FAQ's for Medicaid Service Coordination (MSC) Service Coordinators

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What is Health Home Care Management?

Health Home Care Management is a new way to coordinate care, combining developmental disability services and supports with health and wellness services.

This new way of coordinating care is an enhanced version of the Medicaid Service Coordination (MSC) program, offering individuals more options, greater flexibility and better outcomes.

Health Home Care Management will be provided by Care Coordination Organizations (CCOs).

What is a CCO?

CCOs are organizations formed by existing developmental disability service providers. These new organizations will be staffed by Care Managers with training and experience in the field of developmental disabilities.

What is a Care Manager?

Care Managers will help coordinate services across systems, including the Office for People With Developmental Disabilities (OPWDD), the Department of Health and the Office of Mental Health, providing people with developmental disabilities one place to plan all their service needs. Many Care Managers will be current Medicaid Service Coordinators who have received additional training to become Care Managers in the new system.

How can I become a Care Manager?

MSCs currently working for provider agencies will have the opportunity to become Care Managers and work for Care Coordination Organizations (CCOs).

Will current MSC Service Coordinators be grandfathered in to the Health Home Care Manager role?

Health Home Care Manager education and experience requirements will be waived for existing MSC Service Coordinators who apply to serve as Care Managers for CCOs. CCOs will be required to provide Health Home core services training for current MSCs who do not meet the minimum education and experience requirements. This training will be provided by the CCO. It is anticipated that most Service Coordinators will transition to Care Manager roles.

What are the qualifications to become a Care Manager?

Health Home Care Managers who serve adults and children with developmental disabilities must meet the following qualifications:

- A Bachelor of Arts or Science degree with two years of relevant experience, OR
- A License as a Registered Nurse with two years or relevant experience, OR
- A Master's degree with one year of relevant experience.

What if I decide not to become a Health Home Care Manager?

All future service coordination will be provided by Health Home Care Managers. This new job opportunity offers the chance for career growth and more rewarding outcomes for you and the people you support. In your current role as a Medicaid Service Coordinator, you are required to assist with this transition to CCOs as part of your job responsibilities, whether or not you decide to become a Health Home Care Manager in the new system.

Why is OPWDD switching from Medicaid Service Coordination to Health Home Care Management?

Health Home Care Management is an improved type of service coordination that will better support people, including those with complex needs. It will allow for better information sharing, resulting in more flexible and comprehensive service planning.

When will the transition to Health Home Care Management take effect?

Care Coordination Organizations will begin providing Health Home Care Management services on July 1, 2018.

Is Health Home Care Management a form of Managed Care?

No, Health Home Care Management should not be confused with Managed Care. Managed Care will take several years to develop in the OPWDD system and will be offered at a future date.

How will the CCOs work with the Front Door process?

The Front Door will continue to be the means by which OPWDD connects people to the services they need and want by determining OPWDD eligibility and referring eligible individuals to CCOs for care management services. Health Home Care Managers will work with individuals and their advocates and request OPWDD service authorization through the OPWDD Regional Offices.

How often will someone receiving Health Home Care Management be seen face-to-face?

For individuals who are transitioning from Service Coordination to Health Home Care Management, the enrollment process will include a review of the current services in place and an evaluation of any possible immediate needs. This review will be documented on a Checklist and will serve as the initial onboarding meeting and the Care Plan "addendum" while the new Life Plan is developed using person-centered processes. It is expected that a Life Plan will be completed by the person's next annual review date, keeping people on the same review cycle unless they have a particular need for a review (change in condition) or request a planning meeting.

A face-to-face person-centered planning review must also take place at least once every year, and all members of the interdisciplinary team must participate.

In addition to the monthly documentation of at least one Health Home core service, Care Managers must also adhere to the following face-to-face meeting requirements:

- The Health Home Care Manager must have at least one face-to-face meeting with individuals receiving Tier 1, 2 or 3 level of supports on a quarterly basis (January – March; April – June; July – August and September – December).
- The Care Manager must have monthly face-to-face meetings with individuals receiving Tier 4 level of supports.

What is a Life Plan?

The Life Plan will replace the Individualized Service Plan (ISP). It will be reviewed routinely and updated as needed based upon each individual's goals and changing needs. As a Care Manager, you will work with each individual to create a plan based on their wants and needs. Each Life Plan will include coordination of developmental disability related supports and other services, like medical, dental and mental health.