LIFEPlan CCO NY

ACA/NY
ADVANCE CARE ALLIANCE

PROVIDER RELATIONS WEBINAR

Understanding CCO Care Management and the Role of the Care Manager

LIFEPLAN CCO NY | ADVANCE CARE ALLIANCE

Working together as Coordinated Care Alliance, CCA NY

AGENDA

- Brief Overview: CCANY & Provider Relation's Goals
- Introductions: New CCANY Provider Relation's Team
- Webinar Program: Role of the CCO/Health Home Care Manager
- Q&A

Overview of CCANY & Provider Relations Goals

Nick Cappoletti, CEO

Meet our New Provider Relations Team

Lori Kearsing
VP of Strategic Initiatives

CCANY Directors of Provider Relations

LIFEPlan CCO NY

- **Karen Hoffman** - (315) 930-4502 – karen.hoffman@lifeplanccony.com
  (Northern Upstate Region)

- **Anne Seepersaud** - (607) 214-0618 - anne.seepersaud@lifeplanccony.com
  (Southern Upstate Region)

ACA/NY & LIFEPlan

- **Nadira Bryan** – (914) 359-4588 – nadira.bryan2@lifeplanccony.com
  (Hudson Valley)

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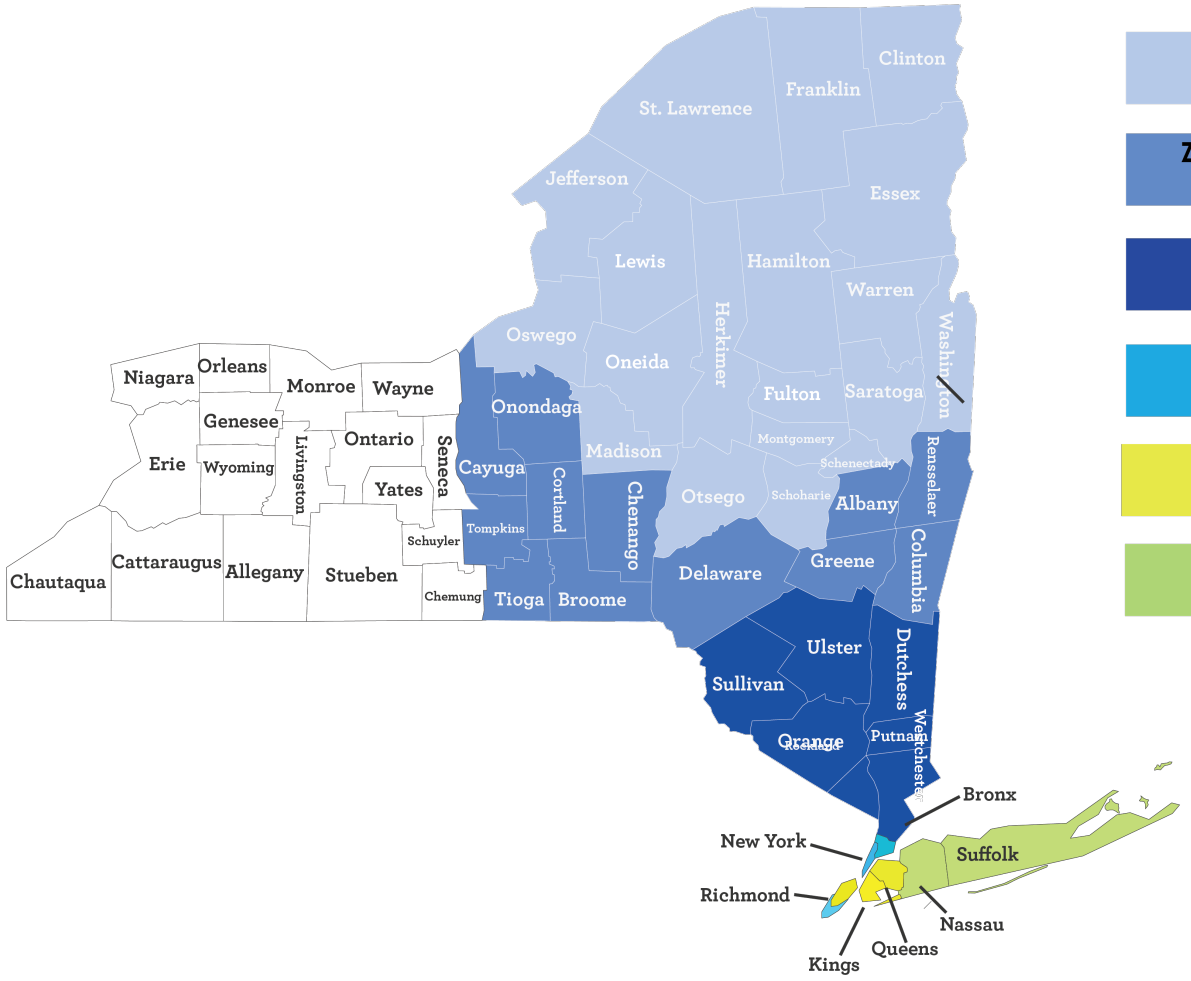
- **Megan Porter** - (646) 281-1916 – megan.porter@myacany.org
  (NYC: Manhattan/Bronx/Staten Island-Richmond County)

- **Krystal Procida** (starts 11/21/22)
  (Brooklyn/Queens/Staten Island-Kings County)

- **Angie Munroe** (starts 11/21/22)
  (Long Island)

Map of 6 Provider Relations Zones



Zone 1: Karen Hoffman
LIFEPlan CCO

Zone 2: Anne Seepersaud
LIFEPlan CCO

Zone 3: Nadira Bryan
ACA/NY & LIFEPlan CCO

Zone 4: Megan Porter
ACA/NY

Zone 5: Krystal Procida
ACA/NY

Zone 6: Angie Munroe
ACA/NY

Role of the Care Manager

Jaime Madden
Chief Operating Officer

Overview of CCO/Health Home Care Management Model

- Implemented in 2018 in place of Medicaid Service Coordination (MSC)
- Conflict-free Care Coordination
- Increased focus on achieving positive health outcomes.
- CCO Care Managers provide coordination of health care, behavioral health and developmental disability services

Role of CCO/Health Home Care Management

- Complete comprehensive assessment as part of the Person-Centered Planning process
- Develop Initial Life Plan, identifying needed services
- Apply for HCBS Waiver approval, identify service providers and connect members to approved services
- Connect members to other medical, behavioral health and community supports and services

Role of CCO/Health Home Care Management

- Re-evaluate Life Plan on a regular basis
- Problem solve when crises arise
- Assist with transitional planning
- Apply for and maintain benefits & entitlements (support to residential provider and rep payee for members in certified settings)
- Advocate for member’s health and wellness
- Report incidents when applicable and support health & safety

Comprehensive Assessment Process

Informs the development of the Life Plan and includes:

- PATHS Assessment
- DDP-2 (completed by Care Manager every 2 years or as needed ***and*** by Waiver Providers)
- LCED Re-Determination (completed by CM annually)
- CAS or CANS (completed by OPWDD/Maximus Staff)
- Other assessments and evaluations completed by other providers/schools

What to Expect from Care Managers: Life Plan Process

- A draft Life Plan is sent to the member/representative and providers in advance of the meeting.
- Care Manager works with the member/representative to identify day, time and place for the Life Plan meeting.
- Care Manager works with the person to identify attendees.
- Service providers are always invited and expected to attend.
- The member needs to be present to be considered a Life Plan meeting.

What to Expect from Care Managers: Life Plan Process

- Assessments, Staff Action Plans (SAP), Self-Direction budget, and other relevant documents are reviewed at the meeting.
- Discuss services, outcomes, and goals and assigns service providers.
- **Signature is required from member and/ or representative(s) for Life Plan approval.** Providers review for feedback.
- Once the member and/or representative(s) approves, provider gives acknowledgement(s).
- Annual and semi-annual Life Plans need to have member and/or representative's approval within 45 days and provider(‘s) acknowledgement within 60 days.

Alignment of Life Plan and Staff Action Plan

- Goals, Levels of Supervision, Tasks and Supports may be assigned to providers following comprehensive assessment process- reviewed at Life Plan meeting.
- POMS and Goals in Life Plan are in general language and will not exactly match the Staff Action Plan. This is not a billing standard issue.
- Staff Action Plans spell out how the provider will deliver the outcome.
- Life Plans should be reviewed with the SAP. Reviews can also be held early to avoid discrepancies.
- Both ACA/NY and LIFEPlan have dispute resolutions processes if service provider does not agree with the content.

Applying for Waiver and Self-Direction Services

- A Life Plan is needed to apply for services.
- OPWDD authorizes the services and the approved units.
- Care Manager contacts providers that deliver the desired service.
- Care Manager can collaborate with identified service providers on completion of the RSA/SARF, to get the services authorized.

Applying for Waiver and Self-Direction Services

- If approved for services but wants to change or add a new service/hours of service (units), Care Manager completes a SARF form with the correct approved units and submits it to the Front Door.
- Care Manager informs the providers of the Waiver NOD.09 and sends it to provider(s) to initiate or modify services.
- Any changes to services need to be reflected in the Life Plan and will require an addendum.

What to Expect from a Care Manager: Visits, Contact and Communication

CONTACT OPTIONS

- **Face-to-Face (F2F):** Care Manager can talk to and see the member at the time, place, modality and others in attendance of the member's choosing. F2F can take place either in-person or via telehealth.

- **In-Person visit:** Member is in the same room or location as the Care Manager.

- **Telehealth:** COVID-19 regulatory flexibility allows the use of video with sound **or** telephone connection to meet Face-to-Face requirements.

What to Expect from a Care Manager: Visits, Contact and Communication

- Everyone enrolled in Comprehensive Care Management is entitled to a monthly service.
- Member's tier determines the minimum visit requirements.
- Tiers 1-3
  - Monthly billable contact/activities & Quarterly F2F
  - Annual & Semi-Annual Life Plan meetings In-Person
- Tier 4 (Non-Willowbrook)
  - Monthly Face-to-face visits (option of opt out of monthly F2F requirements)
  - Quarterly must be in-person
  - Annual & Semi-Annual Life Plan meetings In-Person

What to Expect from a Care Manager: Visits, Contact and Communication

- Willowbrook Class Members
  - Monthly In-Person Face-to-face visits
  - Annual & Semi-Annual Life Plan meetings In-Person
- HCBS Basic
  - Annual & Semi-Annual Life Plan meetings In-Person
  - Contact/activities or can meet up to 2x annually to address unexpected needs

What to Expect from a Care Manager: Tier 1-3 Face-to-Face Requirement

Quarterly face-to-face may be in person or through telehealth, once per quarter.

- Jan-Mar
- Apr-June
- July-Sept
- Oct-Dec

COVID-19 Flexibility

Ability to use telehealth modalities for any visit by video or phone. After PHE ends, only video is accepted.

What to Expect from a Care Manager: Tier 1-3 In Person Requirement

Minimum of twice annual in person visits.

- Annual Life Plan
- Semi or other meeting chosen by the member/rep
- Must occur in each half of the year – Jan-June and July-Dec

COVID-19 Flexibility

Telehealth modalities as a substitute for in-person visits until the Federal PHE ends. After the Federal PHE, telehealth will only be video with sound

What to Expect from a Care Manager:
Tier 4 In Person Requirement

Minimum of one visit per quarter. One must be annual Life Plan meeting

- Jan-Mar
- Apr-June
- July-Sept
- Oct-Dec

COVID-19 Flexibility

Telehealth modalities as a substitute for in-person visits until the Federal PHE ends. After the Federal PHE, telehealth will only be video with sound

What to Expect from a Care Manager: Willowbrook Class Members

Required to have monthly IN-PERSON face-to-face visits.

COVID-19 Flexibility
Currently, all apply until the end of the PHE.

Wrap-Up: Recent Changes in Response to Provider Feedback

- New Provider Relations department dedicated to sharing information and clarifying care management practice.
- Enhanced communication through individual provider meetings, monthly newsletters and webinars.
- Call Center model to ensure needs met more quickly and efficiently.
- Community Resource Tool to better promote providers to staff, members and families.

Wrap-Up: Recent Changes in Response to Provider Feedback

- New Care Management Institute to advance the skills and training of the workforce.
- Other Care Manager recruitment and retention strategies under review including an Apprenticeship program and potential grant opportunities to support workforce development and retention.
- Joint advocacy at the State level

Additional Resources

More Information about the CAS

opwdd.ny.gov/providers/coordinated-assessment-system-cas

ACA/NY

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Questions