Financial Alignment Capitated Readiness Review
New York State Fully Integrated Duals Advantage (FIDA) Readiness Review Tool

As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, the Centers for Medicare & Medicaid Services (CMS) and participating States want to ensure that every selected Medicare-Medicaid plan (referred to as Fully Integrated Duals Advantage (FIDA) Plans throughout this document) is ready to accept enrollment, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population. Every selected FIDA Plan must pass a comprehensive joint CMS/State readiness review.

CMS and the State of New York Department of Health (State / NYSDOH) have developed a State-specific readiness review tool based on stakeholder feedback received through letters and public meetings, the content of the Memorandum of Understanding signed on August 23, 2013, applicable Medicare and Medicaid regulations, and Interdisciplinary Team Policy issued on June 5, 2014.

The New York Readiness Review Tool is tailored to State's target population and the requirements of the approved FIDA Demonstration. It addresses the following functional areas of health plan operations related to the delivery of Medicare and Medicaid services including:

- Assessment processes
- Care coordination
- Confidentiality
- Participant protections
- Participant and provider communications
- Monitoring of first-tier, downstream, and related entities
- Organizational Structure and Staffing
- Performance and quality improvement
- Provider credentialing
- Provider network
- Systems (e.g., claims, payment, etc.)
- Utilization management

All State readiness review tools will address key areas that directly impact a beneficiary's ability to receive services including, but not limited to: assessment processes, care coordination, provider network, staffing, and systems to ensure that the organization has the capacity to handle the increase in enrollment of the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria also focus on whether a FIDA Plan has the appropriate Participant protections in place, including but not limited to, whether the FIDA Plan has policies that adhere to the Americans with Disabilities Act, uses person-centered language and reinforces beneficiary roles and empowerment, reflects independent living philosophies, and promotes recovery-oriented models of behavioral health services.

All readiness reviews will include a desk review, site visit, and a separate network validation review. Additional criteria related to enrollment functions and systems will also be provided with additional guidance. Assessment of all criteria will be completed before FIDA Plans receive enrollment.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	Assessment Processes	
	A. Transition to New FIDA Plan and Continuity of Care	
101	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.
102	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 currently serving FIDA Participants, but who are 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.
103	The FIDA Plan has policies and procedures to: a. 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; b. 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.
104	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.
105	The FIDA Plan assures that, within the first ninety (90) days of coverage, it will provide: a) In outpatient settings, up to ninety (90) days' worth of temporary supply(ies) of drugs, consistent with 42 CFR § 423.120(b)(3), when the Participant requests a refill of a non-formulary drug (including drugs that are on the FIDA Plan's formulary but require Prior Authorization or step therapy under the FIDA Plan's Utilization Management rules) that otherwise meets the definition of a Part D drug during the	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.

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	first ninety (90) days following Enrollment in the FIDA Plan; and b) A ninety (90) day supply of drugs when a Participant requests a refill of a non-Part D drug that is covered by Medicaid.	
106	Criterion deleted	
107	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 and are provided consistent with the requirements of Chapter 6 of the Prescription Drug Benefit Manual, 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.
108	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*	
109	The FIDA Plan: a. Ensures that each Participant receives and actively participates in a comprehensiv Registered Nurse (RN) within 30 days (for Opt-In enrollment) or within 60 days (for I individual's enrollment effective date and used by the Interdisciplinary Team (IDT) t Centered Service Plan (PCSP); b. Uses the NYSDOH Approved Assessment Tool which includes the following domai • Social; • Functional; • Medical; • Behavioral; • Community-based or facility-based long-term services and supports (LTSS) • Wellness and prevention; • Caregiver status and capabilities; and • The Participants' preferences, strengths, and goals.	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. Includes a review of need for reasonable accommodations.	
110	The Plan ensures that: a. all Participants receive a comprehensive assessment within 30 days (for opt-in enrollment) or 60 days (for passive enrollment) of the individual's enrollment effective date; b. The assessment is performed using the NYSDOH Approved Assessment Tool, which will be the Uniform Assessment system for New York (i.e., UAS-NY); c. The assessment is performed in-person with the Participant (e.g., in the Participant's home, hospital; acute care facility, assisted living facility; nursing facility); and d. The assessment is performed by a Registered Nurse (RN).	The FIDA Plan shall submit its Assessment P&P with timeline for fulfilling the 30-day and 60-day requirements, 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, contracting, and conducting the assessment.
111	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.
112	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;	Assessment P&P explains how often and when the assessment and re-assessment are provided to new and current Participants.

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	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-person with the Participant (e.g., in the Participant's home, hospital; acute care facility; assisted living facility; nursing facility), using the NYSDOH Approved Assessment Tool.	
113	The FIDA Plan has policies for staff to follow up and to document when a Participan comprehensive assessment or re-assessment. The FIDA Plan must obtain a signed re or must document in the Participant's record the FIDA Plan's efforts to involve the P signed refusal to participate.	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.
	Care Coordination	
	A: Care Management and Interdisciplinary Team (IDT)	
201	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 Participants.
202	The FIDA Plan's policies: a. Permit IDT's care decisions to serve as coverage determinations and service authorizations; and a. 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 (or providers, designees, and/or representatives on behalf of the Participant) appeals the IDT service authorizations.	Care coordination P&P states that the IDT decisions serve as service authorizations and describes a process for resolving any disagreements among IDT.
203	The IDT should: a. Be person-centered; b. Be built on the Participant'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.
204	The FIDA Plan ensures that the composition of the team will include: a. the Participant and/or, in the case of incapacity, an authorized representative;	The care coordination or IDT P&P includes a description of how the FIDA Plan will compose the

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	b. Participant's designee(s), if desired by the Participant; c. The FIDA Plan Care Manager; d. The Primary Care Provider (PCP) or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant; e. Behavioral Health Professional, if there is one, or a designee with clinical experience from the Behavioral Health Professional's practice who has knowledge of the needs of the Participant; f. FIDA Plan Care Manager; g. Participant's home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of the needs of the Participant, if the Participant is receiving home care and approves the home care aide/designee's participation on the IDT; h. Participant's nursing facility representative who is a clinical professional, if receiving nursing facility care; and i. Additional individuals including: • Other providers either as requested by the Participant or his/her designee or as recommended by the IDT members as necessary for adequate care planning and approved by the Participant and/or his/her designee; or • The RN who completed the Participant's Assessment, if approved by the Participant and/or his/her designee.	IDT and determine the team members.
205	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.
206	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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207	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, reasonable accommodations, 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.
208	The FIDA Plan's process for care manager assignment includes the following: a. Assigning to each Participant a care manager with the appropriate experience and qualifications based on a Participant's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers and associated reasonable accommodations); and b. Mechanisms to guarantee the right of each Participant to choose and change his/her care manager at any time. CMS and the State are not prescribing a specific level of experience and qualifications for care managers. Rather, the FIDA Plan shall explain how it defines appropriate experience and qualifications for care managers. In addition, care	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.

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	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.	
209	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).
210	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)	
211	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.
212	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. Need for reasonable accommodations; d. Measureable goals, interventions, and expected outcomes with completion timeframes; e. Involvement of the Participant and caregivers; and f. Requirements that services must be provided in the least restrictive community setting; g. The Participant's wishes in determining the place of service; and h. 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.
213	The FIDA Plan ensures that the IDTs use the Participants' comprehensive	Care planning P&P includes these timeframes and

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	assessments to complete the Person-Centered Service Plans (PCSP) for all Participants. The PCSP must be completed within 30 days of completion of the comprehensive assessment. The process for completing the PCSP is culturally competent and meets other requirements outlined in the IDT Policy issued in final form on June 5, 2014.	describes the process for meeting the timeframes.
214	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.
215	The Person-Centered Service Plan contains the following: a. Prioritized list of Participant's concerns, needs, and strengths; including need for any reasonable accommodations; 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: vi. The person(s)/providers responsible for specific interventions/services; and vii. 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, including any reasonable accommodations; h. Participant choice of services (including self-direction);	Care planning P&P states that the FIDA Plan assures that these elements are incorporated into the Person-Centered Service Plan.

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	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.	
216	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.
217	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*	
218	The FIDA Plan assures that all Participants have the opportunity to direct their own services through the consumer-directed personal assistance option.	FIDA Plan P&Ps on self-direction include this requirement.
219	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 at 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.	FIDA Plan P&Ps on self-direction include this requirement.
220	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; 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.	Sample Participant communications demonstrating that the FIDA Plan has provided the information contained within this criterion to all Participants.
221	The FIDA Plan's policies regarding self-direction conform to the State requirements.	FIDA Plan P&Ps on self-direction describe how the

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	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	FIDA Plan will meet the State self-direction requirements.
	D. Coordination of Services	
222	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 (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); 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, including whether reasonable accommodations were offered and delivered and the types of reasonable accommodations provided; 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.
223	The FIDA Plan describes how the IDT and Utilization Management (UM) facilitates timely and thorough coordination between the FIDA Plan, the IDT, the PCP, and other providers (e.g., behavioral health providers, non-emergency medical transportation, durable medical equipment repair, dental providers, community-	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.

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	based and facility-based LTSS, etc.).	
	E. Transitions Between Care Settings	
224	FIDA plan has a policy and procedure for insuring that the hospitals and nursing facilities 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.
225	For Participants who are residents of or who are admitted to nursing facilities and who wish to move or return to the community, the FIDA Plan has policies to ensure that the IDTs refer these Participants, where appropriate, to the Money Follows the Person (MFP) program within 2 business days of the Participants (who are residents) receiving a comprehensive assessment and within 2 business days of a new admission of a Participant. The FIDA Plan has policies to ensure that the IDT cooperates with the work of the MFP contractor as it relates to the Participant.	Sample communications the FIDA Plan plans to send to Participants living in institutional settings contain information related to accessing community supports.
226	FIDA Plan tracks the number of Participants who wish to move to the community and are referred to the MFP Program and reports this information to the State.	Sample report(s) from the FIDA Plan describes how it tracks Participants wishing to move to the community and referrals to the MFP Program.
227	The 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 or the FIDA Plan provide any prior authorizations for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery.	Care setting transitions P&P describes how IDTs will be informed of an impending hospital discharge and the process IDTs or the FIDA Plan will use to provide any prior authorizations.
228	The FIDA Plan has a policy and procedure for monitoring transfers to minimize unnecessary complications during care setting transitions and hospital re-admissions.	Care setting transitions P&P explains how the FIDA Plan and providers work together to minimize unnecessary complications related to care setting transitions and hospital readmissions and how the FIDA Plan monitors transfers and hospital readmissions.
229	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

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		settings
230	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.
231	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.
232	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	
233	Criterion deleted	
234	FIDA Plan policies and procedures require FIDA Plan staff to cooperate with the Participant Ombudsman as follows: a. Respond to FIDA Participant Ombudsman calls, emails, letters, and faxes within 1 business day of the contact; b. Designate a single staff person to serve as liaison between the FIDA Plan and the FIDA Participant Ombudsman; c. Provide the FIDA Participant Ombudsman with general plan-specific information about coverage, policies, and procedures and also Participant-specific information about the Participant's coverage, PCSP, IDT, and more; d. Obtain, as necessary, the Participant's authorization for the FIDA Participant Ombudsman to act on his/her behalf; e. Document all interactions with the FIDA Participant Ombudsman, including, but not limited to, the reason for the contact, the options discussed, the resolution reached, the timing of contact and resolution, and any follow-up steps required as a result of the interaction; and f. Notify Participants of the availability of the FIDA Participant Ombudsman in enrollment materials; annual notice of grievance and	Participant Ombudsman (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 obtain Participant authorization for the PO to act on his/her behalf and track the nature of the PO questions.

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	appeal procedures; all written notices of denial, reduction or termination of a service; and at the time a Participant contacts the FIDA Plan regarding a grievance or appeal (e.g., calls to the Participant services telephone line or coverage, determinations, grievances, and appeals telephone line).	
	Confidentiality	
301	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.
302	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.
303	FIDA Plan ensures privacy and security of Participant health records and provides for access by Participants to such records.	Privacy P&P
	Participant and Provider Communications	
	A. Participant and Provider Communications	
401	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. FIDA 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 the phones Monday through Friday from 8:00 A.M. to 8:00 P.M. Eastern Time, excluding holidays.	Participant services telephone line P&P (which includes general Participant services, coverage determinations, appeals, and grievances, and nursing hotline) confirms that the hotline is toll-free and available during required times for medical services, community-based and facility-based LTSS, and drugs.
402	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:	Participant services telephone line P&P (which includes general Participant services, coverage determinations, appeals, and grievances, and

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	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; g. Information on the availability of reasonable accommodations and how they can be arranged and delivered; and h. The procedures for a Participant to change FIDA Plans or to opt out of the Demonstration and information on how Participants can access the Enrollment Broker to effectuate such a change.	nursing hotline) confirms that all of the listed information will be available to customer service department representatives. Staffing plan
403	The FIDA Plan operates a toll-free call center for coverage determinations (including exceptions and prior authorizations), grievances, and appeals that: a. Is staffed with live customer service representatives available to respond to providers or Participants; b. Operates during normal business hours and, at a minimum, from 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 (which includes general Participant services, coverage determinations, appeals, and grievances, and nursing hotline) confirms that the hotline is toll-free and available during required times.
404	The FIDA Plan operates a nursing hotline with live nurses available to answer clinical questions 24 hours a day, 7 days a week.	Participant services telephone line P&P (which includes general Participant services, coverage determinations, appeals, and grievances, and nursing hotline) confirms that the hotline is toll-free and available during required times.
405	The FIDA Plan maintains a contract with a language line company that provides interpreters for non-English speaking and limited English proficiency Participants. In	Contract with language line company or draft contract for language line or existing MLTC language line contract includes these requirements, including

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	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.	mandatory hours of operation.
406	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.
407	The FIDA Plan: a. Translates the following 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 FIDA Plans of any changes to these languages. The materials that must be translated into these languages, include but are not limited to: i. Summary of Benefits (SB); ii. Annual Notice of Change (ANOC); iii. Evidence of Coverage (i.e., EOC / Participant Handbook); iv. Formulary; v. Provider / Pharmacy Directory; vi. Part D Transition Letter; vii. NYSDOH Approved Assessment; viii. PCSP; and ix. Ad-hoc communications regarding payments / reimbursements. b. The FIDA Plan ensures that these documents are updated.	IDT P&P describes how the FIDA Plan will ensure that required documents are translated and that translations are continually reviewed and updated.
	B. Stakeholder Feedback	

1. Criteria Number	2. Criteria Reference	3. Example Evidence
408	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 five NYC counties). For FIDA Plans servicing Nassau, Suffolk, and Westchester Counties, FIDA Plans must hold at least two Participant Feedback Sessions each year in each of these counties. a. Participants must be invited to raise problems and concerns and to provide positive feedback. b. The FIDA Plan must allow for Participants to participate in-person and remotely, and Participants can choose whether they want to participate in-person or remotely. c. The FIDA Plan must assist Participants with the costs, transportation, reasonable accommodations, and other challenges of attending these in-person Participant Feedback Sessions. d. The FIDA 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
409	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 FIDA Participant Ombudsman. a. The PAC must be composed primarily of Participants, with at least 60% of those serving on the PAC being FIDA Plan Participants. b. The PAC overall composition must reflect the diversity of the FIDA Participant population. c. The FIDA Plan must have a plan for the PAC to meet at least quarterly and conduct these meetings in-person. d. The FIDA Plan must establish a process for the PAC to provide input to the FIDA Plan. e. The FIDA Plan must facilitate and provide all transportation and supportive services, including reasonable accommodations, necessary to ensure in-person access to PAC meetings. f. The FIDA Plan must share with the PAC any updates or proposed changes as well as information about the number and nature of grievances and appeals, information about quality assurance and	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	improvement, information about enrollments and disenrollments, and more. g. The PAC members must be invited to voice questions and concerns about topics including but not limited to quality of life and service delivery and must be encouraged to provide input and feedback into topics raised by the FIDA Plan. h. 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. The FIDA Plan is encouraged to include Participant representation on their boards of directors.	
	C: Pharmacy Technical Support	
410	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.
411	The FIDA Plan ensures that pharmacy technical help desk 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.
	Participant Protections	
	A. Participant Rights	
501	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.
502	The FIDA Plan policies articulate that it will notify Participants of their rights and	Participant rights P&P provides a timeline for

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	protections (including appeal and grievance rights) at least annually, in a manner appropriate to their condition and ability to understand.	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.
503	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.
504	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.
505	The FIDA Plan has policies and procedures to ensure that it provides reasonable accommodations. The policies and procedures ensure that the FIDA Plan informs Participants, in general, of their right to reasonable accommodations and specifies how to obtain reasonable accommodations from the FIDA Plan and providers, including the process, who decides whether the accommodations will be provided, and the process for appealing any decisions.	Participant rights P&P states that the FIDA Plan informs Participants of their right to reasonable accommodation and specifies how to obtain reasonable accommodations from the FIDA Plan and providers, including the process, who decides, and how to appeal any decisions. Participant rights P&P ensures that the FIDA Plan and its providers are required to provide reasonable accommodations.
	B: Appeals and Grievances	
506	The FIDA Plan staff receive training on Participant protections, including but not	Training materials contain information about the

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	limited to: a. The IDT coverage determination and PCSP development processes; b. Reasonable accommodations; and c. Appeals and grievance processes.	FIDA Plan's organization and coverage determination processes, the appeals and grievance processes, and reasonable accommodations.
507	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.
508	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 Participant Ombudsman.	Grievances and appeals P&P explains the extent to which the FIDA Plan will assist a Participant in filing an appeal or grievance and the extent to which the FIDA Plan may and must refer to the Participant Ombudsman.
509	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; b. Final disposition of the grievance; and c. The date that the FIDA Plan notified the Participant of the disposition.	Screenshots of or reports from the tracking system in which Participant grievances are kept include these elements. 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.
510	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:	Grievances P&P includes these specifications

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	
511	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.
512	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	Appeals P&P includes these specifications

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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 and their providers or 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. 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.	
513	The FIDA Plan policies and procedures reflect the requirement that the FIDA Plan	Appeals P&P includes these specifications.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	auto forward any adverse decision to the Integrated Administrative Hearing Office at the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA) within 2 business days of the decision being reached – with a copy to NYSDOH Office of Health Insurance Programs Department of Long Term Care staff. This step occurs electronically to the secure mailbox to be established by OTDA and it occurs regardless of the amount in controversy (i.e., there will be no amount in controversy minimum imposed for matters before OTDA). 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. 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 Office at the FIDA Administrative Hearing Unit at the OTDA and that no action is needed by the Participant.	
514	The FIDA Plan: a. Provides 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 request is made to the FIDA Plan by the later of: i. Ten calendar days of the postmark date on the notice of the decision that is being appealed; or ii. The intended effective date of the Action; b. States in its written acknowledgement of appeal: i. Whether the appeal was received within the timeframe required for continuing benefits; and ii. That the benefits will continue pending an appeal up to and including the Medicare Appeals Council; and c. Reiterates its process for continuing benefits in its Notification of Appeal Decision to the Participant.	Appeals P&P includes these specifications

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	C: Participant Choice of PCP	
515	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	
516	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.
517	The FIDA Plan can connect Participants with the appropriate resources or services if a Participant calls during a mental health crisis.	Emergency services P&P addresses how the FIDA Plan is prepared to provide emergency behavioral health services to Participants in crisis.
518	The FIDA Plan ensures access to emergency care and urgently needed care in accordance with State and Federal requirements.	Emergency services P&P
	Organizational Structure and Staffing	
	A. Organizational Structure and Staffing	
601	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; d. A single point of contact for reasonable accommodations; and e. A single point of contact for pharmacy services.	Staff resumes indicate that qualified and experienced staff with appropriate expertise fills these positions.
602	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		behavioral health).
603	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, and behavioral health).	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	
604	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.
605	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.
606	The FIDA Plan: a. Demonstrates that it has sufficient care managers to: i. Facilitates IDT activities and communication; ii. Facilitates assessment of Participant needs, including need for reasonable	Care manager qualifications P&P includes those listed. Note that the evidence submitted for Part (a) of this criterion must address all 4 elements of this criterion: facilitating IDT activities and communication; facilitating assessment of Participant needs, including need for reasonable

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	accommodations; iii. Assists in developing, implementing, and monitoring the PCSP, including assisting Participants in obtaining reasonable accommodations; and iv. Serves as the lead of the IDT. b. Ensures 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., ratio of care managers to Participants) is reasonable to ensure appropriate care coordination and care management. i.	accommodations; assisting in developing, implementing, and monitoring the PCSP, including assisting Participants in obtaining reasonable accommodations; and serving as the lead of the IDT. Evidence submitted for this criterion must also include a detailed description of how the FIDA Plan will ensure it has sufficient care managers to conduct these functions on an ongoing basis throughout the FIDA Demonstration. For Part (b) of this criterion, 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.
607	Care managers must have: a. The appropriate experience and qualifications commensurate with a Participant's individual needs (i.e., communication, cognitive, or other barriers); b. Knowledge of: i. Physical health; ii. Aging and loss; iii. Appropriate support services in the community; iv. Frequently used medications and their potential negative side-effects; v. Depression; vi. Challenging behaviors; vii. Alzheimer's disease and other disease-related dementias; viii. Behavioral health; and ix. Issues related to accessing and using durable medical equipment, as appropriate.	Job descriptions include relevant educational and experience requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
608	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.
609	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.
610	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: 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.
611	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		determinations and redeterminations involving medical necessity. Job description for the medical director includes this responsibility.
	C: Staff Training	
612	The FIDA Plan has a cultural competency and disability training plan that: a. Ensures that all FIDA employees and members of the IDT who are not employees deliver culturally-competent services in both oral and written communications with Participants; b. Includes training on: i. Accessibility and accommodations;, ii. Independent living and recovery models: iii. Cultural competency; iv. Wellness philosophies; and v. *Olmstead* requirements.	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.
613	The FIDA Plan staff that come in contact with Participants or providers 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.
614	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;	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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; s. How to explain Participants' rights to reasonable accommodations and how to assist Participants in obtaining reasonable accommodations and handle inquires related to grievances and appeals; and t. 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.	provided, the frequency of the training, and a mechanism to measure competency of staff upon completion of training.
615	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.
616	The FIDA Plan has scripts for its Participant services telephone line call center customer service staff including, but not limited to: a. Benefit information; b. Information about the right to reasonable accommodations, how to	Copies of Participant services telephone line call center customer service staff scripts contain content related to the competencies listed in the criteria

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	obtain them, and how to appeal a decision; c. Continuity of care requirements; d. Enrollment/disenrollment rules and procedures for referral to the enrollment broker; e. Formulary information; f. Pharmacy information, including whether an Participant's pharmacy is in the FIDA Plan's network; g. Provider information, including whether a Participant's physician is in the FIDA Plan's network; h. Out-of-network coverage; i. Claims submission, processing, and payment; j. Formulary transition process; k. Comprehensive Assessment and PCSP development requirements; l. IDT role and processes; m. Self-direction; n. Coverage determination, grievance, and appeals process (including how to address Medicaid drug and Medicare Part D appeals); o. Information on how to obtain needed forms; p. Information on replacing an identification card; and q. Service area information.	
617	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		services.
	Performance and Quality Improvement	
	Performance and Quality Improvement	
701	The FIDA Plan collects and tracks critical incidents and reports of abuse for Participants receiving community-based or facility-based LTSS. The FIDA Plan also documents and tracks that Participants are advised of their ADA-related rights, to what extent reasonable accommodations are provided, and grievances and appeals related to those rights.	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.
702	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, quality of life, and specific defined elements related to IDT processes and care management services. The FIDA Plan has policies and procedures, a staffing plan, and a staff supervision structure to ensure that it will collect and report all quality measures and will fulfill 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	
801	FIDA Plans must adhere to managed care standards at 42 CFR Part 438.214 and 42 CFR Part 422.204. Beginning in Demonstration Year 2, FIDA Plans must ensure that new Providers and Providers who are re-credentialed meet the following accreditation, credentialing, and re-credentialing requirements: a) FIDA Plans must use the CAQH credentialing application process for FIDA Plan credentialing and recredentialing of all providers within provider types covered by the CAQH application and use the single, uniform FIDA Participating Provider Supplemental Information Form for Providers Applying Through CAQH for obtaining additional information. b) FIDA Plans must employ the single, uniform FIDA Participating Provider Credentialing Application for Providers Not Applying Through CAQH for credentialing and re-credentialing of all providers within provider types not	Provider credentialing P&P includes these requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	covered by the CAQH credentialing process.	
802	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.
803	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.
804	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 evidence-based best practice and 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 Participants 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	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 evidence-based best practices and how the FIDA Plan will monitor and enforce the use of evidence-based best practices.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	evidence-based practices. a. e. FIDA Plans will be required to demonstrate how they will hold their providers to evidence-based practices specific to their practice areas.	
	Provider Network	
	A: Establishment and Maintenance of Network, including Capacity and Services Offered	
901	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.
902	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.	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.
903	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.
904	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	Provider network P&P explains how and when services outside of the network may be covered and under what circumstances.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	not available within a reasonable distance from the Participant's place of residence.	
905	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.
906	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. As all providers must meet accessibility requirements, the FIDA Plan updates the provider directory information to remove any providers found to not be in compliance with accessibility requirements.	Provider network P&P includes time-frames for updating provider directory and search functionality (for online provider directories).
907	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, the FIDA Plan ensures that it contracts with or has a payment arrangement with all nursing facilities in the Demonstration Area to ensure Participants' residency and access to services are not interrupted for the duration of the Demonstration. For 'new to service' Participants (meaning those not already receiving facility-based LTSS), the FIDA Plan ensures that it contracts or makes payment arrangements with a minimum of eight (8) nursing facilities per county in their network. The FIDA Plan ensures that it meets minimum quality standards to be established for years two and three of the Demonstration.	Provider network P&P includes requirements for contracting and/or having a payment arrangement with all nursing facilities.
908	Criterion deleted	
	B: Accessibility	
909	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.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
910	All medical, behavioral, and community-based and facility-based LTSS network providers receive training in physical accessibility, which is defined in accordance with U.S. Department of Justice ADA guidance for providers, in the following areas: a. Their obligation to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities. b. Utilizing waiting room and exam room furniture that meet needs of all Participants, including those with physical and non-physical disabilities. c. Accessibility along public transportation routes and/or provide enough parking; d. 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	
911	The FIDA Plan has a policy that specifically states that "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.
912	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	Each of the listed elements is included in the provider training curricula. Template specifies that completion of these trainings is mandatory.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	
913	The FIDA Plan: a. Conducts trainings for IDT members on: i. IDT policies and procedures; ii. The person-centered service planning processes; iii. Cultural competence; iv. Accessibility and reasonable accommodations; v. Independent living and recovery; vi. Wellness principles; and vii. Other required training, as specified by the State, which will include ADA / *Olmstead* requirements; b. Requires IDT members to agree to participate in approved training; c. Documents completion of training by all IDT members, including both employed and contracted personnel; and d. Addresses non-completion of the training.	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.
914	The FIDA Plan training for all providers and IDT members includes: a. Coordinating with behavioral health and community-based and facility-based LTSS providers; b. Providing information about accessing behavioral health and community-based and facility-based LTSS; and c. Furnishing 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).
915	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.
916	The FIDA Plan has procedures to address LTSS providers who are not required to	Data systems management guidelines for LTSS

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	have National Provider Identifiers (NPIs).	providers address community-based and facility-based LTSS providers who are not required to have National Provider Identifiers (NPIs).
917	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	
918	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.
919	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). Information on Section 508 compliance is available at www.section508.gov.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	E: Ongoing Assurance of Network Adequacy Standards	
920	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.
921	The FIDA Plan has a policy and procedure that states: a. The IDT arranges for necessary specialty care, community-based and facility-based LTSS, and behavioral health; and b. An adequate provider networks is available to accommodate this care.	Care coordination P&P states that the IDT arranges for necessary specialty care, community-based and facility-based LTSS, and behavioral health, and the provider network P&P ensures an adequate provider network is available. List of network providers includes specialties in all geographic regions for the Demonstration.
	Monitoring of First-Tier, Downstream, and Related Entities	
1001	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.
	Systems	
	A: Data Exchange	
1101	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: a. Person-Centered Service Plan; b. Participant benefit plan enrollment, disenrollment, and enrollment-	*Note: For Parts a. and f., the FIDA Plan does not have to have a fully integrated technology solution. It is acceptable for the Plan to provide information that outlines the process for receiving/sending/storing this clinical information

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	securely, e.g. faxing. 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.
1102	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.
1103	The FIDA Plan ensures that health information technologies and related processes	Baseline documentation should include policies and

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	support national, state and regional standards for health information exchange and interoperability.	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.
1104	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.
1105	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.
1106	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.
1107	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	
1108	The FIDA Plan processes accurate, timely, and HIPAA-compliant claims and adjustments and calculates adjudication processing rates. This includes a process	Baseline documentation should include:

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	and timeframe for managing pended claims.	1) Claims processing P&P that details claims processing turnaround timeframes, steps for managing pended claims, including turnaround times, and methods for ensuring claims processing accuracy. 2) Claims processing statistics (e.g. average daily/monthly claims processed, pended and denied, percent paper, etc.).
1109	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.
1110	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.
1111	The claims system fee schedule includes all medical, community-based and facility-based LTSS, home and community-based services (HCBS), Medicare and Medicaid	Baseline documentation should illustrate the following:

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	services.	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.
1112	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	
1113	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.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
1114	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.
1115	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.
1116	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.
1117	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 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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		with the external vendor, as well as oversight P&Ps.
	D. Provider Systems	
1118	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. ADA-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*	
1119	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.
1120	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.
1121	The FIDA Plan audits the pharmacy system on a regular basis. This includes	Baseline documentation should include the FIDA

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	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.
1122	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.
1123	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 unique routing identifiers and Participant identifiers.	Baseline documentation should include the FIDA Plan and its PBM's P&Ps and related workflows for determining appropriate claims payment for Part D covered drugs, Medicaid-covered drugs and can be properly coordinated with secondary payers.
1124	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 90-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.
1125	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 ensure continuity of care and access to medication for the Participants in the event the PBM systems are inaccessible.	Baseline documentation should include information about the PBM's disaster recovery and business continuity plan for confirming benefit coverage, ensuring that contracted pharmacies are able to determine which drugs are covered under the Demonstration, and that Participants receive their

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		required medications.
	F. Care Coordination and Care Quality Management Systems	
1126	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; j. Pharmacy data; and k. Evidence that Participants are informed of their ADA rights, how to obtain reasonable accommodations, the reasonable accommodations provided; and how to file a grievance and appeal.	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.
1127	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.
1128	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.
1129	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		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 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.
1130	The care coordination system includes a mechanism to alert Interdisciplinary Team (IDT) members of ED use or inpatient admissions.	*Note: The mechanism to alert the IDT members does not have to be a technical solution. It is acceptable for the FIDA Plan to provide information that outlines the process for notifying the IDT of ED and inpatient admissions within a specified timeframe. 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.
1131	The FIDA Plan has systems to permit the transfer of service plans from MLTC plans	Baseline documentation should include:

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	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.	1) The FIDA Plan's P&Ps for obtaining service plans from MLTC plans or FFS providers. 2) A description of the process for incorporating the service plan into the participant record in the FIDA Plan's care management system. 3) 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.
	G. Health Information Technology and Integrated Records	
1132	• FIDA Plans must maintain a health record to which all members of the IDT have swift and easy access. FIDA Plans are strongly encouraged to use an electronic health record system that meets the Meaningful Use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Regardless, the IDT must have and implement a communications and information sharing plan (as outlined in the IDT Policy) that allows the Participant's health information and Patient-Centered Service Plan to be accessible to the IDT. FIDA Plans are encouraged to join regional health information networks or qualified health information technology (HIT) entities for data exchange and share information with all providers participating in a Person-Centered Service Plan.	Baseline documentation should include: 1) The FIDA Plan's P&Ps describing its existing ability to meet these HIT and integrated records system standards. 2) A description and screenshots of the system utilized to monitor the status of orders for tests, treatments, services and referrals. 3) The FIDA Plan's P&Ps that support the use of evidence based clinical decision making tools, consensus guidelines and clinical best practices. 4) 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.
	H. Enrollment Systems	
1133	The FIDA Plan receives, processes, and reconciles in an accurate and timely	Baseline documentation should include the FIDA

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	manner: a. The CMS Daily Transaction Reply Report (DTRR) from the CMS designated enrollment vendor; and b. The benefit and enrollment maintenance file from the State.	Plan's P&P on processing and reconciling enrollment files. Documentation should also include the FIDA Plan's enrollment systems schematic that details the daily enrollment processing capacity.
1134	If the FIDA Plan receives a CMS DTRR with confirmation of a successfully processed enrollment transaction that is missing 4Rx data, the FIDA Plan submits a 4Rx transaction (TC 72) to CMS' enrollment vendor within 72 hours of receipt of the DTRR. The 4Rx data elements are: a. RxBIN – Benefit Identification Number; b. RxPCN – Processor Control Number; c. RxID – Identification Number; and d. RxGRP – Group Number.	Baseline documentation should include the FIDA Plan's P&P for creating and submitting 4Rx transaction files. Additional information should include data specifications detailing the listed data elements.
1135	The FIDA Plan's enrollment/member system includes each of the following data elements: a. Name; b. Date of birth; c. Gender; d. Telephone #; e. Permanent residence address; f. Mailing address; g. Medicare #; h. ESRD status; i. Other insurance COB information; j. Language preference and alternative formats; k. Participant signature and/or authorized representative signature; l. Date of signature; m. Authorized representative contact information; n. Employer or union name and group number; o. Which FIDA Plan the Participant is currently a member of and to which FIDA Plan the Participant is changing; p. Information provided under "please read and sign below" q. Release of information; r. Option to request materials in a language other than English or in	Documentation should include screenshots of the FIDA Plan's enrollment/member system that confirms each data element listed is available in the system.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	alternate formats; and s. Medicaid #.	
1136	For passive enrollments, the FIDA Plan sends the following to the Participant 30 days prior to the effective date of coverage: a. A FIDA Plan-specific Summary of Benefits; b. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided by the FIDA Plan; c. A combined provider and pharmacy directory that includes all providers of Medicare, Medicaid, and additional benefits; and d. Proof of health insurance coverage that includes the 4Rx prescription drug data necessary to access benefits so that the Participant may begin using FIDA Plan services as of the effective date of enrollment.	Baseline documentation should include the FIDA Plan's P&P detailing the processes and timeframes for sending the Participant materials. The FIDA Plan should also illustrate how it systematically tracks when these materials are sent, if applicable.
1137	For passive enrollments, the FIDA Plan sends the following to the Participant no later than the last calendar day of the month prior to the effective date of coverage: a. A single ID card for accessing all covered services under the FIDA Plan; and b. A Participant Handbook (Evidence of Coverage).	Baseline documentation should include the FIDA Plan's P&P detailing the processes and timeframes for the single ID card and the Participant Handbook (Evidence of Coverage). The FIDA Plan should also illustrate how it systematically tracks when these materials are sent, if applicable.
1138	For opt-in enrollments, the FIDA Plan provides the following materials to the Participant no later than ten business days from receipt of CMS confirmation of enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later: a. A comprehensive integrated formulary; b. A combined provider and pharmacy directory; c. A single ID card; and d. A Participant Handbook (Evidence of Coverage).	Baseline documentation should include the FIDA Plan's P&P detailing the processes and timeframes for sending the Participant materials. The FIDA Plan should also illustrate how they systematically track when these materials are sent.
	Utilization Management	
	A: The FIDA Plan has a utilization management (UM) program to process requests for initial and continuing authorizations of covered services	
1201	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.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
1202	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 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.	The FIDA Plan's UM program description includes this definition of medically necessary. The FIDA Plan's IDT P&Ps include this definition of medically necessary. The FIDA Plan's P&Ps for adjudicating appeals include this definition of medically necessary.
1203	The FIDA Plan defines the review criteria, information sources, and processes that the IDT will use to review and approve the provision of items and services. FIDA Plan UM staff are not members of the IDT.	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.
1204	The FIDA Plan has policies and systems to detect both under- and over-utilization of items, 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).
1205	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).
1206	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 items and services available.	Out-of-network service authorization P&P explains how a Participant or provider may obtain authorization for an item or service being provided by a provider outside of the FIDA Plan's network.
1207	The FIDA Plan describes its processes for communicating to all IDTs and service	The UM program description details mechanisms for

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	providers which items and 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).	informing network providers of prior authorization requirements and procedures. The FIDA Plan's provider materials describe prior authorization requirements and procedures.
1208	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 Participants; 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.
1209	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, the FIDA Plan shall use the list of covered items and services shared with plans on February 7, 2014.	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.	
1210	The FIDA Plan has a policy and procedure for the IDT to appropriately inform Participants, in the event that the Participant refuses to participate in the service planning process, of coverage determinations, including tailored strategies for Participants with communication barriers (i.e., alternative formats and other reasonable accommodations that may be needed to communicate with Participants with any disabilities).	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.
1211	For the processing of requests for initial and continuing authorizations of covered items and services, the IDT and the FIDA Plan shall have in place and follow written policies and procedures consistent with the IDT Policy issued by NYSDOH and CMS on June 5, 2014.	The UM program descriptions for the IDT explains the process for obtaining initial and continuing authorizations for services consistent with the IDT Policy issued by NYSDOH and CMS on June 5, 2014. The prescription drug manual explains the process

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		for obtaining approval for prescription drug coverage that is considered urgent.
1212	The FIDA Plan and IDT ensure that prior authorization requirements are not applied to the following services: 1) Emergency or Urgently Needed Care; 2) Out-Of-Network Dialysis when the Participant is out of the service area; 3) Primary Care Doctor visits; 4) Family planning and Women's Health specialists' services; 5) For any Participant that is an Indian eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services; 6) Public health agency facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB/DOT); 7) Immunizations; 8) Palliative Care; 9) Other Preventive Services; 10) Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services; 11) Dental Services through Article 28 Clinics Operated by Academic Dental Centers; 12) Cardiac Rehabilitation, first course of treatment (a physician or RN authorization for subsequent courses of treatment); 13) Supplemental Education, Wellness, and Health Management Services. 14) Prescription drugs: a. Which are on the formulary, or a. b. Which are not on the formulary, but where the request is made for an existing prescription within the 90-day transitional period.	The UM program descriptions for the FIDA Plan and IDT lists those items and services that are not subject to prior authorization and this list is consistent with the required elements.
1213	The FIDA Plan policies and procedures require both the Plan and IDTs to follow the	The UM program description for the IDT includes

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	FIDA Demonstration rules for the timing of authorization decisions for all covered services. The Plan and IDTs must make authorization decisions in the following timeframes and provide notice that meets the timing requirements set forth in 42 C.F.R. § 438.210(d): 1) For a service that must be pre-authorized, the IDT or FIDA Plan must decide and provide notice of a determination to the Participant or Participant's designee and the Participant's health care provider by telephone and in writing within three business days of receipt of the necessary information. 2) For a determination involving continued or extended health care services, additional services for a Participant undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, the FIDA Plan or IDT shall provide notice of such determination to the Participant or the Participant's designee, which may be satisfied by notice to the Participant's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, in which case the FIDA Plan shall provide notice of the determination within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. 3) For a determination involving health care services which have been already delivered, the FIDA Plan shall provide notice of the determination within fourteen days of receipt of the request for service. 4) Failure by the IDT or FIDA Plan to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to the FIDA Demonstration appeals process. 5) For standard authorization decisions, the FIDA Plan shall provide notice as expeditiously as the Participant's health condition requires and no later than 3 calendar days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if: • The Participant or the Provider requests an extension, or • The FIDA Plan can justify (to the satisfaction of NYSDOH and CMS upon request) that: o The extension is in the Participant's interest; and o There is a need for additional information where:	these requirements.

1. Criteria Number	2. Criteria Reference	3. Example Evidence
	o There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and Such outstanding information is reasonably expected to be received within 14 calendar days. 6) FIDA Plan will ensure that when Participants are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization, IDTs or the FIDA Plan shall provide any prior authorizations for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery. 7) For expedited service authorization decisions, where the Provider indicates or the FIDA Plan determines that following the standard timeframe could seriously jeopardize the Participant's life or health or ability to attain, maintain, or regain maximum function, the FIDA Plan must make a decision and provide notice as expeditiously as the Participant's health condition requires and no later than 24 hours after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if: • The Participant or the Provider requests an extension; or • The FIDA Plan can justify (to NYSDOH and CMS upon request) that: • The extension is in the Participant's interest; and • There is a need for additional information where: o There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and o Such outstanding information is reasonably expected to be received within 14 calendar days.	
1214	Any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested must be made in accordance with the IDT Policy (dated June 5 , 2014) and process requirements and in compliance with 42 CFR 438.210.	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

1. Criteria Number	2. Criteria Reference	3. Example Evidence
		show that this individual has the appropriate experience and training to conduct this function.
1215	Criterion deleted	