



What does the Need for “Ongoing and Comprehensive” Service Coordination Mean?

To receive Medicaid Service Coordination a person must demonstrate that they have a need for ongoing and comprehensive service coordination. The following information provides clarification on what is meant by “ongoing and comprehensive” and is to be used as a guide in determining whether a particular individual meets that need. Also included in this guidance is a worksheet that may be used to assist when making such a determination.

Note: Willowbrook Class Members are deemed to be in need of ongoing and comprehensive service coordination as a result of the findings, rights and obligations set forth in the Permanent Injunction dated March 11, 1993. The following assessment process does not apply to class members who seek enrollment or continued participation in MSC.

1. The person’s need for service coordination is clearly ongoing and not episodic.
 - MSC is not to be used solely for establishing eligibility for the HCBS Waiver in order to obtain Medicaid.
 - The individual requesting services does not already have their needs met through natural and other supports already in place.
 - The person has needs that are so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services.

2. The person’s need for service coordination is “comprehensive”, meaning all inclusive or covering widely. This means that the person demonstrates at least one of the following:
 - Unmet needs in multiple areas or life domains in which the assistance of a service coordinator is necessary.
 - Health and safety or the person’s general well-being would potentially be jeopardized if not for the ongoing interventions, monitoring, advocacy and assistance specifically provided by the service coordinator.
 - Major life changes or changes in the person’s daily life activities that have occurred over the last six months or are likely to occur within the next 12-18 months.
 - Reconfiguration of services that have occurred over the last six months or are likely to occur within the next 12-18 months.

Examples of reconfigured services and/or major life/daily life activity changes include but are not limited to: valued outcomes that indicate movement from a certified residence to one’s own home or apartment; seeking to obtain employment; and transitioning to more individualized self-directed services.

3. The ongoing assistance of a service coordinator is necessary for the timely and effective arrangement of needed services/supports (including health and safety related

services/supports and monitoring/advocacy) and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options. This ongoing assistance is facilitated through activities associated with: (a) plan development, **AND** (b) plan implementation, **AND** (c) plan maintenance and monitoring.

- This means that it is likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by developing, implementing, and monitoring/maintaining the plan of care and arranging for service linkages for the person and providing other allowable service coordination interventions/actions (assessment, service plan development, implementation, monitoring, maintenance, referrals and linkages, and advocacy).
- This can also mean that the person needs the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options (e.g., moving out of a certified residence) that they may not have ever considered in the absence of this relationship and ongoing communication with their service coordinator. These interactions and discussions must be clearly documented in the service coordination record.
- The service coordination records need to clearly indicate that without specific identified service coordination interventions, the person would be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life.

Expectations for Ongoing and Comprehensive Service Coordination:

- Over time, through the ongoing and comprehensive service planning process, the service coordination records should show that unmet needs become met needs as a result of service coordination activities.
- Over time, a person's valued outcomes and service configurations will likely show changes due to the ongoing and comprehensive planning and implementation work between the person and their service coordinator.
- When individuals are already enrolled in MSC, if the service coordination records do not show any changes to valued outcomes and corresponding supports and services within a reasonable amount of time (e.g., such as 12-18 months) and/or there is no other indications in the service coordination records that indicate that progress is being made or that demonstrates that the service coordination staff interventions/activities are helping to sustain the person in his/her community or are otherwise, useful and not duplicative of what other services and supports are required to provide and/or what parents of minor children are reasonably expected to provide (e.g., health monitoring in 24 hour certified settings; for minor children under the age of 18, parents should be monitoring that routine health services are obtained/received), it can be reasonably assumed that the ongoing assistance of a service coordinator is not necessary.
- Individuals who are waiver enrolled and who are no longer eligible for MSC will be withdrawn from MSC and transferred to Plan of Care Support Services (PCSS). All withdrawals from MSC must be carried out in accordance with due process procedures as outlined in the MSC Vendor Manual.



Medicaid Service Coordination (MSC) Assessment of the Need for Ongoing and Comprehensive Service Coordination

This worksheet may be used to assist in making the determination as to whether a person meets the need for ongoing and comprehensive service coordination. Complete the following items and the accompanying checklist.

Name of Individual: _____

1. Identify all services and supports the person currently receives.

	Current Services/Supports Received	Funding Source	Describe how the person currently accesses these services, i.e. who helps the person obtain/maintain these services?
1.			
2.			
3.			
4.			
5.			

2. Identify the person's unmet needs for which the assistance of a service coordinator is necessary. For each unmet need describe anticipated actions by the service coordinator that will assist the person to meet this need, and the anticipated timeframe that is likely for this need to be met (in months).

	Unmet Need	Service Coordinator Actions	Time Frame
1.			
2.			
3.			
4.			
5.			

3. Clearly describe potential and/or likely consequences/implications for the individual if they were to not receive MSC.

	Yes	No
<p>1. Is the person's need for service coordination clearly ongoing and not episodic in nature?</p> <p>MSC is not to be used solely to establish eligibility for HCBS Waiver services to obtain Medicaid. The individual requesting services does not already have their needs met through natural or other supports that are already in place.</p>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person's need for service coordination comprehensive?		
a. Does the person exhibit unmet needs in multiple areas or life domains?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are the person's needs so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services if not for the interventions and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
c. Would the person's health and safety or general well-being be potentially jeopardized if not for the <u>ongoing</u> interventions, monitoring, advocacy and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
d. Has the person experienced major life changes or changes in daily life activities that have occurred over the last six months or are anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has the person experienced a reconfiguration of services over the last six months or is a reconfiguration of services anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the ongoing assistance of a service coordinator necessary for the timely and effective arrangement of needed services/supports and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options?		
a. Is it likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by performing allowable service coordination functions?	<input type="checkbox"/>	<input type="checkbox"/>
b. Does the person need the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options?	<input type="checkbox"/>	<input type="checkbox"/>
c. In the absence of service coordination, would the person be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life?	<input type="checkbox"/>	<input type="checkbox"/>

The individual meets the need for ongoing and comprehensive service coordination if:

- The answer to 1 is yes.
AND
- At least one yes in a-e for number 2.
AND
- At least one yes in a-c for number 3.

Indicate whether the individual meets the need for ongoing and comprehensive service coordination?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>

Completed by: _____ Title: _____ Date: ____ / ____ / ____

Agency: _____