

**FIDA-IDD Demonstration Requirements for Assessment, Service Planning and Authorization, and
Ongoing Care Management
(IDT Policy)**

Revised Effective February 25, 2016

I. INTRODUCTION

This policy specifies how assessment, person-centered service planning and authorization, and ongoing care management will work in the FIDA-IDD Demonstration. Under the FIDA-IDD Demonstration, the Interdisciplinary Team (IDT) conducts the person-centered services planning and participates in ongoing care management activities. The IDT or the FIDA-IDD Plan makes coverage determinations, authorizing FIDA-IDD Demonstration Covered Services as described in Sections IV.B, VI.C, and VII.

II. FIDA-IDD PLAN RESPONSIBILITIES

The FIDA-IDD Plan must establish, implement, and maintain written policies and procedures for operation of IDTs that meet the requirements of this document. These policies and procedures shall specify, but not be limited to: 1) mechanisms, tools, and timeframes for IDT interactions and 2) any policies and procedures necessary for permitting the exchange of information between members of the IDT, other providers, and Participants and their representative and/or designees in a manner consistent with confidentiality requirements.

The FIDA-IDD Plan must provide reasonable accommodations to the Participant and ensure that the IDT provides the Participant with written (or in an alternative format chosen by the Participant) educational materials outlining the IDT policy including opportunities available to self-direct using employer and/or budget authority models and the opportunity to pursue employment options. These materials must include the roles and responsibilities for the Participant and/or their representative and/or designee.

III. ASSESSMENTS

A. Assessments and Reassessments Overview

As outlined in the Three-way Contract, each participant shall receive an Office for People With Developmental Disabilities (OPWDD) Approved Assessment (OAA), a FIDA-IDD Comprehensive Service Planning Assessment (CSPA), and ongoing Comprehensive Reassessments (CR). The OAA will be performed by OPWDD prior to the participant's enrollment into the FIDA-IDD Plan. The CSPA will be performed by the FIDA-IDD Plan no later than thirty (30) calendar days from the individual's Effective Date of Enrollment. As outlined in the FIDA-IDD enrollment guidance, and in accordance with the limitations provided therein, the FIDA-IDD Plan may perform the CSPA prior to the effective date of enrollment. The CR will be performed by the FIDA-IDD Plan for Participants according to the schedule and events outlined within the Three-way

Contract and this IDT policy. The CR will review all the elements of the OAA and all the elements of the CSPA. After the initial OAA is provided to the Plan, subsequent OAA elements of the CR will be completed by a FIDA-IDD Plan employed or contracted Qualified Intellectual Disabilities Professional (QIDP) while the CSPA elements of the CR will be completed by a FIDA-IDD Plan employed or contracted RN.

B. OPWDD Approved Assessment (OAA)

The OAA will be performed by OPWDD and the most recent results will be provided to the FIDA-IDD Plan. After this initial OAA is provided to the FIDA-IDD Plan, the OAA elements will be incorporated into the CR which will be completed in its entirety by the FIDA-IDD Plan. Additional guidance on the CR is included below. Within ten (10) calendar days of when the Enrollment Broker processes a request for enrollment into the FIDA-IDD Plan (by submitting the 834 enrollment file to the FIDA-IDD Plan), OPWDD will provide the FIDA-IDD Plan with the results from the most recent OAA.

C. FIDA-IDD Comprehensive Service Planning Assessment (CSPA)

Each Participant will receive, and actively participate in, a timely CSPA of his/her medical, behavioral health, long-term services and supports (LTSS), and social needs. The CSPA shall be completed by a RN on staff, or under contract with, the FIDA-IDD Plan.

1. CSPA & Initial Enrollment in the FIDA-IDD Plan

A FIDA-IDD Plan Registered Nurse (RN) must review and incorporate the results of the OAA that is provided to the Plan by OPWDD within ten (10) days of the enrollment transaction. The FIDA-IDD Plan will complete a CSPA as part of the care planning process. The CSPA must cover at least the following domains: social, functional, medical, behavioral, wellness and prevention domains, representative and/or designee status and capabilities, as well as the Participants' preferences, strengths, and goals. The RN shall use relevant and comprehensive data sources when completing the CSPA, including the Participant, providers, and caregivers/guardians or designees input.

The FIDA-IDD Plan Care Manger will use the CSPA results, in addition to the results of the OAA, as the basis for developing the integrated, Person-Centered Life Plan called the Life Plan (LP) with the Participant.

The FIDA-IDD Plan must inform Participants of the option to self-direct their own services at a minimum when the CSPA and CR are completed and when the IDT meets to create or update the LP.

2. Timing of the CSPA

No later than thirty (30) calendar days following the effective date of enrollment into the FIDA-IDD Plan, a RN must work with the Participant and his/her representative and/or designee to complete a CSPA. This initial CSPA must be performed by a FIDA-IDD Plan employed or contracted RN in-person with the Participant's location of choice.

3. Participant Refusal to be Assessed

If a Participant or representative or designee refuses to participate in the CSPA, the FIDA-IDD Plan must honor the Participant's existing care plan and use their utilization management process to authorize all additional necessary services for the Participant. However, the Plan should continue to encourage the Participant to be assessed at the intervals and upon the occurrence of the events provided in this IDT policy for the completion of the CR. A Participant, representative and/or designee will be considered to affirmatively decline to participate in the CSPA under the following circumstances:

- Participant, representative, or designee communicates this refusal by phone, mail, fax, in person, or via any other mechanism;
- The Participant, representative or designee expresses willingness to complete the CSPA, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the Participant, representative, or designee must be documented by the FIDA-IDD Plan; or
- The Participant, representative, or designee initially agrees to complete the CSPA, but then declines to answer a majority of the questions in the CSPA.

4. Unable to contact the Participant, Caregiver/guardian, or Designee to complete the CSPA

If the FIDA-IDD Plan is unable to complete the CSPA because the FIDA-IDD Plan is unable to locate the Participant, representative, or designee after three documented attempts, the FIDA-IDD Plan must honor the Participant's existing care plan and use their utilization management process to authorize additional services for the Participant. The FIDA-IDD Plan must document each attempt, including the method of the attempt (i.e. phone, mail, or email), as CMS and the State may validate this number. There may be instances when the FIDA-IDD Plan has a high degree of confidence that the contact information is correct, yet that Participant, representative, or designee is not responsive to the FIDA-IDD Plan's outreach efforts. So long as the FIDA-IDD Plan follows the guidance regarding outreach attempts, these Participants may be included under this provision.

IV. INTERDISCIPLINARY TEAM

A. Interdisciplinary Team Required

The FIDA-IDD Plan is required to use an IDT approach to provide each Participant with an individualized, comprehensive care planning process in order to maximize and maintain every Participant's functional potential and quality of life. For each Participant, an individually tailored IDT, led by a Care Manager employed by or under contract with the FIDA-IDD Plan, will ensure the integration of the Participant's medical, behavioral health, community-based or facility-based LTSS, and social needs as part of the CSPA. The IDT will be person-centered, built on the Participant's specific preferences and needs, and deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.

The FIDA-IDD Plan, through the Care Manager and in consultation with the Participant (and/or the Participant's representative or designee), must identify the individuals who will be on the Participant's IDT. The Care Manager must offer to invite any providers or individuals with a caregiving relationship or clinical history with the Participant and must invite any individual requested by the Participant (and/or the Participant's representative or designee). The IDT members should be identified no later than seven (7) calendar days prior to the IDT meeting. The IDT membership for a particular IDT meeting will be composed of the mandatory participants described in IV.C below and the additional individuals who agree prospectively to either participate in the IDT meeting itself or to review and approve the LP within no more than three (3) calendar days following delivery by the Care Manager. Other invited individuals, including other providers and caregivers who do not agree to participate in the IDT meeting or to review and approve the LP will receive the finalized LP and any subsequent updates to the LP. Other invited individuals, including the Primary Care Physician (PCP), will also continue to receive invitations to subsequent IDT meetings, as requested by the Participant (and/or the Participant's representative or designee) and can elect to participate in IDT meetings or for LP review/approval in the future.

The Participant's initial CSPA will occur no later than thirty (30) calendar days after enrollment (as per Section III.C), and the LP must be finalized no fewer than sixty (60) calendar days following the completion of the initial CSPA (as per Section VI.B).

B. Interdisciplinary Team Authority and Decision-Making Role

All items and services included in the finalized LP serve as authorizations up to the extent allowed under the licensure of the professionals who agree to participate in its development subject to medical necessity review when applicable. Before the initial LP is developed by the IDT, authorizations for items and services not subject to the continuity of care provisions must be made by the FIDA-IDD Plan through the utilization management (UM) process. If the Participant's PCP elects to participate in the IDT meeting or review/approve the LP, all services requiring a physician's order, included therein act as service authorizations, with the exception of the services described below in VII.F which must go through the FIDA-IDD plan's UM process. All Home and Community Based waiver services, ICF-IDD and day treatment services may be authorized by the Participant's duly convened IDT and are not subject to the FIDA-IDD Plan's UM process. If the PCP does not elect to participate in the IDT meeting or review/approve the LP, some ordered services and care decisions included therein may act as service authorizations up to the extent allowed under the licensure of the professionals who agreed to participate in that IDT. Service authorizations made via the LP may not be modified by the FIDA-IDD Plan except in cases where the participant (or providers, representatives or designees on behalf of the participant) appeals the IDT service authorizations. In these cases, the Plan may modify the service authorizations consistent with the appeal decision. The Participant may appeal any IDT decision, regardless of whether the Participant agreed to the decision. During the meeting, the IDT authorizes both ongoing service plan care and services that must be adhered to by the FIDA-IDD Plan.

Notwithstanding the above, between IDT meetings, the FIDA-IDD Plan may authorize services in addition to those included in the LP as needed through the utilization management process.

The Care Manager must review the Participant's LP at least every six (6) calendar months from the previous LP review. This LP review must coincide with a meeting with the IDT at least annually (no more than twelve

(12) calendar months from the previous IDT meeting). These IDT meetings may occur more frequently, as the IDT must reconvene after a CR, which may be triggered by certain events, as described in Section X, or if the Participant (and/or the Participant's representative or designee) requests a meeting.

Between IDT meetings, the FIDA-IDD Plan must make any necessary service authorizations through its utilization management process. In order to ensure that Participants receive timely access to needed services, the FIDA-IDD Plan must authorize any services in line with, or in addition to, the services outlined in the current LP, except as listed in Section VII.B and VII.C. For LPs developed without the participation of a physician, this includes authorizations of items and services outlined in the LP that require a physician's order. Both the IDT and the FIDA-IDD Plan will make coverage determinations, and render service authorizations, with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

C. Interdisciplinary Team Composition

A Participant's IDT **must** be comprised of the following individuals:

1. Participant and/or, his or her representative or designee;
2. The FIDA-IDD Plan Care Manager
3. Participant's primary provider(s) of Developmental Disability services, who has knowledge of the Participant's desired outcomes and service needs;

A Participant's IDT **may** be comprised of the following individuals:

- 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;
- 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;
- 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;
- The PCP or a designee with clinical experience from the PCP's practice who has knowledge of the needs of the Participant. The designee can be a Physician extender including:
 - A Nurse Practitioner licensed by the State of New York or a Physician Assistant who is licensed by State Education Department, Office of the Professions; or
 - A Registered Nurse, if the RN has clinical knowledge of the Participant
 - A Specialist designated as the PCP for the Participant consistent with the Three-way Contract

The FIDA-IDD Plan Care Manager is the IDT lead and facilitates all IDT activities. The Care Manager may request information from the FIDA-IDD Plan's utilization management staff, such as information about medical necessity, clinical guidelines, or evidence-based best practices. The utilization management staff, however, may not participate in IDT meetings, and should not be deemed members of the IDT.

The IDT must at all times meet the minimum requirements outlined above. Additional clinical staff, such as physician specialists, may be added to the IDT for particular meetings as appropriate and as requested by the Participant (and/or the Participant's representative or designee). Any optional member of the IDT may choose not to participate on the next IDT meeting. For example, a Physical Therapist would become part of the IDT if the Participant suffered acute injury requiring rehabilitation. Once treatment is complete, the Physical Therapist would not be invited to subsequent IDT meetings, because they lack current goals or objectives (assuming no additional social, functional, medical, behavioral, wellness, or prevention need is discovered, or develops, in the meantime).

D. IDT Meetings, the Decision-Making Process, and Standards of Practice

All current IDT members must actively participate in the IDT service planning and care management process. In particular, the Care Manager is responsible for scheduling the IDT meeting at a time convenient to all IDT members. The IDT members who elect to participate in the meeting must attend in person or via means of real-time, two-way communication (such as by telephone or videoconference). IDT members who prospectively elect not to participate in the IDT meeting but do elect to review and approve the LP after the IDT, must respond to the Care Manager within no more than three (3) calendar days following delivery of the LP by the Care Manager.

As described in Section VI.B, the IDT must create and complete the LP within sixty (60) calendar days (or sooner if required by the circumstances or clinically indicated) of the initial Assessment. Thereafter, the IDT must meet to evaluate the LP no more than six (6) calendar months after the date of the last LP. Certain trigger events, as described in Section X, will necessitate a CR, which will require the IDT to reconvene and may require revisions to the LP. The Care Manager must reconvene the IDT within thirty (30) calendar days of the CR. Note that if the IDT is required to convene sooner than twelve (12) calendar months due to a trigger event or at the request of the Participant, the IDT meeting schedule will reset and the next routine IDT meeting will not need to occur until twelve (12) calendar months from the date of that meeting or until another trigger event, whichever is sooner.

E. Clinical Decisions

IDT members must operate within their professional scope of practice, appropriate for responding to and meeting the Participant's needs, and complying with the State's licensure/credentialing requirements. Each member of the IDT must meet the applicable state, federal, or other requirements for his/her profession. The IDT is encouraged to work collaboratively, soliciting input from all members and reaching consensus regarding specific treatment decisions that consider the Participant's specific preferences and needs across multiple domains. Where consensus is not possible, the IDT members should strive for a workable compromise. When a care decision is required to be made by a

provider with a certain licensure and/or certification under the applicable laws and regulations of New York State, the ultimate decision always rests with the appropriately licensed and/or certified treating member(s) of the IDT or the FIDA-IDD Plan.

F. Responsibilities of IDT Members

In addition to participating in the IDT meetings and developing the LP, the mandatory and optional members of the IDT are responsible for coordinating care for the Participant at all times. This responsibility is continuous and independent from their authorizing authority. It remains applicable even when a different entity is responsible for authorizing particular services, as described in Section VII. The IDT must maintain regular communication as and when required and agreed upon by the other members, and must participate in service planning and oversight.

Each IDT member is responsible for: (1) regularly informing the IDT of the medical, functional, and psychosocial condition of each Participant; (2) remaining alert to pertinent input from other team members, Participants, and their representative or designees; and (3) documenting changes of a Participant's condition in the Providers' own medical record for the Participant consistent with policies established by the FIDA-IDD Plan. These responsibilities are intended to inform the IDT members— individually and collectively—and aide in the continued development of the LP. In particular, the Providers' own medical record for the Participant must be considered in developing the LP at the next service planning meeting.

Implementation of the LP requires that the IDT members must either directly deliver services or arrange and confirm delivery of services required under the LP. Precise tasks for ensuring implementation will be assigned during service planning meetings or accomplished by the Care Manager. IDT members will have to work with the Care Manager and collaborate with each other in order to facilitate timely access to appropriate services and the effective and efficient monitoring of the Participant's health and wellness.

G. IDT Ongoing Communication

The IDT determines its own methods and processes for candid and complete communication amongst and between its members. The IDT must establish, implement, and maintain documented internal procedures governing the exchange of information between IDT members, providers, and the Participant and his or her representative or designees consistent with the requirements for confidentiality (e.g. HIPAA). Each team member is responsible for informing the IDT of the social, medical, functional, behavioral, Community-based or Facility-based LTSS and psychosocial condition of the Participant in an ongoing manner.

When decisions are made by the FIDA-IDD Plan outside of the IDT meetings, such decisions must be communicated to the Care Manager and recorded in the shared, accessible Participant record Comprehensive Participant Health Record and then must be communicated to all IDT members within one business day of the decision.

Participants and their representative or designees (who are current IDT members) must be provided with contact information (which is regularly updated) for all other members of the IDT.

H. Participant Involvement on IDT

Participants shall be involved in care planning. Participants must be asked to express their preferences about care, and his or her expression must be respected and incorporated into care decisions, as appropriate. Providers on the IDT must work with the Participant (and his or her Designee and/or his or her Authorized Representative) and consider his or her preferences in making care decisions.

To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the LP must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are obtained as called for in the LP.

In scheduling and arranging meetings for the IDT members, the Care Manager and other IDT members must reasonably accommodate the needs, communication needs and schedule of the Participant (and Home Care Aide(s)) to help ensure that he/she can be available to attend IDT meetings. In the event that the Participant refuses to participate in an IDT meeting, the Care Manager should meet (by phone or in-person) with the Participant both before each meeting to identify and ensure Participant input into goals, needs, preferences, etc., and after each meeting to review the proposed LP. The IDT may subsequently need to reconvene to incorporate information obtained from the Participant and/or representative or designee related to service plan changes requested by the Participant. The Participant must sign a standard written refusal form to participate in each IDT meeting confirming that he/she is choosing not to attend and that his/her non-attendance is not a result of the IDT failing to accommodate the Participant's needs and schedule. If a Participant refuses to participate in the IDT process and also refuses to sign the standard written refusal form to confirm as much, the Care Manager must note the refusal in the Participant's record, along with notes documenting the efforts the Care Manager undertook to include the Participant in the process and to obtain a signed standard written refusal form.

The IDT must keep a record that documents how Participants and families are included in the service planning process, even if they refuse to meet with the IDT.

I. Interdisciplinary Team Member Training

The FIDA-IDD Plan will ensure that IDT members have access to training on the IDT process. IDT members must be notified of the availability of approved training on the person-centered planning processes, cultural competence, disability, accessibility and accommodations, and wellness principles, along with other required training. This will include ADA/Olmstead requirements. The Care Manager shall promote these trainings at the initiation of the IDT process and will remind members of its availability as a part of ongoing communication with the members of the IDT.

J. IDT Education and Support of Participant

The IDT must:

1. Educate, empower and facilitate the Participant to make choices within the parameters of the FIDA-IDD Demonstration and to exercise his or her rights and responsibilities, including the opportunity to participate in self-direction and be employed in the Participant's community;
2. Involve the Participant as an active team member, including providing information and explanations using plain language understandable to the Participant and/or representative or designee, and stress Participant-centered collaborative goal setting;
3. Provide the supports necessary for the Participant to keep doing things he or she enjoys, to follow through on prescribed treatments, and to remain physically active;
4. Establish a set of guidelines or care responsibilities for the entire team and distribute these to Participant;
5. Provide education to the Participants and families regarding health and social needs;
6. Identify the Participant's informal support systems/networks in relationship to his or her functional and safety needs;
7. Assess and assist the Participant in identifying and addressing quality of life issues;
8. Provide links/coordination/integration with care providers across settings;
9. Assist the Participant in accessing reasonable accommodations from the FIDA IDD and providers and ensuring that providers are accessible;
10. Provide information about and assist Participant in maintaining and establishing community links;
11. Provide information about services available through the Area Agency on Aging to adults age 60 and older;
12. Provide information about and assist Participant with housing and transportation issues and other community benefits and services;
13. Assist the Participant and/or designated representative to realize his/her role as the daily self-manager; and
14. Ensure that the Participant, representative and designee are knowledgeable about his/her rights as a FIDA-IDD member and the availability of assistance from the FIDA-IDD Ombudsman.

K. IDT Coordination of FIDA-IDD Plan and Other Available Services for Participant

As appropriate, the IDT shall coordinate care for Participants with:

1. The court system (for court ordered evaluations and treatment);
2. Specialized providers of health care for the homeless (if the Participant is homeless or has become homeless and this is necessary while the IDT is working to help the Participant secure housing), and other providers of services for victims of domestic violence;
3. Family planning clinics, community health centers, migrant health centers, rural health centers and prenatal care providers;
4. Women, Infants and Children (WIC);
5. Programs funded through the Ryan White CARE Act;
6. Other pertinent entities that provide services out of network;
7. Voluntary community-based services;
8. local governmental units responsible for public health, mental health, intellectual/developmental disability or Chemical Dependence Services; and
9. Local government Adult Protective Services and Child Protective Services programs.

Coordination may involve mechanisms to ensure coordinated care for Participants, such as protocols for reciprocal referral and communication of data and clinical information on Participants.

V. CARE MANAGER

A. Care Manager Selection

Participants will be assigned a FIDA-IDD Plan staff or contract Care Manager who has the appropriate experience and qualifications to address the Participant's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers). A Participant has the right to choose a different Care Manager and change her/his Care Manager at any time. Again, choice of Care Manager is limited to those Care Managers available within the FIDA-IDD Plan care management staff and those that have room in their caseload to handle care management responsibilities for additional Participants. At all times, the FIDA-IDD Plan must ensure that the Care Manager's caseload is reasonable to provide appropriate care management.

B. Requirements for Care Managers serving Willowbrook Class Members

Care Managers serving Willowbrook Class Members will coordinate with OPWDD to assure the provision of services are delivered in a manner that comports with the requirements of the permanent injunction.

C. Care Manager Qualifications

Care Managers must be an RN, Licensed Social Worker or Psychologist and have knowledge of physical health, aging, appropriate support services in the community (e.g., community-based and facility-based LTSS), frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate.

D. Care Manager Responsibilities

As the lead member of the IDT, the Care Manager has many responsibilities, which can be found throughout this policy document. This subsection describes some of the most important responsibilities.

The Care Manager must communicate and provide the Participant with written (or in an alternative format chosen by the Participant) educational materials outlining the IDT policy including opportunities available to self-direct using employer and/or budget authority models. These materials must include the roles and responsibilities for the Participant and or their representative or designee.

In addition, the Care Manager must ensure that

- The Support Broker (SB) is notified in the event that the IDT makes changes to the authorization for self-directed services; and
- The IDT receives and promptly reviews the SB notification to the FIDA-IDD Plan of any circumstances that may affect the Participant's or, if applicable, the Participant's representative or designee's ability to fulfill the Participant's responsibilities under the self-direction program and make changes in the Participant's authorization and reauthorization as needed.

During the initial and subsequent IDT meetings, Care Managers must ask each IDT member to give their thoughts on the questions or topics being discussed. This includes the members' preferences or recommendations regarding their preferred course(s) of action. The Care Manager must then summarize the discussion and any conflicts.

The Care Manager must ensure that all IDT responsibilities are being met, and must assist the IDT members where possible or necessary. Implementation of the LP means that the IDT members must either directly deliver or arrange and confirm delivery of services required under the LP. The precise tasks involved with carrying out the LP will be assigned during the IDT meeting, and supervised, coordinated, and/or directly accomplished by the Care Manager.

For example, in the instance of a Participant that requires x-rays, the IDT members do not simply note that the Participant needs x-rays in the LP. Instead, the IDT members are responsible for all care management involved in obtaining the x-rays for the Participant. In this case, the Care Manager (or Care Management team under the direction of the Care Manager) would likely be the one responsible for scheduling the x-rays at the appropriate off-site network provider, arranging the transportation, confirming the appointment, preparing the Participant, ensuring the Participant makes the appointment, ensuring the

Participant is transported safely home, following-up to obtain the x-rays and radiology reports, and ensuring that the x-rays and radiology reports make it to the appropriate IDT members for review and discussion. And, the Care Manager must also ensure that all these steps occur in a timely fashion, in accordance with the access standards for the FIDA-IDD Demonstration and as dictated by the needs of the Participant.

Any number of these tasks could be delegated to other members of the IDT, if agreed to by the IDT during service planning and recorded in the LP. This may be ideal when a Participant has a close friend or family member who has proven reliable in carrying out similar logistical tasks. In that case, the Care Manager would still be responsible for overseeing that the tasks are being accomplished. The Care Manager would have to step-in when the responsible IDT member is no longer able or willing to provide an appropriate level of coordination (i.e. a level of coordination equivalent to what the Care Manager could have provided absent the delegation).

To the extent that the Participant is able, willing, and agreeable to be responsible for scheduling his/her own appointments and services, the LP must clearly outline which services the Participant will be responsible for scheduling, how the Care Manager will support the Participant in these activities, and what monitoring the Care Manager will do to ensure that necessary appointments, tests, etc. are authorized and obtained as called for in the LP.

Upon the occurrence of a trigger event, as described in Section X, the Care Manager must notify the IDT, and ensure that a CR will be conducted within the appropriate timeframe.

VI. LIFE PLAN

A. LP is Required

Person-centered service planning is the process of creating and implementing a written LP with and for the Participant. Person-centered service planning includes consideration of the current and unique psychosocial and medical needs and history of the Participant, as well as the Participant's functional level, behavioral health needs, language, culture, and support systems. Person-centered service planning is completed by the Participant and his/her IDT members. LPs must contain measurable goals, interventions, and expected outcomes with completion timeframes. The Participant is the center of the person-centered service planning process. The process must be tailored to the Participant's culture, communication style, physical requirements and personal preferences.

B. Transition to FIDA-IDD LP

During a Participant's transition to a FIDA-IDD Plan, the Participant will continue to receive services, including any community-based or facility-based LTSS, in their preexisting service plan (the service plan in place prior to enrollment in the FIDA-IDD Plan). The Participant's pre-existing service plan must be honored, as written, for ninety (90) calendar days or until the LP is finalized and implemented, whichever is later. However, a Participant may choose to begin receiving services in accordance with the approved LP

prior to the ninety (90) calendar day deadline. During this transition, the FIDA-IDD Plan will adhere to all transition requirements for services outlined in the Three-Way Contract. A person who lives in an OPWDD certified residence is eligible to receive residential habilitation from his or her current residential habilitation provider as long as the Participant's LP continues to describe the need for service. The FIDA-IDD Plan shall allow Participants who are receiving Behavioral Health Services to maintain current Behavioral Health Service Providers (i.e., Participating and Non-Participating) for the current Episode of Care. The IDT may review a current Episode of Care to determine whether it needs to be continued with the Behavioral Health Service Provider that was providing services before the Participant's Enrollment in the FIDA-IDD Plan. This requirement will be in place for not to exceed two (2) calendar years from the date of a Participant's Effective Date of Enrollment and applies only to Episodes of Care that were ongoing during the transition period from Medicaid Fee-For-Service (FFS) to Enrollment in a FIDA-IDD Plan.

C. Timing of Life Plan

A LP must be completed for each Participant by and with that Participant's IDT within sixty (60) calendar days of the FIDA-IDD Plan completing the CSPA and within thirty (30) calendar days of the FIDA-IDD Plan completing the CR. Prior to the initial IDT meeting, service authorizations related to new needs for service may be made by, and only by, the FIDA-IDD Plan via the Utilization Management (UM) process.

D. The LP as Authorization

Once a service or treatment has been agreed to by the IDT and/or FIDA-IDD Plan, and entered into the LP, that service or treatment is authorized until the LP is changed. The FIDA-IDD Plan may not disallow any service or treatment authorized in the final LP. Any additional services needed that are not addressed by the IDT are subject to the FIDA-IDD Plan's UM process, as more fully described in Section VII. If an appropriately licensed physician does not participate in the IDT, any physician ordered services included in the Life Plan must be authorized by the FIDA-IDD Plan's UM process. All Home and Community Based waiver services, ICF-IDD and day treatment services may be authorized by the Participant's duly convened IDT and are not subject to the Plan's UM process.

Each individual who prospectively agrees to participate on the IDT as a member (including the Participant) or review/approve the LP must approve the LP. Acceptable methods of approvals from IDT members, other than the Participant, are (1) verbal, but noted in the LP with a date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person or (4) wet signature on the LP. The FIDA-IDD Plan may confirm the Participant's approval by using a signature page at the IDT meeting or sent to the Participant after the meeting to obtain a wet or electronic signature. The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not necessarily that they agreed with the ultimate care plan that was reached. In addition, the Care Manager must document and attest that the LP accurately reflects the scope of what the Participant approved. The Participant may approve the LP before or after any necessary UM process but

the Care Manager must explain to the Participant any changes in the final LP from the version drafted during the IDT meeting.

If the IDT includes any of the services listed in VII.F in the LP, even if a physician participates in the IDT meeting, the FIDA-IDD plan may perform a review through their UM process to confirm that the service is medically necessary. For services listed in VII.F included in the LP, the LP will serve as the order/prescription for the service and the UM process will be limited to assessing medical necessity only. This medical necessity review will comply with the UM timelines outlined in the three-way-contract.

When UM is required for any reason, a complete LP will have 1) the Participant's signature and 2) the PCP's signature and/or UM approval. When physician-level authorization and/or UM is not required, a LP may be considered complete with only the Participant's signature. The completion of the LP is used for reporting and appeal rights purposes. Please see the instructions for the ICDN model notices for further detail on when each of the ICDN notices must be provided.

The LP must be printed and provided to the Participant and his/her representative or designee along with language clearly specifying the right of the Participant to appeal a LP update or revision, including the steps for how to request an appeal.

E. Service Planning Process

The IDT must meet for the purpose of developing the initial LP and updating the LP when a CR has been completed and a LP update is indicated. The Care Manager will schedule the meeting at a time that is conducive to Participant participation and convenient to the members of the IDT. The Care Manager should also take into consideration the primary goals of Participant attendance and timeliness of LP planning. When in-person meetings are not possible, those IDT members should participate telephonically or by video conference. The LP is to be drafted by the IDT members through the IDT meeting process. The Care Manager shall come prepared to present information he/she has available about prior service plans, current needs, and more, and can come to the meetings with a proposed or draft LP to present to the IDT members for their review.

During the service planning meetings, the Care Manager will request that each IDT member explicitly communicate his or her thoughts on questions being considered, including his/her recommendations and/or preferred course(s) of action.

The Participant always has a right to appeal LPs and other service authorization decisions through the FIDA-IDD Plan appeal process.

During each IDT meeting, the IDT members should:

1. Review the purpose of the meeting;
2. Review and discuss the most recent Outcome data, CSPA/ CR, EHR/medical records/progress notes, and existing service plan;
3. Identify Participant requests, including those that accord with the Participant's religious or cultural beliefs;
4. Provide information about the Participant specific to each discipline and expertise;
5. Brainstorm approaches to care across all fields (e.g., Social Work suggests a nursing intervention, Nursing suggests an activity intervention, etc.);
6. Review the medication plan for polypharmacy and opportunities for medication dosage reduction and/or elimination;
7. Summarize problems, approaches and goals and incorporate into the LP;
8. Specify goals for the six (6) months/duration of the care plan;
9. Authorize care/services for the six (6) months/duration of the care plan;
10. Identify who is responsible for implementation of each element of the care plan;
11. Review advance directives;
12. Determine communication plan for IDT meeting participants and other providers and caregivers for the six (6) months/duration of the care plan;
13. When a Participant is determined to be likely to require a level of care provided in a nursing facility or ICF-IID, inform the Participant and/or his/her designee of any feasible alternatives and offer the choice of either institutional or home and community-based services;
14. Discuss with the Participant his/her choice to direct their own services through self-directed services. The discussion will include a review of how this could work and if the Participant has chosen to self-direct the Participant obligations related to this choice;
15. In addition to the above, during service plan meetings, the IDT should also review and discuss:
 - Feedback from each IDT member about how the Participant's needs and preferences are being met under the current service plan and any suggested changes.
 - Evaluate the effectiveness of the current LP and implement modifications as needed in collaboration with the Participant and other providers as appropriate.
 - Discuss problems, issues, interventions related to triggers and any other concerns raised at last care planning. If relevant, review previous issues raised at last care planning.
 - Obtain feedback from each team member regarding how the Participant is functioning and suggested interventions for targeted problems; and
16. Include anything else appropriate for the needs of the Participant.

F. LP Form

The FIDA-IDD Plan must develop a LP form to be used by all IDTs in developing a Participant's LP. The form must include a space for the IDT members to sign and date the LP and must include language clearly specifying the following:

1. The right of the Participant to appeal a LP;
2. That signing the LP does not preclude appeal;
3. Instructions for requesting an appeal; and
4. Contact information for the FIDA-IDD Ombudsman.

Each member of the IDT, including the Participant, representative and designee(s) must each receive a signed written copy (hard copy or electronic) of the final LP.

G. LP and Electronic Care Coordination Record Content

The LP must specify the Participant's desired outcomes, care and services needed to meet the Participant's desired outcomes and known and anticipated medical, functional, social, and cognitive needs identified in the OAA, CSPA, and ongoing CR. The LP must address all care and service needs of the Participant irrespective of whether they are being provided by the FIDA-IDD Plan. The LP must specify:

1. All active chronic problems, current non-chronic problems, and problems that were previously controlled and or classified as maintenance care but have been exacerbated by disease progression and/or other intervening conditions;
2. All current medications taken by the Participant.
3. For each need identified, the LP must state the problem, interventions to resolve or mitigate the problem, the measurable outcomes to be achieved by the interventions, the anticipated time lines in which to achieve the desired outcomes, and the staff responsible for conducting the interventions and monitoring the outcomes;
4. Reasonable long-term and/or short-term goals for all problems identified;
5. All services authorized and the scope and duration of the services authorized;
6. A schedule of preventive service needs or requirements;
7. Participant's goals and preferences and how they will be addressed, taking into consideration the Participant's expectations, characteristics, and previous daily routines;
8. Method and frequency of evaluating progress towards goals and documentation of progress toward the goals including success, barriers, or obstacles;
9. Potential problems that can be anticipated, including the risks and how these risks can be minimized to foster the Participant's highest feasible level of well-being;
10. Participant decisions around self-directed care and whether the Participant is participating in CDPAS or home and community-based services (HCBS) self-directed services;
11. Communications plan;
12. How frequently specific services will be provided;
13. How technology and tele-health will be used;

14. Known needed physical and behavioral health care and services;
15. Continuation of ongoing course of medical treatment (e.g. chemotherapy, chiropractic care, etc.);
16. Right of the Participant to appeal a LP, including the steps for how to request an appeal;
17. The Participant's consent to Money Follows the Person participation;
18. Participant choice of service providers;
19. Individualized back-up plans;
20. The person(s)/providers responsible for specific interventions/services;
21. Participant's informal support network and services; Participant's need for and plan to access community resources and non-covered services; and
22. A record of all reasonable accommodations and policy modifications required for the Participant; and anything else appropriate for the needs of the Participant.

H. LP Documentation

The LP is a comprehensive care plan. For this reason, the IDT should include items and services in the LP as noted in Section VI.G above, as well as any appropriate items and services listed in section VII.B and/or VII.C, even though these items and services do not require authorization.

For example, if the IDT determines that the Participant should receive a regimen of daily low dose aspirin, that regimen should be recorded in the LP, even though there was no need to authorize it, as described in Section VII.B.12.

I. LP Monitoring

Monitoring of the LP requires that the IDT members must monitor the Participant's medical, functional, social, and cognitive status. IDT members monitor status by direct observation when providing services, informal observation of the Participant, self-report by Participants, feedback from representatives or designees, reports from network providers, or communication among IDT members. The FIDA-IDD Plans will monitor the LPs and any gaps in care will be addressed in an integrated manner with the IDT. The IDT must monitor the Participant's representative or designee's ability to fulfill the Participant's responsibilities under the self-direction program and make changes in the Participant's authorization and reauthorization as needed.

VII. AUTHORIZATION OF FIDA-IDD COVERED ITEMS AND SERVICES

The Covered Items and Services listed in Section VII.B are items and services that require neither IDT authorization, FIDA-IDD Plan authorization, nor authorization from any other providers.

The Covered Items and Services listed in Section VII.C., are items and services that do not require IDT or FIDA-IDD Plan authorization but do require authorization by a specialist.

Other than the services listed in VII.B and VII.C, all items and services must be authorized by either the

IDT or the FIDA-IDD Plan. As indicated above in Sections IV.B and VI.C, the IDT is able to authorize most items and services through the LP development process up to the limits of the licensure of the professionals who participate. As described below, services listed in VII.F must go through the FIDA-IDD Plan's UM process. Any items or services indicated in the most recent version of the LP are authorized by virtue of the IDT's agreement to the LP. The services will remain authorized until the IDT changes the LP so that those services are no longer indicated. There shall be no additional internal or external review of the LP within the FIDA-IDD Plan. If the Physician does not participate in the IDT or prospectively agree to review and approve the LP, physician ordered services must be authorized by the FIDA-IDD Plan through their utilization management process. However, between IDT meetings, the FIDA-IDD Plan is responsible for authorizing items and services not indicated in the LP. All service authorizations shall be made with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

In the event that the need for services is a change of condition that would prompt a CR in accordance with Section X below, the Comprehensive CR and LP update/revision process will begin immediately and will take place in accordance with the timeframes outlined in Sections X.A. and XI.D.

A. Specificity of the LP Service Authorizations

In drafting the LP, the IDT should consider the following: The LP should specify amounts or durations of services. For example, if the Participant is in need of personal care, the number of hours during which a personal care attendant will stay with the Participant each day should be specified. However, not all authorizations have to be as precise. The IDT or the FIDA-IDD Plan may provide non-specific authorizations as appropriate and as allowed under the Provider Benefit Package (PBP). An example might be that the IDT or the FIDA-IDD Plan authorizes the Participant to receive transportation to medical appointments. The IDT or the FIDA-IDD Plan might authorize the nature of the transportation or the need for an aide during transportation but the IDT or the FIDA-IDD Plan would not need to specify the precise number of trips ahead of time, when the precise number of medical appointments during the LP period is likely unknown.

B. Items and Services That a Participant May Access Directly (and Without Prior Authorization or Approval)

The following items and services may be directly accessed and obtained by the FIDA-IDD Participant without review and without prior authorization or approval:

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 American 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; and
14. Prescription drugs:
 - Which are on the formulary, or
 - Which are not on the formulary, but where a refill request is made for an existing prescription within the ninety (90) calendar-day transitional period.

Specialists' visits themselves may be prior authorized by the IDT or the FIDA-IDD Plan, as appropriate for the Participant's condition, but in multiple visit authorizations and not in single visit increments. The FIDA-IDD Plan may not require authorization for single visits to specialists due to the special needs of FIDA-IDD Participants. Instead, access to specialists should be authorized by the IDT or the FIDA-IDD Plan through standing authorization or through pre-approval of a fixed number of visits to the specialist.

C. Services that Must Be Authorized by a Specialist (not the IDT or FIDA-IDD Plan)

The following items and services must be authorized by the specialist indicated and cannot be authorized by the IDT or the FIDA-IDD Plan. These items and services do not need to be included in the LP.

1. Preventive Dental X-Rays – These require Dentist authorization;
2. Comprehensive Dental – These services require Dentist authorization;
3. Eye Wear – These require Optometrist or ophthalmologist authorization; and
4. Hearing Aids – These require Audiologist authorization.

D. Before Assembly of the IDT Team

Notwithstanding the requirements of this section, and subject to the continuity of care provisions, in the interim period between the effective date of enrollment and the date upon which the LP has been completed, service authorizations related to new needs for service that arise during this time may be made by the FIDA-IDD Plan through its UM process.

E. Prescription Drugs

IDT approval is not required for drugs, however, the IDT may authorize drugs as part of the LP development process and, at a minimum, is required to discuss and incorporate a list of medications in use by the Participant within the LP. Whether during transition to a FIDA-IDD Plan or otherwise, if a Participant goes to the pharmacy with a drug prescription and the drug appears on the formulary and no prior authorization is required, the prescription should be filled. If the drug requires a prior authorization and one is on file, the prescription should be filled. If the drug requires an authorization and no authorization is on file, the Pharmacy Benefit Manager (PBM) will contact the FIDA-IDD Plan to either approve or deny the request.

In the case where a request for a non-formulary drug occurs during the transition period as described in Section VI.B, and the request is for a refill of an existing prescription, the FIDA-IDD Plan must authorize the request.

F. Services Subject to Medical Necessity Review

Even if the IDT includes appropriately licensed providers, approval of the following services included within the LP will still be subject to a medical necessity review according to the PBP and the timelines called for under the three-way contract. If these services are included within the LP, the FIDA-IDD plan may not deny or reduce coverage on any basis other than medical necessity. To the extent any of these services are accessed pursuant the locations or benefits listed in VII.B above, they may not be subject to prior authorization and may be accessed directly.

1. Inpatient Hospital Acute Care
2. Inpatient Hospital Psychiatric Care (including Partial Hospitalization)
3. Skilled Nursing Facility/Nursing Home
4. Home Health Services
5. Home Infusion Services
6. Respiratory Care
7. Ambulatory Surgery
8. Outpatient Hospital Surgery
9. Outpatient Substance Abuse Services / Mental Health Services
10. Outpatient Blood Services
11. Outpatient Diagnostic Procedures (Angiograms, CT scan, MRI, etc.)
12. Chiropractic Services
13. Occupational Therapy
14. Podiatry Services
15. Psychiatric Services
16. Physical Therapy and Speech Therapy
17. Durable Medical Equipment / Prosthetics / Orthotics
18. Kidney Disease and Conditions (End Stage Renal Disease)
19. Private Duty Nursing

VIII. RIGHT TO APPEAL

To the extent that the Participant does not agree with the LP or any coverage determination the Participant may appeal in accordance with the appeal process outlined in the Three-Way Contract. The LP form must include language clearly specifying the right of the Participant to appeal a LP, including the steps for how to request an appeal.

IX. CARE MANAGEMENT

A. Care Management Role of IDT

While the Care Manager is the facilitator of the IDT activities, the whole IDT is required to manage care and take all steps necessary to ensure that the Participant receives the items and services the Participant needs, including those called for in his/her LP. The care management system includes processes for:

1. Sharing clinical and treatment plan information;
2. Obtaining consent to share confidential medical and treatment plan information among providers consistent with all applicable state and federal law and regulation;
3. Providing Participants with written notification of authorized services;
4. Enlisting the involvement of community organizations that are not providing covered items and services, but are otherwise important to the health and well-being of Participants; and
5. Assuring that the organization of and documentation included in the care management record meet all applicable professional standards.

B. Documenting Care Needs and Service Delivery

In addition to the LP, the Care Manager on behalf of the FIDA-IDD Plan must maintain a single, comprehensive health record for each Participant in accordance with accepted professional standards. At a minimum, the comprehensive health record must contain the following documentation of all care and services rendered to the Participant by providers, and must be made available to all IDT members:

1. Appropriate identifying information;
2. Documentation of all services furnished, including the following:
 - A summary of emergency care and other inpatient or long-term care services;
 - Items and services furnished by Network and Out-Of-Network providers;
3. Current and past CSPA, CR's, LPs, and any file notes that include the Participant's response to treatment;
4. Laboratory, radiological and other diagnostic test reports;
5. Medication list ;
6. Skilled nursing facility / nursing facility to hospital transfer forms, if applicable;
7. Hospital discharge summaries, if applicable;

8. Reports of contact with informal support (for example, representative or designee);
9. Physician orders;
10. Discharge summary and disenrollment justification, if applicable;
11. Advance directives, if applicable; and
12. A signed release permitting disclosure of personal information.

The FIDA-IDD Plan shall establish, maintain, and require its participating providers to maintain a medical record for each member that is consistent with current professional standards and shall use this to document all care provided. At a minimum, the providers should maintain accessible notes, charts, and records of the items and services provided. Notes included in shared electronic health records should detail the care delivered by providers throughout the period covered by the LP. This information may contain a) subjective information reported by the Participant (e.g., complaints, concerns, effectiveness of ongoing therapy, etc.); b) objective data collected by the provider (e.g., vital signs, weight, examination of body systems, random blood sugar test, etc.); c) assessment (e.g., diagnosis, presumptive condition, etc.); d) treatment plan (e.g., medication, procedure, lifestyle activity, self-management strategy, etc.); and e) education (e.g., demonstration of self-management technique, discussion about disease stages, explanation of medication side effects, etc.).

Notes may also document an exchange between providers (e.g., documentation of a discussion with the physician managing the case of a hospitalized Participant, summary of a meeting with a nursing facility's care planning team for a Participant placed in a skilled nursing facility, description of a home care coordinator's visit to the contracted home care facility to review contractor records, etc.) or between IDT members and the Participant's family or other representative or designee (discussion of a proposed change in a Participant's LP, discussion of a grievance filed by the Participant and/or family, etc.). This information is essential to the IDT care management process. The notes should give sufficient information to enable other providers to know what care has been given to the Participant. The notes should also explain the details of the encounter and the clinical judgment applied so that subsequent care enhances therapy without redundancy or contravention and inform the IDT's patient-centered care planning.

At any time, the Participant may request a copy of the current LP. The Care Manager must ensure that a written copy is furnished to the Participant upon such request. The Participant may choose to receive the LP electronically or by mail.

X. COMPREHENSIVE REASSESSMENT

A. Timing of Comprehensive Reassessment (CR)

The FIDA-IDD Plan must conduct a CR on an annual basis based on the completion date of the initial CSPA. The OAA elements of the CR must be administered by the QIDP and the CSPA elements of the CR must be

administered by an FIDA-IDD Plan employed or contracted RN. The FIDA-IDD Plan must conduct the CR as expeditiously as possible in accordance with the circumstances and as clinically indicated by the Participant's health status and needs, and in no case more than thirty (30) calendar days after the occurrence of any of the following:

1. As warranted by the Participant's condition but at least annually after the CSPA completion date;
2. When there is a change in health status or needs of the Participant due to:
 - A hospital admission that is expected to result in a needed change in the Participant LP;
 - Transition between care settings;
 - For example, when Participants are in a hospital awaiting discharge because of a need for nursing facility placement authorization, the IDT or FIDA-IDD Plan shall provide any prior authorizations for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery;
 - Change in functional status;
 - Loss of a representative, or designee;
 - Change in diagnosis that is significant enough to effect a Participant's life planning or treatment; OR
3. As requested by the Participant, representative, designee, or his/her Provider; and based on a Participant's personal outcome measures not being attained; and
4. As requested by a member of the IDT.

In situations where a transition between care settings is to occur, a CR may be conducted either within the 48-hour period before the transition or within the thirty (30) calendar-day post-discharge period provided above.

For purposes of the CR, a "change in diagnosis" occurs when a Participant is diagnosed with a health condition that is not a self-limiting, temporary health condition, or a condition that will not normally resolve with standard medical attention within a two (2) calendar week period. In the event of a temporary health condition, the Participant is expected to return to baseline within this short two (2) calendar week period of time and, thus, a CR is not required unless the temporary health condition has not resolved as it should have by the end of the two weeks. One example would be a sinus infection. In the event of a Participant getting a sinus infection, the LP is not required to be updated to reflect the several days use of prescription medication. On the other hand, if a Participant was hospitalized for a decubitus ulcer it is expected that a CR would be performed and the LP would be updated to monitor for and prevent against decubiti.

Upon the occurrence of an event requiring the completion of the CR, the IDT must meet and make any necessary updates to the LP within thirty (30) calendar days or as soon as clinically indicated.

XI. LIFE PLAN REVISIONS AND UPDATES

A. LP Updates

The LP must be reviewed at least every six (6) calendar months from the previous LP review. This LP review must coincide with a meeting with the IDT at least annually (no more than twelve (12) months from the previous IDT meeting). These IDT meetings may occur more frequently, as the IDT must reconvene after a CR, which may be triggered by certain events, as described in Section X or if the Participant requests a more frequent meeting LP updates must occur within six (6) months of the previous LP authorization or sooner in accordance with the timeframes outlined above in Section X. The Participant's IDT will meet in person, telephonically, or by video-conference to discuss and review the Participant's status, existing LP, and Comprehensive CR and, if necessary, will revise the Participant's LP.

B. LP Update/Revision Process

As described above in Section VI.E, updates to the LP are made through service planning meetings. These meetings should be fully attended in person with the Participant, where possible. Where in-person meetings are not possible, those IDT members should participate telephonically or by video conference.

Updates are made directly to the service plan in a way that preserves the history of care and enables the team to trace the effectiveness of interventions over time. New problems are added as they are identified, and resolved problems should be retained for monitoring. The rationale for eliminating or relocating a resolved problem to maintenance care must be documented in the LP.

The LP is routinely updated as the IDT monitors the Participant's health status. The IDT members meet for updates and revisions and complete service planning steps as outlined above.

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 or designee of any feasible alternatives and offers the choice of either institutional or home and community-based services.

C. LP Update/Revision Form

The IDT must generate a new printable LP, or update an existing one (as long as the final form will be an easily readable, understandable document), for any LP update or revision. Each individual who prospectively agrees to participate on an IDT member (including the Participant) or review/approve the LP must approve the updated or revised LP. Acceptable methods of approvals from IDT members, other than the Participant, are (1) verbal, but noted in the LP with a date the verbal approval is given, (2) email or electronic signature, (3) wet signature on a separate signature page in person or (4) wet signature on the LP. The FIDA-IDD Plan may confirm the Participant's approval by using a signature page at the IDT meeting or sent to the Participant after the meeting to obtain a wet or electronic signature. The form should make it clear that the signature is an attestation that said member was involved in the IDT process, and not

necessarily that they agreed with the ultimate care plan that was reached. In addition, the Care Manager must document and attest that the LP accurately reflects the scope of what the Participant approved. The updated or revised LP must be printed and provided to the Participant and his/her representative or designee along with language clearly specifying the right of the Participant to appeal a LP update or revision, including the steps for how to request an appeal.

XII. QUALITY IN ASSESSMENT, CARE PLANNING, CARE MANAGEMENT, AND IDT PROCESSES

The FIDA-IDD Plan will report on specific defined elements related to evaluating the impact of the IDT, how decisions are made, which IDT members supported or opposed particular service authorization decisions, what services prompt differences of opinion, and more. Plans are expected to monitor the quality of the care management services being provided by the Care Manager and any other similar concerns raised by the IDT process. The FIDA-IDD Plan will also capture information to monitor and oversee the CSPA/CR, LP, and care management process. More details about this reporting are included in the FIDA-IDD Plan Reporting Requirements.

The Contract Management Team will closely monitor issues and will be available to address case-by-case problems.

A detailed list of covered services are located in Appendix A of the FIDA-IDD Three-Way contract.