



Office for People With Developmental Disabilities

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The Role of the Medicaid Service Coordinator (MSC)/Care Planner in the Coordinated Assessment System (CAS) Process

The MSC or care planner (e.g. Qualified Intellectual Disability Professional (QIDP), treatment team leader, care coordinator/manager) will play a vital role in the assessment process by assisting the assessor with confirming/obtaining contact information, scheduling/coordinating, providing documentation for review, and reviewing of the output summaries with the person/actively involved family member or LG. The MSC/care planner's quick response to an assessor's request is important because the CAS assessment is a **time sensitive process**.

To assist the MSC/care planner in understanding his/her role, the MSC/care planner will be provided the following documents: CAS Brochure, Documentation Review List, and The Coordinated Assessment System (CAS): Summary Guidance Document for the Person/Family and Provider Conversation.

Initial MSC/Care Planner Contact

The CAS assessor will contact the MSC/care planner to verify/obtain the following information:

- Person's contact information
- Identification of knowledgeable individual(s)
- Identification of Legal Guardian (LG) and/or actively involved family member/key staff
- Communication/language access needs

MSC/Care Planner's Role in the Assessment Process

The assessor will contact the person and schedule an interview.

- The assessor will communicate to the MSC/care planner the date and time of the interview.
 - o If the MSC/care planner learns that the person is experiencing a change in his/her life that requires the assessment to be rescheduled (i.e., hospitalization, unexpected emergency/crisis, etc.), the MSC/care planner will contact the assessor as soon as possible.
- The assessor will inform the MSC/care planner if the person has identified an individual that he/she would like to have present at the interview for support.
 - o The MSC/care planner will be asked to inform the individual identified for support, the location and time of interview.
 - o If the MSC/care planner is aware of other key individuals in the person's life that he/she would want to have at the assessment interview, the MSC/care planner will be asked to inform the individual(s) of the location and time of the interview.
- The assessor will need to review certain documents in order to complete the assessment (refer to the Documentation Review for the Coordinated Assessment System (CAS) document for guidance).

- The MSC/care planner will ensure that all obtainable and requested documentation be available for assessor to review on the assessment date. MSCs/care planners do not need to make copies of documents as assessors will review them at the location.

CAS Summaries

The CAS Summaries and Summary Guidance Document will be available 24 hours after the CAS is finalized (Note: Finalization of the CAS could take up to three days from assessment reference (interview) date).

- The CAS Summaries and Guidance document can be found in the “Supporting Documents” section of the person’s file in CHOICES.
 - **The MSC/care planner is responsible for reviewing the CAS Summaries with the person/actively involved family member/LG within 30 days from availability. This review should occur when the MSC/care planner is able to meet and/or have a conversation with the person and/or actively involved family member/LG to discuss the CAS Summaries. In addition, this conversation needs to be documented as well as any issues or concerns that result from it.** The CAS Summaries should not be distributed without having a proper discussion and review of them. The MSC/care planner should also utilize the Summary Guidance Document to facilitate this discussion.
 - The MSC/care planner should ensure that any new information found in the CAS Summaries is addressed and documented in the monthly note and/or the ISP.

Questions and/or concerns regarding CAS Summaries should be emailed to: coordinated.assessment@opwdd.ny.gov