**Guidance for Providing Care Coordination and Management to Medicaid Members Enrolled in MLTC Plans and Health Homes**

The role of Managed Long Term Care (MLTC) Plans is to provide coordination of long term care services and supports as provided by the MLTC benefit package for eligible individuals who need more than 120 days of community based long term care services. Health Home care management is a State Plan service that is required to be offered to all members that meet Health Home eligibility requirements. Eligible individuals enrolled in MLTC Plans may also be enrolled in a Health Home. Health Home care management services are carved out of the MTLC benefit package, thus both the MLTC Plan and the Health Home may bill for their respective services and formalize their respective roles by entering into an Administrative Service agreement (ASA). A template ASA has been developed by the Department. Reference to the ASA will be included in the MLTC Plan contracts with the Department with the next amendment.

The template ASA allocates a primary role for the service coordination of long term care services to the MLTC Plan and a primary role for the service coordination of behavioral health care and other services and supports that are outside of the MLTC benefit package to the Health Home. MLTC Plans are responsible for coordination with the Health Home and are not responsible for Health Home management or performance or any services outside the scope of their benefit package. While the template ASA provided by the Department may not be altered, a description of the in-plan and out of plan services and the respective responsibilities of the MLTCP and the Health Home should be included as an Appendix to the ASA. A suggested template for this Appendix has also been developed. MLTC Plans and Health Homes have requested additional guidance on documenting their collaborative approach to care coordination in the client’s care plan record. A suggested template for a client level Care Planning and Coordination form has also been developed.

The State requires a collaborative, team approach to service coordination between the Health Home and the MLTCP. It will be the responsibility of the Health Home and the MLTC Plan to determine which care manager will serve as the lead care manager, for each individual client. This decision will be based on the primary needs of the client and must be documented on the Care Planning and Coordination form. MLTC Plans and Health Homes are encouraged to identify liaisons to participate in periodic meetings that will include MLTC Plan care coordination and Health Home care management staff. The goals of these periodic meetings should be:

* Insure a team approached focus to care coordination and avoid duplication
* Improve positive outcomes for the member
* Discuss quality improvement initiatives

The ability of the MLTC Plans and Health Homes to define their respective roles via an ASA and the associated Appendix, combined with use of a client level Care Planning and Coordination form, along with structured defined lines of responsibility and regular communication, will serve to ensure that MLTC Plan care coordination and Health Home care management services are not duplicated.