CMS-NYSDOH Responses to Comments on Draft Readiness Review Tool

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
1.	**ALL**	If the suggested evidence includes a policy the plan does not have, but other evidence (e.g. a provision in downstream contracts) could demonstrate compliance, can alternate evidence be submitted in place of a newly drafted policy?		Yes. Unless the evidence column indicates that a certain document **must** be submitted (e.g., the comprehensive assessment P&P), the evidence column provides an example of acceptable or expected evidence. Therefore, if evidence other than a policy or procedure is available and demonstrates the full scope of expected compliance with a criterion, that other evidence may be submitted (i.e., existing contract). Please note that the FIDA Plan must identify the page number and section of the other evidence that addresses the criterion. No change to the criteria is needed. Please see statement in the desk letter.
	Assessment Processes (page 1)			
2.	A1	How are we going to receive notification of the care already being received? The assessment tool notes that the continuity of care plan must describe the process by which the FIDA Plan will transfer person-centered service plans (PCSP) to other FIDA Plans or other plans when an enrollee disenrolls from the FIDA Plan.	It is not immediately clear from the tool or the Memorandum of Understanding (MOU) whether the PCSP should be transferred to Maximus, who will serve as the enrollment / disenrollment program for the Demonstration or directly to the Participant's new plan. Could you please provide additional clarity on how that process would work?	The FIDA Plan must describe how it will obtain existing service plans for Participants. CMS and the State do not anticipate any involvement of Maximus in transferring the existing service plan to the FIDA Plan. No change to the criterion is necessary.

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3.	A1	Is the 90-day continuity of care for the member only apply to the first time they enroll in a FIDA plan or is it applicable for the second, third, fourth enrollment as members move from plan to plan?	Minimize the 90day continuity of care policy to avoid encouraging plan hopping.	The 90-day continuity of care for the Participant applies each time s/he enrolls in a FIDA Plan. For example, if a Participant enrolls in one FIDA Plan and later enrolls in a second FIDA Plan, the Participant would have a second 90-day continuity of care period when s/he enrolls in the second FIDA Plan. No change to the criterion is necessary.
4.	A1	Are members allowed to enroll in FIDA and then decide to enroll in a Medicare Advantage Plan from month to month? So there is no lock in for the Medicare Advantage Plan enrollment?		Per pages 8 and 58 of the MOU, Participants may opt out of or disenroll from a FIDA Plan at any time. Requests to disenroll from a FIDA Plan or enroll in a different FIDA Plan will be accepted at any point after a Participant's initial enrollment occurs and is effective on the first of the month following receipt of the request. If the Participant disenrolls from a FIDA Plan, s/he may enroll in a Medicare Advantage Plan. There is no lock in for Medicare Advantage Plan enrollment. No change to the criterion is necessary.
5.	A2	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.	Health plans can exclude providers based on justifiable reasons (e.g., improper past billing practices, quality of care issues, etc.)	Yes. FIDA Plans are required to conduct Center for Program Integrity checks for all providers and exclude those not authorized to bill Medicare and/or Medicaid. No change to the criterion is necessary.
6.	A2	The assessment tool notes that FIDA Plans must, on an ongoing basis, contact providers who are not already members of their network with information on becoming credentialed as in-network providers.	We suggest that the tool clarify that the focus of contacting out-of-network providers should be on providers who are working with members to the FIDA plan.	We have clarified the criterion to read: "On an ongoing basis, and as appropriate, FIDA Plans must also contract providers currently serving FIDA Participants, but who are not already members of their network with information on becoming credentialed as in-network providers".
7.	E2	We will need to monitor out-of-network (OON) activity - PS/Network will need review this & reach out re:	Will need set parameter around this	Contracting is not required. No change to the criterion is necessary.

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		contracting for network expansion. - Will contracting be required regardless of the number of members using the OON provider?		
8.	A2	Will FIDA Plans be required to send explanation of benefits (EOBs) to the members?		See Question 52.
9.	A4	Maintain nursing facility providers for the duration of the demonstration	Does this mean only the nursing facility and not the other providers?	This criterion applies only to nursing facility providers; not to other providers. No change to the criterion is necessary.
10.	A4	Whether continuity of care related to services provided by nursing facilities will require plans to contract with all nursing homes in each service area	Plans will not be required to contract with all out of network nursing homes for purposes of continuity of care	Page 66 of the MOU states the following: vi. The following minimum access standards apply to facility-based LTSS services: a) For "new to service" Participants (meaning those not already receiving facility-based LTSS), FIDA Plans must enter into contracts or make payment arrangements with nursing facilities as meets the minimum access standards outlined for all providers in this section and as further outlined in the Three-Way Contract. b) For Participants that are not new to services but are transitioning from a MLTC plan, from another FIDA Plan, or from Medicare and/or Medicaid FFS, FIDA Plans must either enter into contracts or make other payment arrangements with all nursing facilities in the Demonstration Area to ensure Participants' residency and access to services are not interrupted." No change to the criterion is necessary.

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11.	A5	The quantity of medication to be dispensed of a non-Part D drug during the first 90 days of coverage needs clarification. Is it up to a 30 day supply or 90 day supply?		The RR criterion states that the FIDA Plan will provide a 90-day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid. No change to the criterion is necessary.
12.	A5	RR draft states: 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.	Comment: If the drug is covered by Medicaid ADD file TOC wouldn't apply.	Although a particular drug is in a drug category that is covered by NY Medicaid, a given drug within that covered category may not be covered by the plan. New York did not require FIDA Plans to cover all the drugs within a required category, FIDA sponsors are only required to cover "at least two drugs that are not therapeutically equivalent and bioequivalent in each category and class of covered drugs, except where a particular category or class includes only one drug." The transition policy then ensures that beneficiary has a sufficient supply of the drug that is covered by Medicaid generally, even if that particular drug is not covered by the plan (presumably while the plan transitions the beneficiary to a plan-covered drug). The 90-day transition also ensures that beneficiaries have sufficient supplies of their current medications in the event that the plan-covered medications are subject to prior authorization from the plan, for example. New York indicated in its May 2013 guidance (OTC and RX Drug Categories Included in FIDA ADD File) that FIDA Plans are permitted to establish their own prior authorization processes with regard to drug coverage. As such, Medicaid-covered, non-Part D drugs that are also covered by the plan could be subject to prior authorizations that could interfere with a beneficiaries' access to the drug in the absence of the transition policy. No change to the criterion is necessary.

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13.	A6	The criteria state that there must be a temporary fill of a 90 day supply. The "suggested evidence" implies the P&P should have 30 days.	Is the requirement to supply 30 or 90 days of drugs?	We have clarified the suggested evidence for this criterion to read: "Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 90 days."
14.	A6	RR draft states: 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**. Question: Is it the State's intention to have both Part D eligible and ineligible but covered by Medicaid drugs be covered for 90 days?	Comment: Below would be the policy if standard part-D TOC process was followed and then the proposed Medicaid (non-part d) process per MOU. Part D transition process - will apply in the non-LTC setting such that the transition policy provides for at least a one-time, temporary 30-day fill, multiple fills up to a cumulative 30-day supply are allowed to accommodate fills for amounts less than prescribed, anytime during the first 90 days of a enrollee's enrollment in a plan, beginning on the Enrollee's effective date of coverage. Medicaid transition process - The transition policy will apply to all prior approved drugs existing in the	We have clarified the suggested evidence for this criterion to read: "Transition plan P&P and/or drug dispensing P&P defines temporary drug supply in outpatient settings to be at least 90 days."

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			Medicaid ADD file for 90 days from the time of enrollment. Prior approved drugs will not be terminated at the end of 90 days without advance notice to the Enrollee and transition to other drugs, if needed.	
15.	A7	RR draft states: 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.	Comment: LTC TOC part D guidance is not for a fill of 91 days but as described below. LTC transition fills are allowed multiple fills up to a 31-day supply per fill, except for oral brand solids which are limited to 14 day fills with exceptions as required by CMS guidance... LTC transition fills are allowed for cumulative days supply of at least 91 days and up to 98 days consistent with the dispensing increment.	The Assessment A7 criterion is correct as written. No change to the criterion is necessary.

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16.	B1	What is timely?		We have eliminated reference to "timely" and clarified the first sentence of the Assessment B1 Criterion to read: "The FIDA Plan ensures that each Participant receives and actively participates in a comprehensive assessment completed by a Registered Nurse (RN) within 30 days of enrollment and used by the Interdisciplinary Team (IDT) to develop the Person-Centered Service Plan (PCSP)."
17.	B1	Will the intake assessment be the FIDA Plan's responsibility, or will it be the State's responsibility?		It is the FIDA Plan's responsibility to ensure that each Participant receives and actively participates in the comprehensive assessment. No change to the criterion is necessary.
18.	B1	Is the assessment to be completed by the IDT or RN? In Criteria B2 and B4 the audit tool says RN.	The FIDA Plan ensures that each participant receives and actively participates in a timely comprehensive assessment completed by a registered nurse and used by the IDT to develop the Person Centered Service Care Plan.	The assessment shall be completed by an RN. We have clarified the first sentence of the Assessment B1 Criterion to read: "The FIDA Plan ensures that each Participant receives and actively participates in a comprehensive assessment completed by a Registered Nurse (RN) within 30 days of enrollment and used by the Interdisciplinary Team (IDT) to develop the Person-Centered Service Plan (PCSP)."

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19.	B2	The Readiness Review tool states that the FIDA Plan must ensure that all Participants receive a comprehensive assessment within 30 days of enrollment, and that the assessment is performed using the NYSDOH Approved Assessment Tool. If a FIDA Plan is administering the NYSDOH Approved Assessment Tool (i.e. the Uniform Assessment System for NY or UAS-NY) prior to enrollment in order to determine eligibility, does the UAS-NY need to be administered a second time within 30 days after the member starts on the plan?		FIDA Plans do not play a role in determining which individuals are eligible for the FIDA Demonstration, and a FIDA Plan would not conduct a comprehensive assessment of a Participant until after that Participant has enrolled in the FIDA Plan. No change to the criterion is necessary.
20.	B2	The assessment tool notes that an initial assessment must be performed within 30 days in the member's home.	If a member is in a sub-acute facility or hospital when they are first enrolled does that delay the assessment, or can it be done in the facility or hospital setting?	We have clarified the B2c criterion to state: "The assessment and reassessment is conducted in-person with the Participant (e.g., in the Participant's home; hospital; acute care facility; assisted living facility; skilled nursing facility)."
21.	B2	The assessment tool notes that New York will utilize the "NYSDOH Approved Assessment Tool." It does not refer to the UAS-NY.	Can you clarify whether the NYSDOH Approved Assessment Tool is the UAS-NY, or whether the State and CMS are developing an alternative assessment tool for FIDA plans?	The NYSDOH Approved Assessment tool is the UAS-NY tool. We have clarified the Criterion B2b to State: "The assessment is performed using the NYSDOH Approved Assessment Tool, which will be the UAS-NY tool".
22.	B2	Does the 30 day requirement for performing the assessment also apply to new enrollees, that is, enrollees not transitioning from MLTC or other	Need guidance on how services would be authorized for Day 1 of enrollment for those new	The criterion states that "all Participants receive a comprehensive assessment within 30 days of enrollment". This means *all* Participants regardless of which plan the Participant transitions from.

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		plans? How would a FIDA plan develop a plan of care and authorize services for Day 1 of enrollment if the assessment is not performed prior to the date of enrollment? Is the FIDA Plan given discretion to complete another assessment or is it required? Sometimes a new assessment is not appropriate or necessary, even if there has been a change in circumstance (e.g. planned hospital admission for minor surgery, FIDA already aware of hours needed if caregiver is no longer available). If passively enrolled from our MLTC will they require assessment w/i the 30 day time frame or will it follow their current schedule?	enrollees where there is no history of service or care plan. ICS respectfully suggests that FIDA plans are able to triage the need for a reassessment and clearly document if it is not needed.	No change to the criterion is necessary.
23.	B2	What is the plan's role in determining clinical eligibility?		The FIDA Plan has no role in determining eligibility for the FIDA Demonstration. No change to the criterion is necessary.
24.	B2	Will the pre enrollment process be similar to the way MLTC enrollment happens so that some assessments would be done prior to enrollment similar to the current MLTC enrollment processes?		Please note that FIDA Plans will not handle enrollment functions under the FIDA Demonstration. Rather, enrollment functions are the responsibility of the Enrollment Broker. No change to the criterion is necessary.
25.	B3	complete PCSP within 30 days of completing assessment	Recommend completing the initial PCSP within 90 days of enrollment	As stated on pages 61-62 of the MOU, "Within 30 days of the FIDA Plan conducting a comprehensive assessment, a Person-Centered Service Plan will be completed for each Participant by the Participant's IDT".

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				No change to the criterion is necessary.
26.	B4	The triggering events represent an extremely broad spectrum of reasons for which a reassessment would need to be performed. Certain triggering events should not automatically be reason for reassessment (i.e., loss of a caregiver, change in diagnosis, request by member or family member). Reassessments are very costly and should be closely aligned with the professional judgment of the clinical team and care manager. Changes in the PCSP can occur without the need for a full reassessment as in cases of changes in diagnosis. A re-assessment must occur upon change in diagnosis - Does this apply to any change in any diagnosis or a significant change in diagnosis?	Limit the triggering events to a hospital admission, transition between care settings, significant changes in functional status or IDT call for further investigation, or professional judgment of the clinical care team and care manager.	We are maintaining the trigger events as outlined on page 61 of the MOU and in the Assessment B4 Criterion. No change to the criterion is necessary.
27.	B4, B5	How to handle someone who refuses the assessment? Can we disenroll for noncompliance? With respect to a participant's refusal to participate in comprehensive assessment or reassessment, CMS/NYSDOH needs to provide guidance on whether there needs to be any external reporting of such	Further guidance is needed on whether FIDA Plan needs to report such participant refusal to FIDA NYDOH or CMS, and/or follow any specific guidelines for actions or related documentation of such.	Criteria require FIDA Plan to have policies and procedures of how they document when a Participant refuses to participate in the assessments. Further detail on when a FIDA Plan will be allowed to disenroll a Participant will be included in the Three-way Contract. No change to the criterion is necessary.

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		occurrences.		
	Care Coordination (page 3)			
28.	A2	"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." - Does the entire IDT need to be involved in the decision including family support and physicians? If not all members are available, does this mean a decision can't be made or is appealable?	Is it correct that all service authorizations including inpatient stays are the responsibility of the IDT? Better clarification on who is required to be involved in determinations is needed. Do members of the IDT need to all be present or simply invited? Can any decisions be made outside of the convening of the IDT? If a member needs additional support and the Plan approves, does the IDT have to agree? What about for a reduction when the Plan's ruling matches the UAS-NY? Who rules when the FIDA Plan and the family disagree if the family is part of the IDT?	Yes. All service authorizations, including inpatients stays are the responsibility of the IDT. See page 63 of the MOU. Additional clarification on the precise roles and the decision-making processes will be provided in the Three-way Contract or additional guidance that may be incorporated by reference into the Three-way Contract. No change to the criterion is necessary.
29.	A4	With respect to IDT composition, this list of team members is broad and may not be applicable to every enrollee.	Establish the IDT composition in alignment with the needs of each enrollee and as guided in the Model of Care.	We have clarified the criterion to state: "The FIDA Plan ensures that the composition of the IDT will include: a. the Participant and/or his/her designee; b. The designated care manager; c. The primary care physician; d. Behavioral health professional, as applicable (i.e., for Participants with behavioral health needs); e. Home care aide or appropriate nursing facility staff,

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				depending on where the Participant resides; 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".
30.	A7	What is timely? How are patient refusals handled?		Please see pages 64-65 of the MOU for details on minimum access standards for providers. Refusals will be discussed in the Three-way Contract or additional guidance that may be incorporated by reference into the Three-way Contract. No change to the criterion is necessary.
31.	A8	What is considered "appropriate experience and qualifications" of a care manager?	Clarification of appropriate experience is needed.	We have clarified the criterion to state: "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). CMS and the State are not prescribing a specific level of experience and qualifications. Rather, the FIDA Plan shall explain how it defines appropriate experience and qualifications for care managers. In addition, 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. The process includes mechanisms to guarantee the right of each Participant to choose and change his/her care manager at any time".

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32.	C2	Criteria denotes annual care plan meetings	There should be a semi-annual care plan meeting to coincide with the assessment requirements.	We have clarified the criterion to state: As outlined on page 61 of the MOU and in the Assessment B4 Criterion, the FIDA Plan informs Participants of the option to self-direct their own services with each comprehensive assessment and re-assessment, and the IDT informs the Participants of the option to self-direct their own services when the PCSP is updated.
33.	D1	What is considered culturally competent? Do we need to accommodate cultural requests?		Yes, FIDA Plans should to the extent possible, accommodate cultural requests. We have clarified the criteria (D1b) to state: "Ensuring that care coordination is provided in a culturally competent way (i.e., care coordination is provided to Participants in a manner that is sensitive to age; gender; sexual orientation; cultural, linguistic, racial, ethnic, and religious backgrounds; and congenital or acquired disabilities)".
34.	D2	Does the state have specific thoughts on the exchange of data between the FIDA plan and the IDT?		Please see Systems Criteria F1 and G1.
35.	E1	What happens if a care manager finds out a SNF is not following this practice (i.e., requirement for 3-day hospital stay)? Who do we tell and how do we tell them?		No change to the criterion is necessary. However, all FIDA Plans must do ongoing monitoring with all first-tier, downstream and related entities that it holds contracts with for the FIDA Demonstration. To the extent, a first-tier, downstream or related entity is not following a contractual provision then the FIDA Plan must take whatever action has been negotiated between the parties to correct the non-compliance.
36.	E2	How do we access the Money Follows the Person Program?	Instructions / direction on how to access MFP.	The criterion will be "greyed out" and pended for review at a later date.
37.	E2	Further clarification is needed about "preadmission screening teams"	Clarify FIDA Plan resources and criteria/standards needed for preadmission screening teams	The criterion will be "greyed out" and pended for review at a later date.

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38.	E4	Plans are required to set up authorizations within 48 hours of a discharge but services are most often not defined until right before a discharge.	Requirement should be that Plans be required to set up authorization within 48 hours of notification of discharge plan. Can you confirm that this provision means that within 48 (clock) hours of being informed of an impending hospital discharge a FIDA plan will provide needed prior authorizations?	Please see pages 63-64 of the MOU. Yes, this criterion requires that IDT provide any prior authorizations within 48 hours of an impending hospital discharge. No change to the criterion is necessary.
39.	E5	Does the hospital need to notify the plan of acute stay transitions? Or is this referring to transitions to different levels of care?		The criterion does not require a hospital to notify the FIDA Plan. The criterion requires the FIDA Plan to have a process in place to monitor transfers during care setting transitions and hospital re-admissions. No change to the criterion is necessary.
40.	E5	We are not always prospectively notified of ED activity. In fact many times the only ED activity we are made aware of are those resulting in an admission		Minimizing unnecessary complications during care setting transitions is a key element of the FIDA Demonstration. FIDA Plans will need to have policy and procedures explaining how they will work with providers to minimize complications related to care setting transitions and hospital readmissions. Please see Systems Criteria F1 and G1. No change to the criterion is necessary.
41.	E6	Further clarification is needed about establishing requirements around reducing preventable injuries in hospitals, nursing facilities, and during transfers between settings.	Further guidance is needed with respect to "preventable injuries" for the FIDA Plan policies and procedures.	The intent of this requirement is to ensure that FIDA Plans have policies in place that encourage quality in care settings and during the transfers between care settings. For example, to reduce preventable conditions within the hospital setting, the FIDA Plan

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		What is the intent of the requirement? Please provide examples.		should develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with Federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.6(f)(2), and 42 C.F.R. § 447.26, and guidance and be consistent with any State policy. The FIDA Plan should also have policies that prevent and monitor nursing facility "preventable injuries" such as pressure ulcers or falls. No change to the criterion is necessary.
42.	F1	What are the required elements that determine a working relationship with the PO?	Define the expectation of the PO/Plan relationship.	This criterion is greyed out. More information will be provided at a later date. No change to the criterion is necessary.
43.	F2	Plans must respond to the PO within "reasonable timeframes."	Define reasonable timeframes.	The criterion will be "greyed out" and pended for review at a later date.
44.	F2	Please clarify the role of the PO with the FIDA plan and if they will have any role in eligibility determinations. Must the FIDA plan PO liaison be a full time staff person?		The criterion will be "greyed out" and pended for review at a later date.
45.	F2	The assessment tool states that FIDA plans will establish policies and procedures (P&Ps) which identify staff responsible for overseeing and ensuring cooperation with the participant ombudsman (PO) and to prepare a staffing plan for working with the PO.	ICS is committed to working in partnership with the PO and other advocacy and community-based organizations. However, in the absence of a request for proposal or clearer sketch of the PO and its structure, it is difficult to craft detailed P&Ps and	The criterion will be "greyed out" and pended for review at a later date.

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			staffing plans. We suggest graying this item and submitting the P&P detailing the working relationship, the P&P identifying staffing and oversight, and the staffing plan at a later date.	
	Participant and Provider Communications (page 9)			
46.	A1	The assessment tool states that plan sponsors are permitted to use alternative technologies to meet the customer service call center requirements for Saturdays, Sundays, and holidays.	Can you clarify the term alternative technologies in the context of this requirement?	We have clarified the criterion to read: "The FIDA Plan maintains and operates a toll-free general Participant services telephone line call center from 8:00 A.M. to 8:00 P.M. Eastern Time, seven days per week. Plan sponsors are permitted to use alternative technologies, which include interactive voice response system or similar technologies, to meet the customer service call center requirements for Saturdays, Sundays, and holidays. Live customer service representatives must be available to answer phones Monday through Friday from 8:00 A.M. to 8:00 P.M. Eastern Time, excluding holidays."
47.	A1	A.1 states: "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.	Clarify whether live person answering service can be used to meet customer call center requirements for a portion of the required hours 8am-8pm. Can an answering service be used to fulfill this requirement?	Live customer service representatives are required during 8:00 A.M. to 8:00 P.M. Eastern Time, Monday thru Friday (excluding holidays). We have clarified the first sentence of the criterion to read: "The FIDA Plan maintains and operates 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, which include interactive voice response system or similar technologies, to meet the customer service call center requirements for Saturdays, Sundays, and holidays. Live customer service representatives must be available to answer phone calls Monday through

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				Friday from 8:00 A.M. to 8:00 P.M. Eastern Time, excluding holidays." An answering service is not allowed between the hours of 8:00 am to 8:00 pm Monday thru Friday (excluding holidays).
48.	A1 & A3	What is the difference between the toll free Participant service line and the toll free customer service line outlined in 1 and 3 and the required hours of operation? Is the reference to the toll free call center with live customer service the same reference as in #1? Why are the timeframes different between this section and #1?	What is the difference between the toll free Participant service line and the toll free customer service line outlined in 1 and 3 and the required hours of operation	The Participant services telephone line call center (A1) will be available to answer general Participant questions. The coverage determination, grievance, and appeal toll-free call center (A3) is available to respond to provider and Participant questions on the aforementioned topics. Please note that FIDA Plans may combine these two call centers, but doing so would require the coverage determination, grievance, and appeal call center open from 8:00 AM to 8:00 P.M. Eastern Time, seven days per week. No change to the criterion is necessary.
49.	A1 & A3	The readiness review tool indicates multiple hotlines – is this correct? We thought only a Nurse Hotline was required 24/7.		Yes. Multiple toll-free lines are required. Per Participant and Provider Communications A1 and A3 Criteria and in-line with the Medicare Marketing Guidelines, FIDA Plans must maintain and operate a toll-free general Participant services telephone line call center (A1) and a tool-free call center to respond to providers or Participants with information related to coverage determinations (including exceptions and prior authorizations), grievances, and appeals (A3). We added a nursing hotline available to answer clinical questions 24 hours a day, 7 days a week (A4). In addition, Participant and Provider Communications B1 and B2 Criteria require the FIDA Plan or pharmacy benefit manager to have a pharmacy technical help desk call center and pharmacy technical support, respectively.

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50.	A4	The suggested evidence item asks the plan to submit a contract with a language line company, which outlines the mandatory hours of operation and other critical recitations.	Given that a the language line operator may not be selected by the time the desk review takes place, can we submit draft contract language in lieu of a final contract, and then at a later date submit the final contract?	We have clarified the suggested evidence to state: "Contract language line company or draft contract for language line or existing MLTC language line contract includes these requirements, including mandatory hours of operations".
51.	A6	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.	What are the languages	Per State policy, the six non-English languages that vital documents must be translated into are: Spanish, Chinese, Russian, Italian, Haitian-Creole, and Korean. We have updated Participant and Provider Communications A6 Criterion to specify the languages: "Currently, the six most common non-English languages are Spanish, Chinese, Russian, Italian, Haitian-Creole, and Korean. The State will inform the FIDA Plans of any changes to these languages."
52.	A6	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.	Does this requirement include all of the various types of correspondence (EOBs, letters, prior authorization approvals, exception requests, etc.)? Will standardized State-required forms in the 6 required languages be provided in written translated form by the State? This will ensure	We have clarified the criterion (which is 407 in the final tool): "The FIDA Plan translates documents 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. Currently, the six most common non-English languages are Spanish, Chinese, Russian, Italian, Haitian-Creole, and Korean. The State will inform the FIDA Plans of any changes to these languages. The materials that must be translated include, but are not limited to: 1) Summary of Benefits (SB); 2) Annual Notice of Change (ANOC); 3) Evidence of Coverage

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		The FIDA Plan ensures that these documents are updated.	consistency of translated materials among FIDA plans and be cost effective. Plans would still incur printing costs.	(i.e., EOC / Member Handbook); 4) Formulary; 5) Provider/Pharmacy Directory; 6) Part D transition letter; 7) the NYSDOH Approved Assessment Tool ; 8) PCSP; 9) Ad-hoc communications; and 10)vital documents including but not limited to educational materials. The FIDA Plan ensures that these documents are updated. CMS is currently developing an integrated Explanation of Benefits (EOB) for the Demonstration. Until that is complete, the EOB is required for Part D benefits only, but FIDA Plans may send EOBs for other services. The Part D transition letter is already translated by Medicare into Spanish and Chinese and made available. CMS will provide the Spanish templates for the following documents: SB, ANOC, EOC/Member Handbook, Formulary, and the Provider/Pharmacy Directory. " The criterion will be "greyed out" and pended for review at a later date.
53.	A6	This is an excessive translation burden. The FIDA Plan translates vital document, 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	Translation of vital documents should be limited to those languages spoken by 5% of the population in the plan's actual service area as required by all other Medicare Advantage Plans.	This policy is consistent with State Executive Order No. 26 Statewide Language Access Policy, which requires translation of vital documents, including essential public documents such as forms and instructions provided to or completed by program beneficiaries or participants. The translation shall be in 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, and relevant to services offered by each of such agencies. No change to the criterion is necessary.

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54.	A6	What is the targeted timeframe for plans to continually review languages, and documentation translations? Annually? Bi-Annually?		Annually. No change to the criterion is necessary.
55.	B1	The assessment tool states that FIDA plans must conduct at least two Participant Feedback Sessions in its service areas each year.	Can you clarify how these meetings may or may not coordinate and work with the Participant Advisory Committee (PAC)?	The Participant feedback sessions are open to all Participants and the PAC is for a subset of the Participants. No change to the criterion is necessary.
56.	B1	Will the FIDA Plan need to conduct at least 2 Participant Feedback Sessions in each county that is designated under its service area, or 2 in total for the plan's service areas?	Recommend that there be two Participant Feedback Sessions in the service area, regardless of counties served.	We have added the following clarifying sentences to the criterion: "The FIDA Plan must conduct at least two Participant Feedback Sessions in its service areas each year. It is sufficient for a FIDA Plan to hold at least two Participant Feedback Sessions for the five NYC counties (i.e., at least two sessions can cover all five NYC counties rather than at least two sessions in each of the NYC counties). For FIDA Plans servicing Nassau, Suffolk, and/or Westchester Counties, FIDA Plans must hold at least two Participant Feedback Sessions each year in each of these counties".
57.	B1&B2	Combine		We recommend maintaining separate criteria for Participant and Provider Communications B1 and B2 Criteria. The B1 Criteria is focused on Participant Feedback Sessions whereas the B2 Criterion is focused on the Participant Advisory Committee. No change to the criterion is necessary.
58.	B1&B2	Required 2 Participant Feedback Sessions / year and 4 PAC meetings / year	Past experience suggests it is very difficult to secure and have participants attend in-person for these meetings. Recommend requiring B1or B2 (2 times / year) with the option to have participants	We have revised Criteria B1b to state: "FIDA Plans must allow for Participants to attend in-person and remotely, and Participants can choose whether they want to participate in-person or remotely". We have clarified Criteria B2a to state: "The FIDA Plan must have a plan for the PAC to meet at least quarterly and conduct these meetings in-person".

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			and PO engage via phone given their limited ability to travel.	
59.	B2	How much detail is required around the "staffing plan"? Is there any additional information you can share?		The staffing plan shall identify the number of FIDA Plan FTEs and their job titles that will be responsible for organizing and executing the Participant Feedback Sessions and PAC meetings. No change to the criterion is necessary.
60.	C2	What standard hours of operations are we using? Some pharmacies are open 24/7.	Clarification on the standard hours of Pharmacies.	FIDA Plans must have the pharmacy technical support line available for the same hours as its network pharmacies. To the extent the FIDA Plan is contracted with a pharmacy that is open 24 hours a day, 7 days per week, then the pharmacy technical support line must be open 24 hours a day, 7 days a week. No change to the criterion is necessary.
	Participant Protections (page 11)			
61.	A4	Are there no copays for these products?	Conclusion on if there are copays for the FIDA products.	See pages 14-15 of the MOU. No change to the criterion is necessary.
62.	A5	What is considered a reasonable accommodation?		While reasonable accommodations could be defined slightly differently in the Three-way Contract for NY, we expect the definition to be similar to that included in the Massachusetts Three-way Contract: "Reasonable accommodations will depend on the particular needs of the individual and include but are not limited to: (A) Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments; (B) Ensuring that all written materials are available in formats compatible with optical recognition software;

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				(C) Reading notices and other written materials to individuals upon request; (D) Assisting individuals in filling out forms over the telephone; (E) Ensuring effective communication to and from individuals with disabilities through email, telephone, and other electronic means; (F) TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified American Sign Language interpreters for the Deaf; and (G) Individualized forms of assistance." No change to the criterion is necessary.
63.	B1	The suggested evidence for the requirement that the FIDA Plan train staff on appeals and grievances is training modules which detail the appeals and grievance processes.	Given this new appeals process, ICS will need to develop new training modules, materials and processes. It is unlikely that new trainings will be developed by desk review. We would encourage CMS and NYSDOH to accept a training plan during desk review and then at a later date review new materials and modules.	We will delay the review of this criterion to a later date to allow time for FIDA Plans to develop training modules for appeals and grievances. The criterion will be “greyed out” and pended for review at a later date.

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64.	B5	The second piece of suggested evidence related to this item is a staffing plan; however, it is not clear what the State specifically wants to see reflected in the staffing plan. Does the State want to know how the plan will staff for appeals and grievances?		As part of the Organizational Structure and Staffing Section (Criterion 6B), CMS and the State are requesting that FIDA Plans provide a staffing plan to outline how it will staff for grievances and appeals, including how many staff it expects to hire, relative to its anticipated enrollment (e.g., the number of FTEs dealing with coverage determinations, appeals, and grievances, per 1,000 enrollees). A staffing plan is not appropriate for this specific criterion and will be deleted from the tool as part of the example evidence.
65.	B7b	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. Does the acknowledgement of appeal also apply to providers?		Consistent with Medicare Advantage policy, the FIDA Plan will send the written acknowledgement of appeal to the Participant, their providers, or their representatives depending on which individuals files the appeal. We have clarified the criterion to state: "Upon receipt of an appeal, the FIDA Plan sends written acknowledgement of appeal to the Participant and their providers or their representatives (if the Participant did not file the appeal) 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."
66.	B7cii	Standard appeal request should be resolved within 30-calendar days from the date of the receipt of the appeal. Is this timeframe applicable to both pre-service and retrospective appeals? CMS allows 60-calendar days for the resolution of a retrospective appeal. Will the OMB notice inform members that appeals will be resolved in 30-calendar days?		The requirement to review a standard appeal 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 applies to pre-service and retrospective appeals. No change to the criterion is necessary.

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67.	B8	All adverse appeal decision must be auto forwarded to the Integrated Administrative Hearing officer for review; however, is there a specific format we should follow? Will a template be provided for use? What timeframe should appeals be auto forwarded to the Hearing officer?		The details of the procedures will be outlined in the Three-way Contract and in operational policy documents, which will be forthcoming. The criterion will be "greyed out" and pended for review at a later date.
68.	B8	The criteria states that plan must have a process to auto forward any adverse decision to the Integrated Administrative Hearing Office at the FIDA Administrative Hearing Unit at the OTDA. The plan also has to send as Acknowledgement of Automatic Administrative Hearing and confirmation of aid status within 14 calendar days of forwarding the record.	1. Has this unit been established at the OTDA yet? 2. In the MOU, it states there the IAH Officers will be trained. Will there be training for the plans as well for this new process?	The FIDA Administrative Hearing Unit will be established within the Office of Temporary and Disability Assistance in advance of the FIDA Demonstration beginning. No change to the criterion is necessary.
69.	B8	When auto forwarding the Plan's adverse decisions to the Integrated Administrative Hearing Officer, is there an option to also cc a Participant of this decision? This is the current process for MAP.		FIDA Plans must inform the Participant of the adverse decision; solely copying the Participant on the auto-forward is insufficient. In addition to the Notification of the Appeal Decision, FIDA Plans may copy the Participant on the auto-forward. We have added clarifying language to the criterion: "When the FIDA Plan sends Participants a Notification of the Appeal Decision, it shall also state that the adverse decision will be auto forwarded to the Integrated Administrative Hearing Officer at the FIDA Administrative Hearing Unit at the State OTDA. No action is needed by the Participant."

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70.	B9	Does the Plan have to continue services during the full length of the appeals process? This could take months. Do the members (appellant) have to verbally or in writing ask for continuation of benefits? Does providing continuing benefits also apply to plan benefit changes, i.e., removing of a benefit when prior authorization was already given?	Define time frames for aid to continue benefits.	See page 79 of the MOU. Participants, their providers, and their representatives do not need to verbally or in writing request for a continuation of benefits. No change to the criterion is necessary.
71.	B9	What sort of participant notification is needed?		We have added clarifying language to the criterion: "The FIDA Plan will indicate in the written acknowledgement of appeal to the Participant and their providers or representatives (if the Participant does not file the appeal) whether the appeal was received within the timeline required for continuing benefits (i.e., 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) and that the benefits will continue pending appeal through an appeal up to the Medicare Appeals Council. The FIDA Plan will reiterate this message in its Notification of Appeal Decision to the Participant".
72.	D2	Ask for definition of emergency BH services.	Definition of emergency BH services.	We have revised the criterion to state: "The FIDA Plan can connect Participants with the appropriate resources or covered services if a Participant calls during a mental health crisis".

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
	Organizational Structure and Staffing (page 15)			
73.	A1	We need clarification on what that role would be in an integrated model.	Clarification on the role of the Behavioral Health Clinical Director.	The role of the Behavioral Health Clinical Director is to oversee the FIDA Plan's behavioral health services. No change to the criterion is necessary.
74.	A1	Further clarification is needed with respect to difference in the job descriptions between the Director of Long Term Services and Supports and the single point of contact for care coordination and care management		The Director of Long-Term Services and Supports (LTSS) would oversee the FIDA Plans' community-based and facility-based LTSS. The single point of contact for care coordination and care management would be the primary contact for the FIDA Plan's care coordination and care management efforts. No change to the criterion is necessary.
75.	B1c&d	This is okay but having staffing plan under each category is redundant.		If FIDA Plans are able to provide one staffing plan that fulfills all the requirements in the readiness review tool, we do not require multiple submissions. Plans can reference it. No change to the criterion is necessary.
76.	B1	Sufficient staff to complete assessments	Will there be a maximum number of participants passively enrolled into a plan per month, if so what number? Is there a projection for the potential number of participants available by borough / county?	See page 58 of the MOU on the enrollment phase-in process. For staffing, plans should make their best assumption. As part of B1d, FIDA Plans must explain the ratio used to derive that number. More information on the phase-in process will be available soon. No change to the criterion is necessary.
77.	B1	When will the readiness review staffing worksheet be available for review?		The Readiness Review Staffing Worksheet is attached with the Desk Review Letter. Please see those attachments. No change to the criterion is necessary.

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78.	B3	Will there be defined staffing ratios for care management?		We have clarified the criterion to state: "The FIDA Plan demonstrates that it has sufficient care managers to facility IDT activities and communication; facilitate assessment of Participant needs; and 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 caseload is reasonable to provide appropriate care coordination and care management. CMS and the State are not prescribing a specific caseload. Rather, the FIDA Plan shall describe its recommended caseload for care managers and explain why it believes that recommended caseload (i.e., ratios of care managers to Participants) is reasonable to ensure appropriate care coordination and care management."
79.	B4	How is this validated?		During subsequent phases of the readiness review process and closer to implementation, CMS and the State will request the credentials and/or resumes of care managers hired. No change to the criterion is necessary.
80.	B5	Under Organizational Structure #5, it indicates that care coordination must have oversight but care coordination is done by the IDT. Please clarify.		See pages 23 and 62 of the MOU. A care manager is the FIDA Plan's designated accountable point of contact for each Participant's care coordination and care management services. Furthermore, we expect that there is some level of monitoring and oversight of the care managers to ensure that Participants have the appropriate and required contacts or that care managers are not overwhelmed. We anticipate that senior level staff will monitor for this. No change to the criterion is necessary.

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81.	B7	Under Organizational Structure #7, it is indicated that plans must have a care management hotline. Is this the same as a Nurse Hotline or is this something different? Would the care coordination hotline be responsible for coordinating care 24/7?		There are four call centers. These include one for Participant services that handles general Participant questions; a second call center for questions related to coverage determinations, grievances, and appeals; a third call center that serves as a nursing hotline; and a fourth call center for pharmacy technical help desk that is available any time the network's pharmacies are open. Plans are not required to have a separate care management hotline. We have clarified the first sentence of the criterion to state: "The FIDA Plan demonstrates through its staffing plan that it has sufficient employees and/or contractor staff to handle its call center operations, including 1) the general Participant services telephone line; 2) the coverage determinations, grievances, and appeals telephone line; 3) the nursing hotline (which must be staffed to respond to Participant calls 24 hours a day, seven days a week); and 4) the pharmacy technical help desk, in a timely manner for all Participants and explains:…"
82.	B8	The FIDA Plan Medical Director is responsible for ensuring the clinical accuracy of Part D coverage determinations and redeterminations involving medical necessity. Enrollment may not support a full-time medical director-what are the options? Under Organizational Structure #8, it states that the FIDA Plan Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and	Options regarding adding a medical director, if enrollment will not support a full time position.	A full-time Medical Director is required. The criterion requires that the Medical Director is responsible for ensuring the clinical accuracy of all Part D coverage determinations and redeterminations involving medical necessity. No change to the criterion is necessary.

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		redeterminations involving medical necessity. This seems a very burdensome task for the plan medical director. If a FIDA Plan has a PBM, can this be the responsibility of the PBM's medical director?		
83.	B1-8	If the indicated employees have not been hired at the time of readiness review will a job description satisfy the request?		Job descriptions will suffice for the desk review. For example, suggested evidence for B2 states that FIDA Plans provide job descriptions, including relevant educational and experience requirements, and resumes for staff. No change to the criterion is necessary.
84.	C1	Plans must offer training to its providers. Is there a requirement for evidence that training was offered? If providers demonstrate that they have taken a training for one FIDA Plan, will that cover them for all FIDA Plans?	Clarify the requirement to demonstrate that training was offered.	For the desk review, we do not require that FIDA Plans provide evidence that staff or providers have taken training. CMS and the State are only looking for training materials/modules. During subsequent phases of the readiness review process, we will be requesting information on which trainings FIDA Plan staff attended and will request attendance sheets (if in-person trainings). For provider training, we will request which trainings the FIDA Plan offered. No change to the criterion is necessary.
85.	C2	Further specification is needed related to definition/examples of "critical incident and abuse" reporting. This reporting requirement is included under the NYSDOH MLTC contract amendments, but there has yet to be guidance released on it. Does		The training applies only to FIDA Plan staff with direct Participant interaction. No change to the criterion is necessary.

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		this apply to all FIDA Plan staff or just those with direct patient interaction?		
86.	C5	The FIDA plan has information for its customers service hotline, shouldn't the suggested evidence be for customer hotline staff? Of the items that the scripts include are enrollment/disenrollment and questions regarding participant's network – we do not think that these can be handled by the PBM and must be handled at the plan level. Please provide clarification.	Copies of customer service hotline staff scripts contain content related to the competencies in the criteria.	We did not intend for the suggested evidence for this criterion to be limited to pharmacy customer service hotline staff scripts. We have clarified the suggested evidence as follows: "Copies of Participant services telephone line call center customer service staff scripts contain content related to the competencies listed in the criteria.."
87.	C5	The MOU refers to a "Participants services telephone line center" and not a pharmacy call center. However, the plan has to comply with "…current Federal regulatory requirements and CMS guidance requirements for Medicare Advantage plans and Part D plans," which includes some Rx-related information that would probably be referred to the PBM (e.g. formulary transition process, how to address Medicaid drug and Medicare Part D appeals). For these issues, does the State want scripts related to the pharmacy items that would be addressed by the PBM customer service hotline or does the State want both the plan scripts and PBM		Per Participant and Provider Communications Criteria C1 and C2, the FIDA Plan or PBM is required to have a pharmacy technical help desk call center and the FIDA Plan must ensure that the pharmacy technical support is available at any time that any of the network's pharmacies are open. The pharmacy technical help desk is in addition to the Participant services call center referenced in Participant and Provider Communications Criterion A1. The scripts for pharmacy information requested in Organizational Structure and Staffing Criterion C5 pertain to the Participant Services call center, not the pharmacy technical help desk. We have clarified the C5 criterion to state: "The FIDA Plan has informational scripts for its Participant services telephone line call center staff including, but not limited to:…".

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		scripts with identification of which types of questions would be fielded by each hotline? (If the State only wants the FIDA plan's scripts, the scripts for Rx-related questions would simply refer the member to the PBM.)		
	Performance and Quality Improvement (page 19)			
88.	A1	The assessment tool instructs the FIDA plan to collect and track critical incidents and reports of abuse for members receiving community-based or facility based long term services and supports (LTSS).	It is not immediately clear from the tool whether this report should be shared with NYSDOH and CMS or only internally with the QI committee. Can you please provide clarity on the distribution of the report?	The Performance and Quality Improvement (QI) A1 Criterion requires that FIDA Plans provide to CMS and the State the QI program description explaining how the FIDA Plan tracks incidents and cases of abuse for Participants receiving community-based or facility-based LTSS. FIDA Plans do not need to share the entire QI report with CMS or NYSDOH but must at a minimum share the QI program description explaining the elements required in the criterion and the entire QI report must be made available to CMS and NYSDOH upon request. No change to the criterion is necessary.
	Provider Credentialing (page 19)			
89.	1a	The FIDA Plan shall 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.	When will this application be created? When will plans be required to use the application? For all existing and new providers? When new providers being credentialed? Or, when existing providers are being re-credentialed? Please list all provider types that	Further information is forthcoming. No change to the criterion is necessary.

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			require a site visit Recommend the credentialing application be used only on a going forward basis and not require plans to go back and re-do credentialing.	
90.	1a	Page 68 of the MOU page 68 references NCQA certification. Can you please elaborate on how this impacts the Readiness Review?		During readiness review, CMS and the State will only assess whether a FIDA Plan's documentation demonstrates that its meets the criteria in the Readiness Review tool. We will not be assessing whether a FIDA Plan meets requirements outside of the tool (e.g., NCQA standards and those in the Federal regulations cited on page 68 of the MOU that go beyond the tool).
91.	1a	Part C states "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." Please list all provider types that require a site visit. Is a CMS or state review acceptable in lieu of a site visit? Is accreditation such as JCAHO or DNV acceptable in lieu of a site visit?	Please specify tracking expectations for all training. If a provider is contracted with all 25 FIDA plans, are they expected to take the ADA training, cultural competency training, disability training, evidence-based practices training, and primary care provider training (only applicable for PCPs) 25 times?	Providers need not be trained by each FIDA Plan. One FIDA Plan may recognize and track the completion of provider training within another FIDA Plan. No change to the criterion is necessary.
92.	1c	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	Will it be a requirement to conduct a site visit for such providers as home health agencies, ambulance, and those providers who render LTSS services such as Adult Day Health Care, Assisted	We have clarified the criterion to read: "The FIDA Plan shall ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted to all providers, following recognized managed care industry standards and relevant State regulations.

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
			Living Program, Consumer Directed Personal Care Services, etc.?	
93.	1c	Clarify timeframe for credentialing providers prior to becoming network providers given the existing timeframe for the overall Readiness Review and the July 1, 2014 start date?		Further information is forthcoming. No change to the criterion is necessary.
94.	4	Is there a definition of "evidence-based practice" and what is expected of the FIDA Plans?		CMS and the State are not prescribing any particular evidence-based practices for providers. In demonstrating readiness for this criterion, FIDA Plans must indicate which evidence-based practices they are requiring providers to use and how they will ensure that their providers are following these best-evidence practices. No change to the criterion is necessary.
95.	4	Plans must require that providers use evidence-based practices in delivering care. This requirement is listed under the heading of Provider Credentialing. Is this a requirement in advance of credentialing?	Can the use of evidence based practices be monitored post credentialing through other means? How should plans monitor evidence based practices? Are all services subject to these requirements? Does the Plan adopt a set of those rules and share with providers for consideration? What about independent	A4a requires FIDA Plans 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. Suggested evidence to fulfill this criterion includes submitting a provider participant requirement P&P which 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. No change to the criterion is necessary.

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
			medical decision making? Are Plans meant to be that involved in medical practices?	
	Provider Network (page 21)			
96.	A1	Does the provider network P&P have to speak specifically to individuals with developmental disabilities? The NY MOU states that people receiving services from the OPWDD system are excluded from the FIDA Demo. Are non-OPWDD FIDA plans expected to directly contract with Independent Living Centers or similar community-based organizations specifically meant to serve a developmentally disabled population?		No. As stated on page 7 of the MOU, those individuals receiving services from the New York State Office for People with Developmental Disabilities (OPWDD) system are not eligible for the FIDA Demonstration. We do not expect FIDA Plans to include providers exclusively serving individuals with developmental disabilities in their networks for the FIDA Demonstration. No change to the criterion is necessary.
97.	A2	Please list out the target populations under "provider networks are trained in cultural competency for delivering services to the following target populations."		We have clarified the criterion to state: "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 Participants".
98.	A7	What is the difference between a "contract" and "financial arrangement" in this context? Is it a requirement that all nursing facilities must be under agreement and that the actual "network" must include all nursing facilities?	Although it is the intent of the plan to contract with these facilities as needed, it is possible that not all facilities will agree to a financial arrangement.	See page 28 of the MOU for the definition of payment arrangement and page 72 of the MOU for information on out-of-network reimbursement rules. No change to the criterion is necessary.

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
99.	B1	What are linguistically and culturally competent services? Is there a training program available from the state? What needs to be included in training? Will online material suffice?		Culturally competent services are delivered in a manner that is sensitive to age; gender; sexual orientation; cultural, linguistic, racial, ethnic, and religious backgrounds; and congenital or acquired disabilities. Linguistically competent services are delivered in a manner that uses: • Bilingual/bicultural or multilingual/multicultural staff; • Cross-cultural communication approaches; • Foreign language interpretation services including distance technologies; • Sign language interpretation services; • Multilingual telecommunication systems; • Videoconferencing and telehealth technologies; • TTY and other assistive technology devices; • Computer assisted real time translation (CART) or viable real time transcriptions (VRT); • Print materials in easy to read, low literacy, picture and symbol formats; • Materials in alternative formats (e.g., audiotape, Braille, enlarged print); and/or • Varied approaches to share information with individuals who experience cognitive disabilities". No change to the criterion is necessary.
100.	B2b	Who determines what is appropriate? When tracking training, is an office manager completing the training sufficient for all providers he/she is linked to for obtaining credit? Everyone under the same contract? TIN, NPI,	Add list of requirements for training.	The criterion requires that all providers—not just the office manager—completes the required training. We have clarified the B2 criterion to state: "All medical, behavioral, and community-based and facility-based LTSS network providers receive training in physical accessibility, which is defined in accordance with the U.S. Department of Justice ADA guidance for

Row #	Criteria #	Description of Issue or Question	Suggested Revision/Comment	CMS/State Response
		Address? What about for a facility?		providers, in the following areas:…"
101.	C1	What are the State minimum training requirements? Where does one find the schedule of training for a new provider or will we be required to create one?	Define these training requirements, minimum hours, and topics. Could the State develop training for physicians and others with professional licenses as part of license renewal such as ADA, cultural competence and Person-centered care planning?	The criterion will be "greyed out" and pended for review at a later date.
102.	C2	Who provides this material, who is responsible to provide the training to providers and now often, what type of documentation is needed to show proof of training. If the provider has been trained by another FIDA Plan does that count for all FIDA Plans? Does the level of training vary by provider type?		FIDA Plans are responsible for requiring providers to meet applicable State minimum training requirements. CMS and the State expect the FIDA Plans to ensure the training is obtained. Please note that providers need not be trained by each FIDA Plan. One FIDA Plan may recognize and track the completion of provider training within another FIDA Plan. No change to the criterion is necessary.
103.	D1	Most of this will be addressed in the FIDA section of the provider manual. Is a separate handbook needed?		Only the provider manual is needed. No change to the criterion is necessary.
104.	D2	Provider handbook is 508 compliant	Please clarify if handbook needs to be 508 compliant (formatted in a certain way) when made available to providers, or at time of desk review.	We have added the following sentence to the suggested evidence for this criterion. "Information on Section 508 compliance is available at: www.section508.gov".

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105.	E2	This section states that the provider network arranges for necessary specialty care. What is the intended role of care management and the IDT if the provider network arranges for this care? Would this policy preclude the use of prior authorizations or retrospective denials of coverage?		We have clarified this criterion to state: "The FIDA Plan has a policy and procedure that states that a) the IDT arranges for necessary specialty care, behavioral health, and community-based and facility based LTSS and b) an adequate provider network is available to accommodate this care". We also revised the suggested evidence to state: "Care coordination P&P states that the IDT arranges for necessary specialty care and community-based and facility-based LTSS and the provider network P&P ensures an adequate provider network is available".
	Systems (page 25)			
106.	General Comment	During the call held on Wednesday, August 28, it was reported that systems testing readiness review would follow the initial desk review.	Can you clarify which of the pieces of suggested evidence will be expected for a desk review and which may not be expected until a systems testing review?	During the desk review, we are collecting workflow documents and policies and procedures that document the system functions and operational workflows. During the system testing, the FIDA Plans are expected to walk reviewers through the care coordination, claims and pharmacy claims system's functionality. This will include running through test scenarios that demonstrate the FIDA Plan's capabilities for supporting the Demonstration requirements. No change to the criterion is necessary.
107.	A1	Who is this information being exchanged with?	Can the State/CMS provide the FIDA Plans with a list of the entities that they will be required to exchange data with (e.g., Maximus)?	We have clarified the criterion to state: "The FIDA Plan is able to electronically exchange the following types of data with IDT members, CMS and/or its contractors, the State and/or its contractors, and others, as applicable:…"

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108.	A1c, d	Given the July 26th memo from Sharon Donovan regarding encounter data reporting, will it be necessary to show this level of reporting for the Readiness Review? Additionally, how are Medicare and Medicaid claims payment supposed to be demonstrated if the benefit is covered under both programs?		We do not expect to assess encounter data capabilities until after CMS guidance is finalized. Regarding handling benefits covered under Medicare and Medicaid, we are deferring to FIDA Plans to determine that. At this point, we do not expect to provide guidance on that topic. No change to the criterion is necessary.
109.	A2	Please clarify our understanding that the TrOOP Facilitator is located at the PBM.		The FIDA Plan or its contracted pharmacy benefit manager (PBM) is able to exchange Part D data with the TrOOP Facilitator (i.e., Part D Transaction Facilitation Coordinator). This is a requirement outlined in Chapter 14 of the Medicare Prescription Drug Benefit Manual. A November 2011 CMS Memorandum to Part D Plan Sponsors indicates that the TrOOP Facilitator is NDCHealth dba RelayHealth. This entity is the intermediary for collecting the required Part D information on behalf of CMS. The PBM is typically the reporting organization on behalf of the plan, but there may be some instances where the plan submits the data that the PBM collects. No change to the criterion is necessary.
110.	E6b	Claims adjudication system meets 180-day non-Part D transition fill requirements	According to the MOU (Appendix 7, V.f page 71), 90 days is required for prescription drugs not 180 days.	We have revised the E6B to state: "Appropriately meets the 90-day Part D and the 90-day non-Part D transitional fill requirements;".
111.	F1	Can you please confirm the difference between h) Medication Reconciliation Information and j) Pharmacy Data?		In some instances, they may be the same information. Medication reconciliation information should be a list of all the CURRENT medications and dosages the enrollee is taking. Medication reconciliation is

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				generally performed / validated by having a conversation with the Participant. Pharmacy data is typically claims data and the intent here is that there is a place for care managers to view pharmacy claims history to confirm which medications the Participant is taking but also identify medications that have been prescribed and the Participant has not gotten the prescriptions filled. No change to the criterion is necessary.
112.	G1	Can you provide additional information on the requirement around using an EHR system? Also on the commitment to joining a RHIO or HIT. Is there a timeframe for the IT "meaningful use provision" to be implemented for compliance?		Please note that we are encouraging FIDA Plans to have structured information systems, policies, procedures and practice to create, document, execute, update and share information with all of the Participant's providers, as outlined on pages 87-88 of the MOU and in Criterion G1. No change to the criterion is necessary.
113.	G1	The health plan and health information has to be accessible to the team of providers and there are many HIPAA concerns around the PCP and the Home Health Aide to have access to the FIDA Plan's documents and systems. Are there alternative methods that can be used to give information rather than primary access to the FIDA Plan's care management records?	HIPAA compliance concerns	PCPs and Home Health Aides are members of the IDT and must have access to care management records to fulfill their responsibilities as the IDT. No change to the criterion is necessary.

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	Utilization Management (page 31)			
114.	A3	The suggested evidence does not correspond to review criteria.	The FIDA UM Program list the rationale the plan uses to determine which services it approves (e.g., review criteria used, information sources, review processes.	We have revised the suggested evidence to state: "The UM program description includes a description of the review criteria, information sources, and processes that the IDT will use to review and approve the provision of items and services, including prescription drugs".
115.	A3&A5	Can the IDT include UM staff in addition to the care manager and other team members for service development and approvals?	Autonomous UM function is an important method to ensure appropriate and medically necessary utilization.	No. FIDA Plan UM staff is not part of the IDT. We have revised Criterion A3 to state: "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. FIDA Plan UM staff are not members of the IDT".
116.	A4	Based on what criteria?		The UM Program description should include the review criteria that the IDT will use to review and approve the provision of services and prescription drugs. No change to the criterion is necessary.
117.	A7	Will a published authorization grid suffice?		Without knowing the information included on the authorization grid, we cannot provide a response of whether or not it will suffice. Please note though, the criterion also requires the FIDA Plan to articulate how the providers and IDTs are made aware of the requirements. This should include how this information is disseminated to providers and IDTs. No change to the criterion is necessary.
118.	A10	FIDA Plan must cover all services outlined in the Three-way Contract (FIDA Plan does not have copies of Three-way Contract).	FIDA Plans must cover all services outlined in the MOU.as MOU has covered services outlined.	We have clarified the criterion to state: "The FIDA Plan must cover all items and 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. For purposes of the desk review,

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				FIDA Plans shall assume that they cover all services listed in Table 7-A on pages 69-70 of the MOU and as clarified in the Plan Benefit Guidance."
119.	B5	The assessment tool notes that any decision to deny a service authorization request must be made by a health care professional who has appropriate clinical expertise in treating the member's medical condition, performing the procedure, or providing the treatment. The MOU and readiness review tool note that most authorization should be made by the IDT.	ICS is committed to ensuring that our UM team is comprised of clinicians with the full range of expertise to make all necessary service determinations for our members. However, we are concerned that including that full scope of clinicians on each IDT is unwieldy. Can denials made by UM clinicians, not on the IDT, be routed back to the IDT for review before they are effectuated, without having to include each UM clinician on the IDT? For example, a decision about dental service authorization is best made by a dentist, however, it may not be practical to include a dentist on each IDT.	Denials cannot be made by UM clinicians who are not members of the IDT. The details of the IDT authorization process will be specified in the Three-way Contract. We have clarified the criterion to state: "Any decision to deny an item or service authorization request or to authorize an item service in an amount, duration, or scope that is less than requested must be made in accordance with the IDT authorization policy and process requirements."