ACA/NY | LIFEPlan CCO NY Provider Webinar

Q&A: Understanding CCO Care Management & the Role of the Care Manager

General Information

Q: Will this webinar be recorded?

A: Yes, the recording is available on both organizations' websites.

- ACA/NY:
- LIFEPlan CCO NY

Q: Do we receive a certificate for our attendance today?

A: No, this webinar is not an official OPWDD training.

Q: Are ACA/NY and LIFEPlan CCO NY the same organization?

A: No, they are two separate organizations. Last fall, ACA/NY and LIFEPlan CCO NY announced a strategic partnership with the goal of enhancing the quality of our Care Management service. We continue to operate as two separate organizations with two separate governing boards. It is important to note that there are no changes to how either Coordinate Care Organization (CCO) provides Care Management services. Provider agency staff should continue to work with the CCO Care Management staff and leadership in their regions on day-to-day care coordination/care planning matters.

Q: What is your definition of "Provider"?

A: For the purposes of this presentation, when we say "provider" we are referring to agencies who provide one or more OPWDD-funded services.

Q: What is the Federal Public Health Emergency (PHE)?

A: The Federal Public Health Emergency (PHE) is an emergency declaration in effect because of the COVID-19 pandemic. The PHE outlines specific areas of regulatory relief to allow for flexibility in service delivery throughout the pandemic.

Q: How are you supporting the Direct Support Professional (DSP) workforce crisis?

A: ACA/NY and LIFEPlan CCO NY have worked and will continue to work closely with provider, family, and self-advocacy groups across the state to petition for a permanent wage increase for Direct Support Professionals.

ACA/NY | LIFEPlan CCO NY Provider Webinar

Q&A: Understanding CCO Care Management & the Role of the Care Manager

Enrollment & Eligibility

Q: Do ACA/NY and LIFEPlan CCO NY have a department separate from Care Management that assists families with obtaining OPWDD eligibility? Is there an age limit for who they will assist?

A: All initial OPWDD eligibility requests must now go through one of the 7 CCOs in New York State. Both ACA/NY and LIFEPlan CCO NY have dedicated teams who help people in pre-enrollment obtain OPWDD eligibility. We will assist anyone with obtaining eligibility regardless of age. We also assist with applying for Medicaid.

Q: Who reviews and approves enrollment into the Home and Community Based Services (HCBS) waiver?

A: OPWDD reviews the application for the HCBS waiver and makes the final determination.

Q: What is the process for someone who wants to transfer to a CCO from Partners Health Plan (PHP)?

A: Once the CCO is made aware of the person's intent to transfer from PHP, a member of the CCO's enrollment team will contact them or their representative to complete the appropriate consent form. The CCO enrollment staff will also verify Medicaid eligibility and will contact the team at PHP to obtain copies of all required documents. Once the consent and required documents have been received, the CCO enrollment staff will submit the enrollment form to OPWDD via CHOICES. Upon enrollment into the CCO, the Care Manager will complete the necessary comprehensive assessment and Life Plan process. If the member was not previously enrolled in the HCBS Waiver, the Care Manager will work with the member to complete all necessary components of the HCBS Waiver application and supporting documents to submit to OPWDD for review.

Care Manager Responsibilities

Q: What is the expectation for notifying providers and caretakers when there is a change in Care Manager assignment?

A: For planned changes to Care Manager assignment, such as a member request or resignation with notice, the outgoing Care Manager is expected to notify members, families, and providers of the change. For unplanned changes due to unavoidable circumstances, the outgoing Care Manager's immediate supervisor is expected to notify members, families, and providers. *If the member is enrolled with ACA/NY* and you are unsure of Care Manager assignment, you can call the Customer Care Center at 1-833-MY-ACANY or email at questions@myacany.org. They will direct you to the appropriate person. *If the member is enrolled with LIFEPlan CCO NY*, please contact the Care Manager Supervisor or Director for the new Care Manager's contact information.

Q: What is the procedure for inviting providers to Life Plan meetings?

ACA/NY | LIFEPlan CCO NY Provider Webinar

Q&A: Understanding CCO Care Management & the Role of the Care Manager

A: Life Plan meetings should be scheduled well in advance with the time, place, and attendees led by the member's preference. The Care Manager is ultimately responsible for coordinating and scheduling the meeting with all parties. Once a meeting date is confirmed, the Care Manager is to send an invitation to all requested attendees. Approximately 2 to 4 weeks before the Life Plan meeting, the Care Manager will send a confirmation email or letter with the draft Life Plan and meeting reminder. Please let the Care Manager know if there is a change in staff to ensure the correct people are being invited.

Q: Are Care Managers required to attend pre-planning/budget development meetings for Self-Direction?

A: Care Managers are a part of the circle of support and should attend pre-planning meetings when possible, unless the member requests otherwise. However, the Care Manager is not required to attend pre-planning meetings, and not having them in attendance should not prevent the meeting from proceeding.

Q: Does the Care Manager complete the Request for Service Authorization (RSA) and Service Authorization Request Form (SARF)? Is the Notice of Decision (NOD.09) OPWDD's approval response?

A: Yes. The Request for Service Authorization (RSA) is used when first applying for services as part of the HCBS waiver application. The Service Authorization Request Form (SARF) is used to make changes to existing services or to add a new service after the person has been enrolled in CCO services and the HCBS waiver. The OPWDD forms are completed by the Care Manager. The NOD.09 lists the services and amounts that are authorized. If a service was not authorized, reduced, or terminated, then the Regional Office will list this on the NOD.09 and provide information on how to appeal the decision. Please refer to this OPWDD memorandum for more information **here.**

Q: If a member is in a behavioral or health crisis, does the Care Manager take the lead on managing the crisis? How does the Care Manager work with a certified residential provider on these issues?

A: Member health and safety is of the utmost priority and care management services help to ensure a strong plan is in place so that crisis can be avoided. Care management is not itself a crisis service. When a crisis is identified, the Care Manager will work with providers to develop an action plan and may take the lead in coordinating a response. In a community setting, the Care Manager will work to ensure health and safety by identifying appropriate supports and services and connecting the member to those services. In a certified setting, the Care Manager will work with the provider's internal teams, including behavior and nursing services, to ensure a comprehensive response. In the event of an immediate emergency, 911 should be contacted.

Q: If a member is enrolled in Basic HCBS Plan Support, has already had their two annual meetings, and a crisis arises, will a Care Manager address the issue, communicate, and support the member and provider if needed?

A: The regulations for the Basic Plan allow for two additional contacts per year. A member enrolled in Basic can receive assistance from the Care Manager for crisis situations if they have already had two annual meetings. However, depending on the situation and the issue, the Care Management team may recommend that a member moves from Basic to Comprehensive Health Home Care Management to ensure necessary services are in place.

Assessments & Documentation

Q: Will Coordinated Assessment System/Child and Adolescent Needs and Strengths (CAS/CANS) assessments that were done virtually be re-done for accuracy?

A: The CCOs do not oversee the CAS/CANS process. CAS/CANs assessments are conducted by OPWDD. A Care Manager may reach out to notify a member of an upcoming CAS/CANS assessments and can provide documentation and feedback to OPWDD to help ensure the accuracy of an assessment. In the event that the review of the CAS/CANS summary contains inaccuracies or errors, Care Managers follow a specific written process as instructed by OPWDD. Members and families may also reach out to OPWDD directly for assistance if they feel a CAS/CANS is inaccurate.

For information related to CAS/CANs corrections and inaccuracies, click **here**.

Q: How do we obtain DDP2 (Developmental Disability Profile) updates and LCED (Level of Care Eligibility Determination) updates?

A: All waiver service providers are required to complete their own DDP2 for every member at least once every 2 years. This is done independently of the DDP2 completed by the Care Manager and should be based on observations that have been made in that specific program. The DDP2 should be reviewed and discussed with the member, family, and Care Manager annually during the comprehensive assessment process. This is important as the results may impact the member's tier level, Personal Resource Allowance (PRA) for Self-Direction, and Individual Service Planning Model (ISPM) score, which may affect service authorization. There is no requirement for Care Managers to distribute DDP2s.

Q: How do we obtain LCED (Level of Care Eligibility Determination) updates? What if we are not listed on the DOH-5055 or DOH-5201 consent form?

A: LCEDs are now completed and stored in CHOICES. Providers can find the updated LCED under Supporting Documents in the member's record. If the provider cannot locate the LCED in Supporting Documents, they should contact the Care Manager. All active service providers must be listed on the consent form. If they are not listed, the Care Manager must obtain the consent of the member/representative.

ACA/NY | LIFEPlan CCO NY Provider Webinar

Q&A: Understanding CCO Care Management & the Role of the Care Manager

Q: Were the Life Plans in CX360 reconciled to the last finalized Life Plan distributed before the Electronic Health Record (EHR) transfer? How can we receive copies of Life Plans that took place prior to the EHR transfer?

A: All documents including finalized Life Plans were migrated to CX360 as part of the EHR transfer. Please contact the Care Manager for a copy of historical Life Plans. If the member has received services from ACA/NY in the past but is no longer enrolled, document requests must be made by contacting the Customer Care Center at 1-833-MY-ACANY or questions@myacany.org. LIFEPlan CCO is in the process of developing their Customer Care Center. In the meantime, providers can reach out to the Care Manager or Care Manager Supervisor for any needed documents for previously enrolled members. Please note, providers must provide the appropriate consent for the release of information if the member is no longer enrolled with LIFEPlan CCO.

Q: How can providers document a missing Life Plan review when a member is hospitalized or refuses to meet?

A: When a Life Plan review cannot be held as scheduled, the Care Manager will communicate changes to the member's Interdisciplinary Team (IDT). If the member is hospitalized, the review will be rescheduled after the member is discharged. If a member refuses to meet, the Care Manager will assess the member's needs to determine why they are refusing and help address the barrier to scheduling the review. The provider should document all communication from the Care Manager to show good faith in attempting to hold the meeting as required. The Care Manager can also reflect the reason for delay and efforts to reschedule in the IDT summary once the Life Plan has been held.

Life Plans

Q: What is the process of developing the Life Plan?

A: Every member participates in an annual comprehensive assessment process which informs the development of the Life Plan. In preparation for the Life Plan meeting, the Care Manager sends the current draft Life Plan to the member/representative and all invited attendees of meeting, approximately two weeks before the meeting. Once the meeting is held, the Care Manager completes the remaining necessary updates to the Life Plan as discussed at the meeting, led by the member. The Care Manager then submits the Life Plan to their supervisor for review and initial approval. The Care Manager must send the approved plan to the member/representative for review and signature in order for the plan to be considered finalized within 45 days of the Life Plan meeting. Providers responsible for delivering services documented in sections II and/or III of the Life Plan must sign the Life Plan to acknowledge and agree to provide the provider-assigned goals, supports, and safeguards associated with those services, per the finalized plan. The Life Plan is then distributed to all applicable parties no later than 60 days following the Life Plan meeting date.

ACA/NY | LIFEPlan CCO NY Provider Webinar

Q&A: Understanding CCO Care Management & the Role of the Care Manager

Q: In Section IV of the Life Plan, should the effective date of the service match the original approval date listed in CHOICES, or the date of the Life Plan review?

A: When services are newly added to the individual's Life Plan after the initial Life Plan is finalized, the effective date of each new service should correspond to the Life Plan review date on which the new service was added to the Life Plan. For example, The Life Plan was finalized on 2/1/19. The individual requests a new service, and a Life Plan review meeting is held on 5/15/19 to discuss this request. Day Habilitation is added to the individual's Life Plan during the Life Plan review meeting. The effective date for Day Habilitation is 5/15/19. For subsequent plans, the effective date of the service will show as the original effective date in CHOICES on the CR4. Please refer to the 6/2018 ADM "Transition to People First CCO" **here.** Due to the data migration to CX360, providers may see a blend of this in Section IV until a brand new plan is created in the system for the member.

Q: When changes are needed to the Life Plan, is it appropriate to wait for the next review, and when is it necessary to complete an addendum? If someone is requesting to be discharged from a provider, how soon should the Care Manager send the addendum?

A: It is best practice for the Care Manager to complete and distribute an addendum as soon as possible after a change of service. On occasions where a Life Plan review has already been scheduled and is occurring within a short timeframe, it may be more appropriate to wait until that date (ex: new service is authorized on 11/8/22 and a Life Plan review was previously scheduled for 11/14/22).

Q: Can a member create their own Personal Outcome Measures (POM) that are not available in the drop-down list? Is it possible to get a list of the Personal Outcome Measures (POM) drop-down options available for a Life Plan?

A: No, members cannot create their own Personal Outcome Measures. Personal Outcome Measures are set by the Council on Quality and Leadership (CQL) and cannot be altered. A complete list of Personal Outcome Measures can be found on the CQL website **here.**

Q: Will there be a presentation to teach the families about the different sections of the Life Plan?

A: We will explore offering a Member & Family Forum on this topic in the coming months.

Staff Action Plans

Q: Does the Life Plan need to match the Staff Action Plan word-for-word?

A: The Staff Action Plan must be derived from and align with the member's Life Plan but does not need to match word-for-word. The habilitative goals/valued outcomes and safeguards/Individual Plan of Protection (IPOP) are derived from the member's Life Plan. The habilitation service must relate to the individual's habilitative goals/valued outcomes. Using the habilitative goals/valued outcomes as the

starting point, the details of the Staff Action Plan must describe the actions that will enable the individual to reach his/her specific habilitative goals/valued outcomes. Please see the following Staff Action Plan ADM **here.**

Q: Should we use the individual's name in Staff Action Plan? Whose responsibility is it to share with members, representatives, and other providers?

A: HCBS waiver service providers should refer to the Staff Action Plan ADM, which contains regulations outlining the required content and distribution timelines.

Q: We have been told by Care Managers that we must have 3 or more valued outcomes for the service in the Life Plan and on the Staff Action Plan. What are the minimum number of goals and supports required?

A: The minimum requirements are 3 goals and 2 Personal Outcome Measures (POMs). Please refer to the CCO Provider Manual for more information, click **here.**

Q: What can be done to help a member quantify whether a goal/objective in their Life Plan has been achieved? A presentation about the data driven resolution between achieving a Life Plan Personal Outcome Measure/goal and agency Staff Action Plan would be helpful.

A: The goal/objective is identified by the member and the Interdisciplinary Team. The Staff Action Plan developed by the Provider should be utilized to describe specifically what actions the staff will do to assist the member in achieving the goal and what metrics that will be used to determine the member's progress in achieving the goal. We will explore offering a webinar on Life Plans & Staff Action Plans in the coming months.