon receipt of oral or written authorization from a Participant for the PO to engage with FIDA Plan on behalf of a specified Participant. c. Track the nature of the PO questions, the responses provided, and the timeframes within which each matter is resolved.	PO P&P identifies which FIDA Plan staff will be responsible for overseeing and ensuring cooperation with the PO. The PO P&P describes the timeframe in which the FIDA Plan will respond to questions raised by the PO and the process the FIDA Plan will use to track the nature of the PO questions. Staffing Plan

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Confidentiality	
Readiness Review Criteria	**Suggested Evidence**
1. The FIDA Plan provides a privacy notice to Participants, which explains the policies and procedures for the use and protection of protected health information (PHI).	Sample privacy notice to be sent to Participants or privacy P&P explains how the FIDA Plan will safeguard PHI.
2. The FIDA Plan provides a privacy notice to providers, which explains the policies and procedures for the use and protection of PHI.	Sample privacy notice to be sent to providers or privacy P&P explains how the FIDA Plan will safeguard PHI and the provider's role in safeguarding PHI.
3. FIDA Plan ensures privacy and security of Participant health records and provides for access by Participants to such records.	Privacy P&P

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Participant and Provider Communications	
A. Participant and Provider Communications	
Readiness Review Criteria	**Suggested Evidence**
1. The FIDA Plan maintains and operates a toll-free Participant services telephone line call center 8:00 A.M. to 8:00 P.M. Eastern Time, seven days per week. Plan sponsors are permitted to use alternative technologies to meet the customer service call center requirements for Saturdays, Sundays, and holidays.	Participant services telephone line P&P confirms that the hotline is toll-free and available during required times for medical services, community-based and facility-based LTSS, and drugs.
2. The FIDA Plan's customer service department representatives shall, upon request, make available to Participants and potential Participants information including, but not limited to, the following: a. The identity, locations, qualifications, and availability of providers; b. Participants' rights and responsibilities; c. The procedures available to a Participant and/ or provider(s) to challenge or appeal the failure of the FIDA Plan to provide a covered service and to appeal any adverse actions (denials); d. How to access oral interpretation services and written materials in prevalent languages and alternative, cognitively accessible formats; e. How to access the Participant Ombudsman and the NYSDOH Participant Call Center and 1-800-Medicare; f. Information on all FIDA Plan covered services and other available services or resources (e.g., State agency services) either offered directly through the FIDA Plan or through referral or authorization; and g. The procedures for a Participant to changes FIDA Plans or to opt out of the Demonstration and information on how Participants can access the Enrollment Broker to effectuate such a change.	Participant services telephone line P&P confirms that all of the listed information will be available to customer service department representatives. Staffing plan
3. The FIDA Plan operates a toll-free call center with live customer service representatives available to respond to providers or Participants for information related to coverage determinations (including exceptions and prior authorizations), grievances, and appeals. The call center must meet all requirements in CMS Marketing Guidelines Appendix 5, including that it must operate during normal business hours and never less than 8:00 A.M. to 6:00 P.M., Monday through Friday according to the time zones for the regions in which they operate.	Participant services telephone line P&P confirms that the hotline is toll-free and available during required times.
4. The FIDA Plan maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency Participants. In addition: a. The hours of operation for the FIDA Plan's language line are the same for all Participants, regardless of the language or other methods of communication they use to access the hotline; and b. The language line is TDD/TTY accessible.	Contract with language line company includes these requirements, including mandatory hours of operation.
5. The FIDA Plan ensures that it and its providers are able to communicate with their Participants in a manner that accommodates their individual needs, including providing interpreters for those who are deaf or hard of hearing, accommodations for those with cognitive limitations, and interpreters for those who do not speak English.	IDT P&P describes how the FIDA Plan will ensure that IDT members and other providers communicate with Participants in a manner that accommodates individual needs.

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Participant and Provider Communications	
6. The FIDA Plan translates vital documents, including but not limited to forms, plan information, and educational materials, into the six most common non-English languages spoken by individuals with limited-English proficiency in the State of New York, based on United States census data. The NYSDOH approved functional assessment tool is also be provided as translated into these languages. The FIDA Plan ensures that these documents are updated.	IDT P&P describes how the FIDA Plan will ensure that vital documents are translated and that translations are continually reviewed and updated.
B. Stakeholder Feedback	
1. FIDA Plan must conduct at least two Participant Feedback Sessions in its service areas each year. a. Participants must be invited to raise problems and concerns and to provide positive feedback. b. Plan must assist Participants with the costs, transportation, and other challenges of attending these in-person Participant Feedback Sessions. c. Plan must summarize each session and make the summary available to Participants and the public.	Participant feedback P&P describes that the FIDA Plan will conduct at least two Participant Feedback Sessions in its service area(s) each calendar year and assist with the costs of transportation and other challenges of attending in-person, The Participant Feedback P&P also describes the manner and timeframe in which feedback will be summarized and provided to Participants and the public. Staffing plan
2. The FIDA Plan will be required to have at least one Participant Advisory Committee (PAC) open to all Participants and family representatives as well as the Demonstration's Participant Ombudsman. a. The FIDA Plan must have a plan for the PAC to meet at least quarterly. b. The FIDA Plan must establish a process for the PAC to provide input to the FIDA Plan. c. The FIDA Plan must share any updates or proposed changes as well as information about the number and nature of grievances and appeals, information about quality assurance and improvement, information about enrollments and disenrollments, and more. d. The PAC members would be invited to voice questions and concerns about topics including but not limited to quality of life and service delivery and would be encouraged to provide input and feedback into topics raised by the FIDA Plan. e. The FIDA Plan must demonstrate that the Participant PAC composition reflects the diversity of the FIDA Participant population, and participation of individuals with disabilities, including Participants, within the governance structure of the FIDA Plan. f. The FIDA Plan is encouraged to include Participant representation on their boards of directors.	Participant feedback P&P confirms that the FIDA Plan will establish a PAC that is open to all Participants and the Participant Ombudsman, which meets at least quarterly. Bylaws governing the FIDA Plan's PAC state that individuals with disabilities are to participate on the committee (or otherwise have a role in the governance structure of the FIDA Plan), and that the PAC has a process for providing input to the FIDA Plan's governing board. Staffing plan
B: Pharmacy Technical Support-	
1. The FIDA Plan or pharmacy benefit manager (PBM) has a pharmacy technical help desk call center that is prepared for increased call volume resulting from Demonstration enrollments.	The FIDA Plan (or PBM) has a staffing plan that shows how it has arrived at an estimated staffing ratio for the pharmacy technical help desk call center and how and in what timeframe it intends to staff to that ratio.
2. The FIDA Plan ensures that pharmacy technical support is available at any time that any of the network's pharmacies are open.	Hours of operation for technical support cover all hours for which any network pharmacy is open.

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Participant Protections	
Readiness Review Criteria	**Suggested Evidence**
A: Participant Rights	
1. The FIDA Plan has established Participant rights and protections and assures that the Participant is free to exercise those rights without negative consequences.	Participant rights P&P articulates Participants' rights, states that Participants will not face negative consequences for exercising their rights, and includes disciplinary procedures for staff members who violate this policy.
2. The FIDA Plan policies articulate that it will notify Participants of their rights and protections (including appeal and grievance rights) at least annually, in a manner appropriate to their condition and ability to understand.	Participant rights P&P provides a timeline for updating Participants about changes or updates to their rights and protections. Participant rights P&P details how notifications will be adapted based on the Participant's condition and ability.
3. The FIDA Plan does not discriminate against Participants due to: a. Medical condition (including physical and mental illness); b. Claims experience; c. Receipt of health care; d. Medical history; e. Genetic information; f. Evidence of insurability; or g. Disability.	Participant rights P&P addresses that the FIDA Plan will not discriminate and will prohibit its providers from discriminating against Participants based on the enumerated reasons. Staff training includes discussion of Participant rights.
4. The FIDA Plan informs Participants that they will not be balanced billed by a provider for the cost of any covered service, which includes any coinsurance, deductibles, financial penalties, or any other amount in full or in part. This is articulated through policies and procedures and staff and provider training modules.	Participant rights P&P explains that the FIDA Plan informs beneficiaries that they should not be balanced billed for any covered service, any coinsurance, deductibles, financial penalties, or any other amount in full or in part. Training materials for providers and staff cover this rule.
5. The FIDA Plan has policies and procedures to ensure that it provides reasonable accommodations and to ensure that it informs Participants of their right to reasonable accommodation.	Participant rights P&P states that the FIDA Plan informs Participants of their right to reasonable accommodation. P&P ensure that the FIDA Plan and its providers are required to provide reasonable accommodations.
B: Appeals and Grievances	
1. The FIDA Plan staff receive training on Participant protections, including but not limited to: a. The FIDA Plan's organization and coverage determination processes; and b. Appeals and grievance processes.	Training materials contain information about the FIDA Plan's organization and coverage determination processes and the appeals and grievance processes.
2. The FIDA Plan provides Participants with a "Notice of Denial of Medical Coverage" that provides appeal rights Note: CMS and the New York State Department of Health (NYSDOH) will provide FIDA Plans with a template Notice.	The Notice of Denial of Medical Coverage is consistent with the CMS-State template.
3. The FIDA Plan provides Participants with reasonable assistance in filing an appeal or grievance. Any assistance must include information and reminders about the availability of the Participant Ombudsman and how to contact the PO.	Grievances and appeals P&P explains the extent to which the FIDA Plan will assist a Participant in filing an appeal or grievance and extent to which may and must refer to the Participant Ombudsman.
4. The FIDA Plan maintains an established process to track and maintain records on all grievances, received both orally and in writing, including, at a minimum: a. The date of receipt;	Screenshots of or reports from the tracking system in which Participant grievances are kept include these elements.

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b. Final disposition of the grievance; and c. The date that the FIDA Plan notified the Participant of the disposition.	Data summaries or reports detail the types of reporting and remediation steps that are taken to ensure grievances are correctly handled. Grievances P&P define how staff from the FIDA Plan should document grievances within the tracking system.
5. The FIDA Plan's policies and procedures for Participant grievances include the following: a. Participants are entitled to file grievances directly with the FIDA Plan. b. The FIDA Plan must send written acknowledgement of grievances to the Participant within 15 days of receipt. c. If a decision is reached before the written acknowledgement is sent, the FIDA Plan will not send the written acknowledgment. d. The grievance must be decided as fast as the Participant's condition requires but not later than: i. Expedited: Paper review – decision and notification within 24 hours (in certain circumstances outlined in the MOU). For all other circumstances where a standard decision would significantly increase the risk to a Participant's health, decision and notification within 48 hours after receipt of all necessary information and no more than 7 calendar days from the receipt of the grievance. ii. Standard: Notification of decision within 30 calendar days of the FIDA Plan receiving the written or oral grievance. iii. Extension: The FIDA Plan may extend the 30-day timeframe by up to 14 calendar days as outlined in the MOU. The FIDA Plan must justify a need for additional information and have a process for documenting how the delay is in the interest of the Participant. The FIDA Plan has a process to immediately notify the Participant in writing of the reason for delay. e. The FIDA Plan must notify the Participant of the decision by phone for expedited grievances and provide written notice of the decision within 3 business days of decision (expedited and standard). f. The FIDA Plan tracks and resolves all grievances or reroutes grievances to the coverage decision or appeals process as appropriate; and g. The FIDA Plan has internal controls in place to identify incoming requests as grievances, initial requests for coverage, or appeals, and has processes to ensure that such requests are processed through the appropriate avenues in a timely manner.	Grievances P&P includes these specifications Staffing plan
6. The FIDA Plan notifies Participants of all Medicare and Medicaid appeal rights through a single notice specific to the service or item type in question.	Appeals P&P includes these specifications and how the FIDA Plan will monitor compliance with them.

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7. The FIDA Plan maintains policies and procedures for Participant appeals, in accordance with the requirements specified in the CMS-State MOU. These policies and procedures include the following: a. Participants are entitled to file appeals directly with the FIDA Plan. The appeal must be requested within 60 days of postmark date of notice of action if there is no request to continue benefits while the appeal decision is pending. If there is a request to continue benefits while the appeal decision is pending and the appeal involves the termination or modification of a previously authorized service, the appeal must be requested within 10 days of the notice's postmark date or by the intended effective date of the Action, whichever is later. b. Upon receipt of an appeal, the FIDA Plan sends written acknowledgement of appeal to the Participant within 15 calendar days of receipt. If a decision is reached before written acknowledgement is sent, the FIDA Plan will not send the written acknowledgement. c. The FIDA Plan decides and notifies the Participant (and provider, as appropriate) of its decision as fast as the Participant's condition requires but: i. Expedited: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than within 72 hours of the receipt of the appeal. ii. Standard: Paper review unless a Participant requests in-person review - as fast as the Participant's condition requires, but no later than 7 calendar days from the date of the receipt of the appeal on Medicaid prescription drug appeals and no later than 30 calendar days from the date of the receipt of the appeal. iii. Extension: An extension may be requested by a Participant or provider on a Participant's behalf (written or oral). The FIDA Plan may also initiate an extension if it can justify need for additional information and if the extension is in the Participant's interest. In all cases, the extension reason must be well-documented, and when the FIDA Plan requests the extension it notifies the Participant in writing of the reasons for delay and informs the Participant of the right to file an expedited grievance if he or she disagrees with the FIDA Plan's decision to grant an extension. d. The FIDA Plan makes a reasonable effort to provide prompt oral notice to the Participant for expedited appeals and document those efforts. The FIDA Plan sends written notice within 2 calendar days of providing oral notice of its decision for standard and expedited appeals.	Appeals P&P includes these specifications
8. The FIDA Plan has a process to auto forward any adverse decision to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance. This step occurs regardless of the amount in controversy (i.e., there will be no amount in controversy limit imposed). The FIDA Plan has a process to send an Acknowledgement of Automatic Administrative Hearing and Confirmation of Aid Status within 14 calendar days of forwarding the administrative record.	Appeals P&P includes these specifications.
9. The FIDA Plan has a process to provide continuing benefits for all prior-approved Medicare and Medicaid benefits that are terminated or modified, pending internal FIDA Plan appeals, Integrated Administrative Hearings, and Medicare Appeals Council if the original appeal is requested to the FIDA Plan within 10 calendar days of the notice's postmark date (of the decision that is being appealed) or by the intended effective date of the Action, whichever is later. This means that such benefits will continue to be provided by providers to beneficiaries,	Appeals P&P includes these specifications

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and that FIDA Plans must continue to pay providers for providing such services, pending a FIDA Plan appeal under internal FIDA Plan review, Integrated Administrative Hearing Officer review, and Medicare Appeals Council review.	
C: Participant Choice of PCP	
1. The FIDA Plan allows Participant to select his or her PCP and the Participant's right to select a specialist to act as a PCP.	PCP selection and assignment P&P specifies how a participant can choose and change his/her PCP and how a Participant can select a specialist as a PCP.
D: Emergency Services	
1. The FIDA Plan has a back-up plan in place in case a community-based or facility-based LTSS provider does not arrive to provide assistance with activities of daily living.	Emergency services P&P explains how the FIDA Plan is prepared to provide care to community-based and facility-based LTSS Participants when a community-based or facility-based LTSS provider does not arrive to provide care.
2. The FIDA Plan can connect Participants with emergency behavioral health services, when needed.	Emergency services P&P addresses how the FIDA Plan is prepared to provide emergency behavioral health services to Participants in crisis.
3. The FIDA Plan ensures access to emergency care and urgently needed care in accordance with State and Federal requirements.	Emergency services P&P

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Organizational Structure and Staffing	
Readiness Review Criteria	**Suggested Evidence**
A. Organizational structure and staffing	
1. The FIDA Plan identifies a: a. Behavioral Health Clinical Director; b. Director of Long-Term Services and Supports; c. A single point of contact for care coordination and care management; and d. A single point of contact for pharmacy services.	Staff resumes indicate that qualified and experienced staff with appropriate expertise fills these positions.
2. The FIDA Plan's Quality Improvement (QI) committee includes physicians, psychologists, providers with expertise in community-based and facility-based LTSS, pharmacists, and others, who represent a range of health care services used by Participants in the target population.	QI committee members are appropriate based on the target population described in the CMS-state MOU. Note: For FIDA Plans with current QI committees, review will focus on the change in composition to address the new services (e.g., community-based and facility-based LTSS and behavioral health).
3. The FIDA Plan has an individual or committee responsible for provider credentialing who is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, community-based and facility-based LTSS, behavioral health, and pharmacy).	A provider credentialing point of contact or committee is reflected in organizational chart. The provider credentialing point of contact is experienced and qualified to oversee provider credentialing for the full range of providers (e.g., medical, community-based and facility-based LTSS, behavioral health, and pharmacy).
B: Sufficient Staff	
1. The FIDA Plan demonstrates that it has sufficient employees and/or contractors to complete Participant assessments as required by the MOU, in a timely manner (as defined in the MOU and Readiness Review Criteria for Assessment) for all Participants through its staffing plan and explains: a. The FIDA Plan's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the FIDA Plan believes will be needed to perform the function: d. How the FIDA Plan derived that estimate; and e. In what timeframe the FIDA Plan will staff to the level indicated.	The FIDA Plan staffing plan demonstrates that it meets the requirements of the criterion and its estimation is reasonable. The FIDA Plan also submits completed attached readiness review staffing worksheet.
2. Registered nurses who are employed by the FIDA Plan staff, contractors, or providers and perform Participant comprehensive assessments have the appropriate education and experience for the subpopulations (e.g., experience in community-based and facility-based LTSS, behavioral health).	Job descriptions include relevant educational and experience requirements. Resumes for selected staff indicate staff meets job description.
3. The FIDA Plan demonstrates that it has sufficient care managers to facilitate IDT activities and communication; facilitate assessment of Participant needs; ensure and assist in developing, implementing, and monitoring the PCSP, and serve as the lead of the IDT. The FIDA Plan must ensure that the care manager's case load is reasonable to provide appropriate care coordination and care management.	Care manager qualifications P&P includes those listed. The FIDA Plan demonstrates reasonable ratios of care managers to Participants to ensure appropriate care coordination and care management. Care manager qualifications P&P describes the number of Participants assigned to care managers (i.e., caseload ratios), including how these caseloads vary by Participant risk level.
4. Care managers must have the appropriate experience and qualifications commensurate with a Participant's individual needs (i.e., communication,	Job descriptions include relevant educational and experience requirements.

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Organizational Structure and Staffing	
Readiness Review Criteria	**Suggested Evidence**
cognitive, or other barriers). Care managers must have knowledge of physical health, aging and loss, appropriate support services in the community, 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.	
5. The FIDA Plan demonstrates that it has sufficient employees and/or contractor staff to handle care coordination oversight, in a timely manner for all Participants through its staffing plan, and explains: a. The FIDA Plan's estimate of its enrollment over the enrollment period; b. Which staff position(s) will complete the function; c. How many employees in those staff position(s) the FIDA Plan believes will be needed to perform the function: d. How the FIDA Plan derived that estimate; and e. In what timeframe the FIDA Plan will staff to the level indicated.	The FIDA Plan staffing plan demonstrates that it meets the requirements of the criterion and its estimation is reasonable. The FIDA Plan also submits completed attached readiness review staffing worksheet.
6. The FIDA Plan demonstrates that it has sufficient employees and/or contractor staff to handle organization and coverage determinations and appeals and grievances, in a timely manner for all Participants through its staffing plan, and explains: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the FIDA Plan believes will be needed to perform the function: c. How the FIDA Plan derived that estimate; and d. In what timeframe the FIDA Plan will staff to the level indicated.	The FIDA Plan staffing plan demonstrates that it meets the requirements of the criterion and its estimation is reasonable. The FIDA Plan also submits completed attached readiness review staffing worksheet.
7. The FIDA Plan demonstrates that it has sufficient employees and/or contractor staff to handle its call center operations, including care management hotline through its staffing plan in a timely manner for all Participants through its staffing plan and explains: a. Which staff position(s) will complete the function; b. How many employees in those staff position(s) the FIDA Plan believes will be needed to perform the function: c. How the FIDA Plan derived that estimate; and d. In what timeframe the FIDA Plan will staff to the level indicated.	The FIDA Plan staffing plan demonstrates that it meets the requirements of the criterion, its estimation is reasonable and includes how the FIDA Plan will ensure ongoing compliance with the staffing plan. The FIDA Plan also submits completed attached readiness review staffing worksheet.
8. The FIDA Plan Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity.	Utilization management program description or coverage determination P&P includes requirement that medical director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. Job description for the medical director includes this responsibility.
C: Staff Training	
1. The FIDA Plan has a cultural competency and disability training plan to ensure that all staff (including employees who participate in IDTs) delivers culturally-competent services, in both oral and written Participant communications (e.g., person-first language, target population competencies). This includes training on accessibility and accommodations, independent living and recovery models, cultural competency, and wellness philosophies, as well as Olmstead requirements. FIDA Plan must offer training to additional members of the IDT who are not FIDA Plan employees: primary care providers and specialists, as appropriate.	The FIDA Plan's cultural competency and disability training plan (or training P&P) identifies which staff receive this training and how often, and includes a schedule of training activities for new staff. P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training. The FIDA Plan's training materials include training on cultural competency and disability.

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Organizational Structure and Staffing	
Readiness Review Criteria	**Suggested Evidence**
2. The FIDA Plan staff is adequately trained to handle critical incident and abuse reporting. Training includes, among other things, ways to detect and report instances of abuse, neglect, and exploitation of Participants by service providers and/or natural supports providers.	The FIDA Plan's training materials include training on critical incident and abuse reporting and include these topics. P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training..
3. The training program for care managers includes, but is not limited to information detailing: a. Roles and responsibilities; b. Timeframes for all initial contact and continued outreach; c. Needs assessment and care planning; d. Service monitoring; e. Community-based and facility-based LTSS; f. Self-direction of services; g. Behavioral health; h. Durable medical equipment; i. Care transitions; j. Skilled nursing needs; k. Abuse and neglect reporting; l. Pharmacy and Part D services; m. Community resources; n. Participant rights and responsibilities; o. Independent living philosophy; p. Most integrated/least restrictive setting; q. How to identify behavioral health and community-based and facility-based LTSS needs; r. How to obtain services to meet behavioral and community-based and facility-based LTSS needs; and s. Other knowledge areas, including: physical health aging and loss, appropriate support services in the community, 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 FIDA Plan's training materials for care managers include modules or sections on each of these elements. Care coordination P&P describes the process by which care managers will be trained in these specific knowledge areas, including which entity will develop the training materials, how the training will be provided, the frequency of the training, and a mechanism to measure competency of staff upon completion of training..
4. The FIDA Plan's staff is trained on confidentiality guidelines and has received training to meet HIPAA compliance obligations.	The FIDA Plan's training materials include training on HIPAA compliance and confidentiality guidelines. Training P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training..
5. The FIDA Plan has informational scripts for its customer service hotline staff including, but not limited to: a. Request for pre-enrollment information; b. Benefit information; c. Cost-sharing information; d. Continuity of care requirements; e. Enrollment/disenrollment; f. Formulary information; g. Pharmacy information, including whether an Participant's pharmacy is in the FIDA Plan's network; h. Provider information, including whether an Participant's physician is in the FIDA Plan's network; i. Out-of-network coverage; j. Claims submission, processing, and payment; k. Formulary transition process; l. Grievance, coverage determination, and appeals process (including how to address Medicaid drug and Medicare Part D appeals); m. Information on how to obtain needed forms;	Copies of pharmacy customer service hotline staff scripts contain content related to the competencies listed in the criteria. (See State specific MOU for details)

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Organizational Structure and Staffing	
Readiness Review Criteria	**Suggested Evidence**
n. Information on replacing an identification card; and o. Service area information.	
6. The FIDA Plan's training protocols for Participant services telephone line staff include following areas: a. Explaining the operation of the FIDA Plan and the roles of participating providers; b. Assisting Participants in the selection of a primary care provider; c. Assisting Participants to obtain services and make appointments; and d. Handling or directing Participant inquiries or grievances.	Content from training programs or orientation modules demonstrates staff from the FIDA Plan trains its Participant services telephone line staff personnel on these topics and specifications on how the FIDA Plan will monitor that trainings have been completed. Training P&P will also address any ongoing training or update requirements and a mechanism to measure competency of staff upon completion of training.. Step-by-step procedures or a flow chart showing how staff from the FIDA Plan would walk through assisting Participants in explaining or selecting services.

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Performance and Quality Improvement	
Readiness Review Criteria	**Suggested Evidence**
Performance and Quality Improvement	
1. The FIDA Plan collects and tracks critical incidents and reports of abuse for Participants receiving community-based or facility-based LTSS.	QI program description explains how the FIDA Plan tracks incidents and cases of abuse for Participants receiving community-based or facility-based LTSS. Sample annual performance report includes the FIDA Plan's method of tracking and reporting cases of incidents and abuse.
2. The FIDA Plan must report measures that examine access and availability, care coordination/transitions, health and well-being, mental and behavioral health, patient/caregiver experience, screening and prevention, and quality of life. The FIDA Plan has policies and procedures, a staffing plan, and a staff supervision structure to ensure that it collects and reports all quality measures and fulfills all other reporting requirements.	QI program description includes all these elements. The FIDA Plan has policies and procedures, a staffing plan, and a staff supervision structure to ensure that it collects and reports all quality measures and fulfills all other reporting requirements

Provider Credentialing	
Readiness Review Criteria	**Suggested Evidence**
1. The FIDA Plan shall: a. Use the single, uniform, provider credentialing application that will be developed with the input from FIDA Plans and stakeholders, meet Medicare contracting requirements, and be approved for use in the FIDA Program to credential all providers of the provider types specified in the application. b. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the FIDA Plan's provider network that require, at a minimum, that the scope and structure of the processes be consistent with recognized managed care industry standards and relevant State regulations; c. Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted, following recognized managed care industry standards and relevant State regulations; and d. Maintain a documented re-credentialing process that occurs regularly and that requires that physician providers and other licensed and certified professional providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards and any other State requirements.	Provider credentialing P&P includes these requirements.
2. Prior to contracting with a new provider, the FIDA Plan verifies the following: a. A valid license to practice medicine, when applicable; b. A valid Drug Enforcement Act (DEA) certificate, when applicable, by specialty; c. Other education or training, as applicable, by specialty; d. Malpractice insurance coverage, when applicable; e. Work history; f. History of medical license loss; g. History of felony convictions; h. History of limitations of privileges or disciplinary actions; i. Medicare or Medicaid sanctions; and j. Malpractice history.	Provider credentialing P&P states that the FIDA Plan will review these documents and this information, as applicable, prior to contracting with a provider and on an ongoing basis to ensure continuous compliance. It specifies what copies the FIDA Plan will maintain of which documents. Sample initial completed credentialing application instructions.

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3. The FIDA Plan requires all contracted laboratory testing sites maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification.	The FIDA Plan submits a copy of its contract template with its laboratory contractor(s) that requires them to maintain CLIA certification or have a waiver.
4. The FIDA Plan requires providers to use evidence-based practices. In doing so: a. FIDA Plans shall develop and employ mechanisms to ensure that service delivery is evidence-based and that best practices are followed in care planning and service delivery. b. FIDA Plans will have to demonstrate how they will ensure that their providers are following best-evidence clinical guidelines through decision support tools and other means to inform and prompt providers about treatment options. c. FIDA Plans will have to identify how they will employ systems to identify and track patients in ways that provide patient-specific and population based support, reminders, data and analysis, and provider feedback. d. FIDA Plans will be required to demonstrate how they will educate their providers and clinical staff about evidence-based best practices and how they will support their providers and clinical staff (through training or consultations) in following evidence-based practices. e. FIDA Plans will be required to demonstrate how they will hold their providers to evidence-based practices specific to their practice areas.	Provider participation requirement P&P specifies requirements to use best-evidence practices. Provider participation requirement P&P specifies how the FIDA Plan will educate and support providers in using best-evidence practices and how the FIDA Plan will monitor and enforce the use of best-evidence practices.

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Provider Network	
Readiness Review Criteria	**Readiness Review Criteria**
A: Establishment and Maintenance of Network, including Capacity and Services Offered	
1. The FIDA Plan has a clear plan to meet the Medicare and Medicaid provider network standards including those specified in the MOU, which takes into account: a. The anticipated enrollment; b. The expected utilization of services, taking into consideration the characteristics and health care needs of the target populations; c. The numbers and types (e.g., training, experience, and specialization) of providers required to furnish the contracted services, including community-based and facility-based LTSS providers; and d. Whether providers are accepting new Participants.	Provider network P&P defines expected number of Demonstration Participants and required number of providers. P&P specifies how access standards and network requirements specified in the MOU will be met continuously and how compliance will be measured and monitored. Provider network P&P defines specialties covered and how they relate to the specific needs of the target population.
2. The FIDA Plan has a policy and procedure and training materials that demonstrate that the medical, behavioral, and community-based and facility-based LTSS, provider networks are trained in cultural competency for delivering services to the following target populations.	Provider network P&P explains how its primary care, specialty, behavioral health, and community-based and facility-based LTSS providers are prepared to meet the additional competencies necessary to serve Participants within the target population. Provider training materials for all of these groups include modules on cultural competency when serving target populations.
3. The FIDA Plan has a policy and procedure that states that it establishes a panel of primary care providers (PCPs) from which Participants may select a PCP.	Provider network P&P describes PCP requirements and minimum required numbers of PCPs for counties or other FIDA Plan areas and for sub-populations of Participants, if applicable.
4. The FIDA Plan has a policy and procedure that states that it covers services from out-of-network providers and pharmacies when a network provider or pharmacy is not available within a reasonable distance from the Participant's place of residence.	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.
5. The FIDA Plan provides for a second opinion from a qualified health care professional within the network, or arranges for the Participant to obtain one outside the network, at no cost to the Participant.	Provider network P&P provides a description of and process for obtaining second opinion coverage by in-network and out-of-network providers.
6. The FIDA Plan ensures that Participants have access to the most current and accurate information by updating its online provider directory and search functionality on a timely basis.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).
7. The FIDA Plan ensures that it contracts with or has a payment arrangement with all nursing facilities in which any potential Participant resides.	Provider network P&P includes requirements for contracting and/or having a payment arrangement with all nursing facilities.
8. The FIDA Plan ensures that it meets any quality standards for participation of nursing facilities in the Demonstration, as outlined in the Three-Way Contract.	Provider network P&P includes requirements for contracting and/or having a payment arrangement with all nursing facilities.

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B: Accessibility	
1. Medical, behavioral, community-based and facility-based and LTSS, network providers provide linguistically- and culturally-competent services.	Provider network P&P specifies that providers are required to provide linguistically and culturally competent services and training includes training on linguistic and cultural competency.
2. Medical, behavioral, and community-based and facility-based LTSS network providers receive training in the following areas: a. Utilizing waiting room and exam room furniture that meet needs of all Participants, including those with physical and non-physical disabilities. b. Accessibility along public transportation routes and/or provide enough parking; c. Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities.	Provider network P&P requires providers to meet accessibility requirements (physical locations, waiting areas, examination space, furniture, bathroom facilities, and diagnostic equipment must be accessible.) and requires providers to complete training in these areas. Provider training materials detail special needs required by Participants and provide suggestions or solutions on how to work with such Participants. Templates require providers to take these actions as condition for participation.
C: Provider Training	
1. The FIDA Plan requires providers to meet applicable State minimum training requirements, including minimum hours and topics of training.	Provider training P&P include the minimum training requirements, identifies which providers receive which training and how often, and includes a schedule of training for new providers. Provider training P&P will also address any ongoing training or update requirements.
2. The FIDA Plan requires disability training for its medical, behavioral, and community-based and facility-based LTSS providers, including information about the following: a. Various types of chronic conditions prevalent within the target population; b. Awareness of personal prejudices; c. Legal obligations to comply with the ADA requirements; d. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs; e. Types of barriers encountered by the target population; f. Training on person-centered planning (i.e., Person-Centered Service Plans) and self-determination, the social model of disability, the independent living philosophy, and the recovery model; g. Use of evidence-based practices and specific levels of quality outcomes; and h. Working with Participants with mental health diagnoses, including crisis prevention and treatment.	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.
3. The FIDA Plan: a. Conducts trainings for IDT members and IDT members must agree to participate in approved training on the person-centered planning processes, cultural competence, 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. In addition, the FIDA Plan offers similar trainings to additional members of the team: primary care providers and specialists, as appropriate; b. Has a policy for documenting completion of training by all IDT members, including both employed and contracted personnel and has specific policies to address non-completion.	Sample training materials for IDT members and potential IDT members include the required topics. Provider training P&P states that completion of training of IDT members will be documented and defines the consequences associated with non-completion of IDT trainings.

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4. The FIDA Plan's training for all providers and IDT members includes coordinating with behavioral health and community-based and facility-based LTSS providers, information about accessing behavioral health and community-based and facility-based LTSS, and lists of community supports available.	Provider training materials include modules on coordination of care, behavioral health services, community-based and facility-based LTSS, and community supports (see also care manager training in the care coordination section).
5. The FIDA Plan provides training to providers that balance billing is prohibited under the Demonstration.	Provider training materials and provider handbook include information informing providers of no balance billing.
6. The FIDA Plan has procedures to address LTSS providers who are not required to have National Provider Identifiers (NPIs).	Data systems management guidelines for LTSS providers address community-based and facility-based LTSS providers who are not required to have National Provider Identifiers (NPIs).
7. The training program for primary care providers includes: a. How to identify behavioral health needs; b. How to assist the Participant in obtaining behavioral health services; c. How to identify community-based and facility-based LTSS needs; and d. How to assist the Participant in obtaining community-based and facility-based LTSS services.	The FIDA Plan's training materials for PCPs include modules or sections on behavioral health needs and services.
D: Provider Handbook	
1. The FIDA Plan prepares an understandable, accessible provider handbook (or handbooks for medical, behavioral, community-based and facility-based LTSS, and pharmacy providers), which includes the following: a. Updates and revisions; b. Overview and model of care; c. FIDA Plan contact information; d. Participant information; e. Participant benefits; f. Quality improvement for health services programs; g. Participant rights and responsibilities; and h. Provider billing and reporting.	Each of the listed elements is included in the provider handbook.
2. The FIDA Plan makes resources available (such as language lines) to medical, behavioral, community-based and facility-based LTSS, and pharmacy providers who work with Participants that require culturally-, linguistically-, or disability-competent care.	Provider handbook is 508 compliant and includes information on how to access language lines and resources for providers on how to provide culturally, linguistically, or disability-competent care (e.g., overviews and training materials on FIDA Plan website, information about local organizations serving specific subpopulations of the target population).
E: Ongoing Assurance of Network Adequacy Standards	
1. The FIDA Plan ensures that the hours of operation of all of its network providers, including medical, behavioral, community-based and facility-based LTSS, are convenient to the population served and do not discriminate against FIDA Plan Participants (e.g. hours of operation may be no less than those for commercially insured or public fee-for-service insured individuals), and that FIDA Plan services are available 24 hours a day, 7 days a week, when medically necessary.	Provider contract templates include provisions requiring non-discrimination against Participants and convenient hours of operation.
2. The FIDA Plan has a policy and procedure that states that the provider network arranges for necessary specialty care, community-based and facility-based LTSS, and behavioral health.	Provider network P&P states that the provider network arranges for necessary specialty care.

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	List of network providers includes specialties in all geographic regions for the Demonstration.

Monitoring of First-Tier, Downstream, and Related Entities	
Readiness Review Criteria	**Suggested Evidence**
1. The FIDA Plan has a detailed plan to monitor the performance on an ongoing basis of all first-tier, downstream, and related entities to assure compliance with applicable policies and procedures of the FIDA Plan. The FIDA Plan should be in compliance with 42 CFR §438.230 (b), the Medicaid managed care regulation governing delegation and oversight of sub-contractual relationships by managed care entities, and 42 CFR §422.504 (i), the Medicare Advantage regulation governing contracts with first tier, downstream, and related entities.	Monitoring plan provides information on how the FIDA Plan monitors all first-tier, downstream, and related entities.

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Systems	
Readiness Review Criteria	**Suggested Evidence**
A: Data Exchange	
1. The FIDA Plan is able to electronically exchange the following types of data: a. Person-Centered Service Plan; b. Participant benefit plan enrollment, disenrollment, and enrollment-related data; c. Claims data (including paid, denied, and adjustment transactions); d. Financial transaction data (including Medicare C, D, and Medicaid payments); e. Third-party coverage data; f. Health information from provider electronic medical record systems; g. Grievance and appeals; and h. Prescription drug event (PDE) data.	Baseline documentation should illustrate the types of data that can and will be electronically exchanged along with policies and procedures for securing, processing, and validating the exchange of data including EDI system specifications for transmitting ANSI compliant file formats—e.g., 834, 835, 837 transactions. Supporting documentation should include: 1) Information, logs, or reports that detail the current and/or historical volume and frequency of these data exchanges including acceptance/ rejection reports. 2) Documentation of rejection thresholds and data reconciliation processes. 3) File layouts for transmitted data illustrating compliance with transmission of required data elements (e.g., Items 2a-2i). 4) Documentation of FIDA Plan's transaction sets with CMS, the State, and other third party vendors, including where transaction are compliant with HIPAA versioning standards—e.g., HIPAA Version 5010.
2. The FIDA Plan or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator.	Baseline documentation should include data diagram and/or workflow detailing the TrOOP Financial Information Reporting (FIR) process to the TrOOP Facilitator. Supporting documentation should include transaction facilitator certification documentation for its FIR.
3. The FIDA Plan ensures that health information technologies and related processes support national, state and regional standards for health information exchange and interoperability.	Baseline documentation should include policies and procedures for monitoring the standards for health information exchange and interoperability. The FIDA Plan should highlight any HIE networks they currently participate in or are preparing to participate in.
4. The FIDA Plan has a disaster recovery plan to ensure business continuity in the event of a catastrophic incident.	Baseline documentation should include a copy of the FIDA Plan's disaster recovery and business continuity plan and an inventory of the core systems specifically used to operate this Demonstration. Supplemental documentation may include proof of disaster recovery plan validation and testing.
5. The FIDA Plan facilitates the secure, effective transmission of data.	Baseline documentation should include: 1) The FIDA Plan's Data Security and Privacy P&P; 2) The FIDA Plan's Data Security policies as they relate to remote access, laptops, handheld devices, and removable drives. 3) Documentation of processes to document a breach in data integrity and any associated corrective actions.

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Systems	
Readiness Review Criteria	**Suggested Evidence**
6. The FIDA Plan maintains a history of changes, adjustments, and audit trails for current and past data systems.	Baseline documentation should include change management P&Ps
7. The FIDA Plan complies with all applicable standards, implementation specifications, and requirements pertinent to the National Provider Identifier (standard unique health identifier for health care providers).	Baseline documentation should include: 1) FIDA Plan P&P noting compliance with NPI standards, specifications, and requirements. Screenshot of provider data/records illustrating that the NPI data field is populated in the provider systems.
B. Claims Processing	
1. The FIDA Plan processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates.	Baseline documentation should include: 1) Claims processing P&P that details claims processing turnaround timeframes, steps for managing pended claims, and methods for ensuring claims processing accuracy. 2) Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.).
2. The FIDA Plan processes adjustments and issues refunds or recovery notices within 45 days of receipt for complete information regarding a retroactive medical and community-based or facility-based LTSS claims adjustment.	Baseline documentation should include P&Ps on claims adjustments, refunds and recoveries that specify a 45-day processing requirement for retroactive medical and community-based and facility-based LTSS.
3. The claims systems have the capacity to process the volume of claims anticipated under the Demonstration.	Baseline documentation should include the current daily/monthly claims processing statistics, along with projections for anticipated claims volume during optional and passive enrollment under the Demonstration. Documentation should highlight the basis for FIDA Plan estimates as well as highlight mitigation procedures for addressing the large percentage increase in claims volume by FIDA Plan staff without affecting performance standards. Supplemental documentation may include statistics on average claims processed per processor, annual average of claims per Participant (with current plans), aging for pended claims, and other metrics used to monitor and evaluate claims processing performance and capacity.
4. The claims system fee schedule includes all medical, community-based and facility-based LTSS, home and community-based services (HCBS), Medicare and Medicaid services.	Baseline documentation should illustrate the following: 1) The FIDA Plan's process and plan for loading and validating the Demonstration fee schedules. 2) Screen shots of the modules where the fee schedules will be configured and identify how medical, community-based and facility-based LTSS and HCBS Medicare, and Medicaid services are captured within the system.

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Systems	
Readiness Review Criteria	**Suggested Evidence**
5. The claims processing system properly adjudicates claims for Medicare Part D and Medicaid prescription and Medicaid over-the-counter drugs.	Baseline documentation should include: 1) The FIDA Plan's oversight procedures for monitoring pharmacy claims processing including the PBM's plan to configure, test, and implement the benefits and adjudication rules to properly process prescription and over-the-counter drugs for the Demonstration. 2) The PBM's P&P and/or project plan for loading and validating benefit plans (e.g., formularies, system edits for transition period processing) for prescription and over-the-counter drugs. 3) Adjudication workflows that show coordination of Medicare and Medicaid formularies for accurate processing of all prescriptions and over-the-counter drugs.
C. Claims Payment	
1. The FIDA Plan pays all clean electronic within 30 days of receipt and paper claims within 45 days per NYS Insurance Law Section 3224a.	Baseline documentation should include: 1) Claims P&P that describes clean claims payment standards. 2) Claims payment report sample that details the average number of days between receipt and payment of current clean claims.
2. The FIDA Plan or its PBM pays clean claims from network pharmacies (other than mail-order and long-term care pharmacies) within 14 days of receipt for electronic claims and within 30 days of receipt all other claims. The FIDA Plan or its PBM pays interest on clean claims that are not paid within 14 days (electronic claims) or 30 days (all other claims).	Baseline documentation should include: 1) FIDA Plan's or its PBM's claims P&Ps that describe clean claims payment procedures and requirements for meeting processing standards. 2) FIDA Plan's or its PBM's P&Ps that define distinct interest payment requirements for clean electronic and all other claims.
3. The FIDA Plan or its PBM assures that pharmacies located in, or having a contract with, a long-term care facility must have not less than 30 days, nor more than 90 days, to submit to the Part D sponsor claims for reimbursement.	Baseline documentation should include FIDA Plan pharmacy network provider P&Ps that detail the timeframe for submission of FIDA Plan sponsor claims from long-term care facilities.
4. The FIDA Plan's claims processing system checks claims payment logic to identify erroneous payments.	Baseline documentation should include a description of system edits as well as proscriptive and retrospective reporting to identify claims processing trends and anomalies used to identify erroneous claims. Note: If this validation is performed outside of the FIDA Plan, please provide evidence of the contract with the external vendor, as well as oversight P&Ps, and any performance standards.
5. The FIDA Plan's claims processing system checks for pricing errors to identify erroneous payments.	Baseline documentation should include a description of system edits as well as ongoing reporting to identify pricing errors to prevent erroneous

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Systems	
Readiness Review Criteria	**Suggested Evidence**
	payments. The FIDA Plan should provide a listing of all audit processes in place to ensure the integrity of the claims processing payments including both automated and manual audits. Note: If this validation is performed outside of the FIDA Plan, please provide evidence of the contract with the external vendor, as well as oversight P&Ps.
D. Provider Systems	
1. The system generates and maintains records on medical provider and facility networks, including: a. Provider type; b. Services offered and availability; c. Licensing information; d. Affiliation; e. Provider location; f. Office hours; g. Language capability; h. Medical specialty, for clinicians; i. Panel size; j. Accessibility of provider office; and k. Credentialing information.	Baseline documentation should include a description of the system utilized to maintain the core provider system record along with provider system screen shots illustrating where these data elements are captured. Note: If all the required fields aren't currently captured in the provider system data fields, provide an explanation of what changes need to be made to the system and the timing for these modifications..
E. Pharmacy Systems	
1. The FIDA Plan or its PBM generates and maintains or ensures that its PBM generates and maintains records on the pharmacy networks, including locations and operating hours where the FIDA Plan subcontracts the maintenance of the pharmacy network.	Baseline documentation should include: 1) FIDA Plan's or its PBM's P&Ps for maintaining records on pharmacy networks including locations and operating hours. 2) A screenshot or sample of how this information is collected, maintained, and made accessible to Participants.
2. The FIDA Plan or its PBM updates records of pharmacy providers and deletes the FIDA Plan's or PBM's records of no longer participating pharmacies. FIDA Plan ensures that the PBM performs this function in those instances where the FIDA Plan subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the FIDA Plan and as applicable the PBM's P&P for updating/maintaining pharmacy provider network information.
3. The FIDA Plan audits the pharmacy system on a regular basis. This includes auditing the pharmacy system of its PBM on a regular basis in those instances where the FIDA Plan subcontracts the maintenance of the pharmacy network.	Baseline documentation should include the FIDA Plan's P&P for oversight of the PBM's pharmacy systems and data including a listing of audit activities/reports used in ongoing monitoring.
4. The FIDA Plan or its PBM can submit Prescription Drug Event data (PDEs) on a monthly basis.	Baseline documentation should include: 1) FIDA Plan or its PBM P&P that defines the processes and data submission requirements for Part D PDE reporting. 2) FIDA Plan's P&P that outlines the process for monitoring compliance for the PBM's Part D PDE reporting.
5. The FIDA Plan or its PBM is prepared to ensure pharmacies can clearly determine that claims are for Part D covered drugs or Medicaid-covered drugs and secondary payers can properly coordinate benefits by utilizing	Baseline documentation should include the FIDA Plan and its PBM's P&Ps and related workflows for determining appropriate claims payment for Part D

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Systems	
Readiness Review Criteria	**Suggested Evidence**
unique routing identifiers and Participant identifiers.	covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers.
6. The FIDA Plan ensures that the claims adjudication system: a. Distinguishes between filling prescriptions for Part D drugs and non-Part D drugs; b. Appropriately meets the 90-day Part D and the 180-day non-Part D transitional fill requirements; and c. Makes appropriate outreach efforts related to the transitional fills.	Baseline documentation should include: 1) The FIDA Plan PBM's P&Ps for supporting the transitional fill requirements. 2) Evidence of systems capability to support both Part D and non-Part D formularies and transitional fill requirements. The FIDA Plan's P&P for oversight of the PBM performance on transitional fills.
7. The FIDA Plan's PBM has a disaster recovery and business continuity plan to ensure that contracted pharmacies can determine drugs that are covered under the Demonstration and can coordinate benefits properly in the event of systems downtime.	Baseline documentation should include information about the PBM's disaster recovery and business continuity plan of ensuring the proper identification of benefit coverage and continued coordination of benefits with secondary payers.
F. Care Coordination and Care Quality Management Systems	
1. The system generates and maintains records necessary for care coordination, including: a. Participant data (from the enrollment system); b. Provider network; c. Interdisciplinary team membership for specific Participants; d. Participant assessments; e. Participant Person-Centered Service Plans; f. Authorizations; g. Interdisciplinary team case notes; h. Medication reconciliation information; i. Claims information; and j. Pharmacy data.	Baseline documentation should include: 1) An overview of the care coordination systems that outlines the workflow and data elements used in tracking the required care coordination data elements. 2) Description of software solutions (e.g., care management solutions) that will be used to support the systems infrastructure of the care coordination process. This includes documentation of enhancements made to customize systems to facilitate management of the Demonstration population. 3) Screen shots of the application(s) / modules(s) that support these requirements. 4) Description of processes used to profile, measure and monitor enrollee profiles.
2. The FIDA Plan maintains the care coordination system and addresses technological issues as they arise.	Baseline documentation should include the FIDA Plan's help desk and application support P&Ps for managing issues related to the care coordination system.
3. The FIDA Plan verifies the accuracy of care coordination data and amends or corrects inaccuracies.	Baseline documentation should include the FIDA Plan's P&P for ensuring data quality in the care coordination system.
4. The Participant assessments and PCSPs are available to the Participant IDTs and any of the Participant's other providers.	Baseline documentation should include: 1) An outline of the care coordination system that highlights data elements from the PCSP that will be available to the IDT, provider network, and the Participant. 2) The policies and procedures for distributing and securing this information, and the assignment and monitoring of system access. 3) A description of who will and how they will

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Systems	
Readiness Review Criteria	**Suggested Evidence**
	access information in the care coordination system. 4) Description of software solutions (e.g., Web-based EMR or Care Management solutions) that will be used to support the systems infrastructure of the care coordination process. 5) Screen shots of the application(s)/modules(s) that will support these workflows and data requirements, if available. 6) Sample business and data use agreements, and confidentiality policies that govern access to information.
5. The care coordination system includes a mechanism to alert interdisciplinary team members of ED use or inpatient admissions.	Baseline documentation should the FIDA Plan's P&P for tracking ED and inpatient admissions and notifying the interdisciplinary care team. Note: this should include the required notification timeframe for both admission types.
6. The FIDA Plan has systems to permit the transfer of service plans from MLTC plans or FFS providers in place at the time of enrollment and to transfer service plans to another FIDA Plan or MLTC plan at the time of disenrollment.	Baseline documentation should include: 1) The FIDA Plan's P&Ps for obtaining service plans from MLTC plans or FFS providers. 2) The FIDA Plan's P&Ps for transferring PCSPs to another FIDA Plan or MLTC plan at the time of disenrollment. Supplemental documentation may include screen shots of the systems utilized to request and receive service plans and transfer PCSPs to other plans.

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Systems	
Readiness Review Criteria	**Suggested Evidence**
G. Health Information Technology and Integrated Records	
1. FIDA plans are encouraged to have structured information systems, policies, procedures and practice to create, document, execute, update, and share information with all of the Participant's providers. FIDA Plans are encouraged to indicate how they will use and require all providers to use single integrated electronic Participant health and services records and the information technology tools available through the plan for accessing, updating, and sharing information on health history, demographics, care plans, goals, care plan adherence, care gap alerts, clinical referrals, claims information, lab results, provider/enrollee communications, contact logs, progress notes, consultations, physicians orders, and encounters. FIDA Plans are encouraged to have a systematic process to follow-up on tests, treatments, services and referrals – which is incorporated into the Participant's Person-Centered Service Plan. At a minimum, all FIDA Plans are encouraged to have: • Have structured interoperable health information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a Person-Centered Service Plan for every patient. • Use an electronic health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the patient's health information and Person-Centered Service Plan to be accessible to the interdisciplinary team of providers. If the provider does not currently have such a system, they will provide a plan for when and how they will implement it. • Comply with the current and future version of the Statewide Policy Guidance (http://health.ny.gov/technology/statewide_policy_guidance.htm)which includes common information policies, standards and technical approaches governing health information exchange. • Commit to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a care plan. RHIOs/QE (Qualified Entities) provides policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY). • Support the use of evidence based clinical decision making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance.	Baseline documentation should include: 1) The FIDA Plan's P&Ps describing tis existing ability to meet these HIT and integrated records system standards. 2) If the FIDA Plan does not currently meet these standards, the FIDA Plan articulates how it will ensure the PCSPs are available to all IDT members in a timely manner for ongoing management.

Utilization Management	
Readiness Review Criteria	**Suggested Evidence**
A: The FIDA Plan has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services	
1. The FIDA Plan specifies procedures under which the Participant may self-refer services.	The UM program descriptions for the FIDA Plan explains for which services a Participant can self-refer.
2. The FIDA Plan defines medically necessary services as those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or	The FIDA Plan's UM program description includes this definition of medically necessary. The FIDA Plan's IDT P&Ps include this definition of

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Utilization Management	
Readiness Review Criteria	**Suggested Evidence**
threaten some significant handicap. Notwithstanding this definition, FIDA Plans will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules, and coverage guidelines. a. All care must be provided in accordance and compliance with the ADA, as specified in the *Olmstead* decision.	medically necessary. The FIDA Plan's P&Ps for adjudicating appeals include this definition of medically necessary.
3. The FIDA Plan defines the review criteria, information sources, and processes that the IDT will use to review and approve the provision of services and prescription drugs.	The UM program description includes these definitions of medical necessity.
4. The FIDA Plan has policies and systems to detect both under- and over-utilization of services and prescription drugs.	The UM program description for the FIDA Plan details how the FIDA Plan monitors under –and – overutilization of services (e.g., regular data analysis, periodic review meetings).
5. The FIDA Plan has a methodology for periodically reviewing and amending the UM review criteria, including the criteria for prescription drug coverage.	The UM program descriptions for the FIDA Plan explains how often and under what circumstances the plan updates the UM review criteria and who is responsible for this function (e.g., process to integrate new treatments or services into the review criteria, make updates based on clinical guidelines).
6. The FIDA Plan outlines its process for the IDT's authorizing out-of-network services; if specialties necessary for Participants are not available within the network, the FIDA Plan will make such services available.	Out-of-network service authorization P&P explains how a Participant or provider may obtain authorization for a service being provided by a provider outside of the FIDA Plan's network.
7. The FIDA Plan describes its processes for communicating to all IDTs and service providers which services require prior authorizations and ensures that all contracting providers are aware of the procedures and required time-frames for prior authorization (e.g., periodic training, provider newsletters).	The UM program description details mechanisms for informing network providers of prior authorization requirements and procedures. The FIDA Plan's provider materials describe prior authorization requirements and procedures.
9. The FIDA Plan policies for adoption and dissemination of practice guidelines require that the guidelines: a. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; b. Consider the needs of the FIDA Plan's members; c. Be adopted in consultation with contracting health care professionals; d. Be reviewed and updated periodically; and e. Provide a basis for utilization decisions and member education and service coverage.	The FIDA Plan's practice guidelines P&P include these requirements.
10. The FIDA Plan must cover all services as outlined in the Three-way Contract and in the State and Federal guidance and may not impose more stringent coverage rules unless explicitly authorized by the Three-way Contract.	Care coordination or IDT P&P and UM program includes these requirements.
B: The Utilization Management program has timeliness, notification, communication, and staffing requirements in place.	
1. The FIDA Plan has a policy and procedure for the IDT to appropriately informing Participants of coverage decisions, including tailored strategies for Participants with communication barriers.	Plan management guidelines or the FIDA Plan's UM program describes the type of communications sent to Participants by the FIDA Plan or the IDT, regarding their receipt or denial of referrals of service authorizations.

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Utilization Management	
Readiness Review Criteria	**Suggested Evidence**
2. For the processing of requests for initial and continuing authorizations of covered services, the IDT shall: a. Have in place and follow written policies and procedures; b. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions; and c. Consult with the requesting provider when appropriate.	The UM program descriptions for the IDT explains the process for obtaining initial and continuing authorizations for services. The prescription drug manual explains the process for obtaining approval for prescription drug coverage that is considered urgent.
3. The FIDA Plan and IDT ensure that prior authorization requirements are not applied to the: a. Emergency and post-stabilization services, including emergency; behavioral health care; b. Urgent care; c. Crisis stabilization, including mental health; d. Family planning services; e. Preventive services; f. Communicable disease services, including STI and HIV testing; g. Post-stabilization care services; h. Out-of-area renal dialysis services; and i. Other services as specified in the CMS-state MOU.	The UM program descriptions for the FIDA Plan and IDT lists those services that are not subject to prior authorization and this list is consistent with the required elements.
4. The IDT follows the rules for the timing of authorization decisions for Medicaid services in 42 CFR §438.210(d) and for Medicare services in 42 CFR §422.568, 422.570 and 422.572. For overlap services, the FIDA Plan follows the Three-way Contract.	The UM program description for the IDT includes these requirements.
5. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Participant's medical condition, performing the procedure, or providing the treatment.	The UM program description for the FIDA Plan includes this requirement. Resumes for staff who review coverage decisions and for manager show that these staff have appropriate competencies to apply FIDA Plan policies equitably. Resume for the UM manager who reviews denials show that this individual has the appropriate experience and training to conduct this function.
6. The FIDA Plan and IDT ensure that a physician and a behavioral health provider are available 24 hours a day for timely authorization of medically necessary services and coordinate transfer of stabilized Participants in the emergency department, if necessary.	The UM program descriptions for the FIDA Plan and IDT states that a physician and behavioral health provider are available 24 hours a day, seven days a week for timely authorization of medically necessary services and to coordinate transfer of stabilized Participants in the emergencies.

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