OLTL Service Coordination Funding and Service Delivery Models Module

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# Service Coordination Training

Welcome. The Office of Long-Term Living developed this training to support Service Coordinators and their supervisors in developing the skills and knowledge required to provide service coordination services effectively and in compliance with state and federal standards.

This training applies to people performing service coordination in the OBRA Waiver and Act 150.

## Modules Overview

Service Coordination in these programs is a service that assists a participant in gaining access to needed waiver and program services, medical assistance state plan services, and other medical, social, and educational services regardless of funding source. This includes developing plans that include multiple funding sources and varying levels of formal and informal support.

Four online training modules were developed to cover the requirements and best practices required to perform service coordination. These modules are:

* Roles and Responsibilities,
* Funding and Service Delivery Models,
* Developing Service Plans, and
* Monitoring and Updating Service Plans.

Before we move on, let’s take a moment to review some terminology.

## Terminology Updates

A person’s physical and cognitive ability are assessed to determine if they are eligible for the program. This may be referred to as functional or clinical eligibility.

In the enrollment phase, an individual’s clinical eligibility is assessed using two different tools, based on the program.

Let’s start with the Act 150 program. The Functional Eligibility Determination (FED) tool is used to determine clinical eligibility. Along with the Physician’s Certification, the FED determines whether the individual is Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI). The FED is updated during the annual reevaluation.

Now, let’s look at OBRA. The FED tool is also used with the Physician’s Certification to determine clinical eligibility. The level of care for OBRA is called Intermediate Care Facility/Other Related Conditions (ICF/ORC).

In addition to determining an individual’s physical and cognitive capabilities, the enrollment process also assess their long-term services and supports needs. The needs assessment tool for both Act 150 and OBRA is the Care Management Instrument (CMI).

A participant’s plan in both Act 150 and OBRA is called the Individual Service Plan (ISP). Service plans document a participant’s goals, services, risks, and mitigation strategies.

# Funding and Service Delivery Models

In this module, we’ll explore the funding sources available to program participants and service delivery models that participants may select.

## Objectives

After completing this module, you will be able to:

* Identify resources and programs available to fund long-term care services.
* Describe service delivery models.

During emergency situations when the Governor issues a disaster emergency declaration, OLTL may need to make temporary changes to the OBRA waiver through an Appendix K amendment, to allow flexibilities in responding to the emergency.

OLTL may also decide to allow similar flexibilities in the Act 150 Program. If OLTL elects to allow temporary flexibilities to a waiver or Act 150, OLTL will inform providers of the approved changes through a ListServ email.

## Medical Assistance

Let’s get started by reviewing Medical Assistance Services.

Medicaid, referred to in Pennsylvania as Medical Assistance (MA), is health insurance provided to income-eligible Pennsylvanians. It is funded by both the federal and state governments and is administered by the Department of Human Services. This program purchases health care for over 2 million Pennsylvanians.

Pennsylvania’s State Plan outlines the Medical Assistance program for CMS, the federal agency that oversees Medicaid.

MA services for adults cover both physical and behavioral health.

MA physical health services include:

* Inpatient and outpatient hospital services,
* Durable Medical Equipment (DME),
* Occupational, physical and speech therapies,
* Non-emergency medical transportation,
* Prescriptions,
* Physician visits,
* Nursing facility care,
* Family planning services/supplies,
* Home health services, and
* Laboratory and X-Ray services.

MA behavioral health services include:

* Psychiatric counseling,
* Inpatient and outpatient treatment,
* Therapies, and
* Prescriptions.

Service Coordinators are expected to coordinate planning and implementation with MA and other public program case managers. This is to ensure that needs are met, gaps are covered, services are accessed and exhausted appropriately, and that there is no duplication in services. Please note that transportation to access these services is provided through the Medical Assistance Transportation Program (MATP).

MA State Plan Services must be accessed and exhausted before waiver services. SCs work with the MA case managers on these items. Let’s look at some things that relate MA funding.

### Check the State Plan

SCs should always access the state plan when developing service plans.

It is important to understand the state plan and how to access the documentation. For assistance with accessing/funding services and coordination of care, SCs may reach out to the participant's MA insurance plan case manager.

Waiver services can only be used if a needed and justified service is not covered or has been denied by the MA providers.

### Document denials

SCs must keep documentation of denials on file and note the denials in the Home and Community Services Information System (HCSIS). Denial documentation includes prescriptions, recommendations, justification of need, and any other correspondence with the denying entity.

The denial is issued to the participant and may be a written decision notice from the MA Physical Health MCO or a Notice of Decision from OMAP. SCs should obtain written copies of the denial document.

### Submit service requests

SCs should not submit service requests for services or items that might be covered under the state plan without the Notice of Decision or a written decision notice from the MA Physical Health MCO.

### Check with MA provider or OMAP

If SCs do not know if a specific service or item is covered by the State Plan, they can check with an MA provider or case manager.

If SCs think that a provider has given them incorrect or incomplete information, they can contact OMAP for clarification.

Information about the MA state plan and other information sources are in the Resources Document.

## Medicare

Medicare is health insurance for people 65 or older, people under 65 with certain disabilities, and people of any age with End-Stage Renal Disease (or ESRD). ESRD is permanent kidney failure requiring dialysis or a kidney transplant. Medicare is funded by the federal government.

Medicare has multiple parts that cover specific services.

* Part A (Hospital Insurance) covers inpatient hospital care, skilled nursing facility, hospice, and home health care.
* Part B (Medical Insurance) helps cover doctors’ and other health care providers’ services, outpatient care, durable medical equipment, and home health care. It also helps cover some preventative services to help maintain health and keep certain illnesses from getting worse.
* Part C (Medicare Advantage) offers health plan options run by Medicare-approved private insurance companies. Medicare Advantage Plans are a way to get the benefits and services covered under Part A and Part B. Most Medicare Advantage Plans cover Medicare prescription drug coverage (Part D), and some may include extra benefits for an extra cost.
* Part D (Prescription Drug Coverage) helps cover the cost of prescription drugs.

The Medicare program is administered and funded by CMS. Its services are delivered by private insurance companies.

It is important for Service Coordinators to be aware of services that Medicare covers. For the most part, Medicare does not cover long-term care needs. However, parts of service plans such as medical equipment and some preventative services may be covered. Medicare coverage must be accessed and exhausted before waiver funds can be used.

Service Coordinators should discuss Medicare with participants to confirm areas of coverage and any associated fees. If the participant is not sure of their plan or coverage, Service Coordinators (with participant involvement) can call the Medicare case manager.

## Third Party Liability/Resources

Third Party Liability (TPL) refers to the legal obligation of third parties to pay all or part of the expenditures for the care of an individual eligible for MA. By law, MA is intended to be the payer of last resort; all other available third-party resources must meet their legal obligation to pay claims before MA pays for the care of an eligible individual.

Third Party Resources (TPRs) are used to pay for participant services. TPRs include Medicare, TRICARE/CHAMPUS, workman’s compensation, for-profit and nonprofit health care coverage, insurance policies, and other forms of insurances.

Service Coordinators will see both of these terms and acronyms, TPL and TPR, in documentation and regulations. The key concept to keep in mind is that third party sources of funding must be accessed and exhausted before waiver funds can be used.

Examples of third parties that may be liable to pay for services include:

* Medicare
* Private health insurance
* Employment-related health insurance
* Court-ordered health insurance derived by non-custodial parents
* Court judgments or settlements from a liability insurer
* Workers’ compensation
* First-party probate-estate recoveries
* Long-term care insurance
* Other state and federal programs (unless specifically excluded by federal statute)

## Informal Supports

Another key element in developing a service plan is to understand a participant’s informal support system. Informal supports can include family, neighbors, friends, and others who are able to provide individual services and agree to do so.

Informal supports must be noted in the service plan. Other people in the household are considered potential informal supports and identified in the "household composition” section of the Individual Service Plan form. The SC assesses the degree of informal support available and provided as part of the planning process.

Not everyone has informal supports in their lives. Some waiver program participants live alone, have no family, and have no close friends near their homes. Other participants may have local family members who cannot or will not provide support and they are not forced to do so.

Service plans can reflect these situations and assign services accordingly. It is important for SCs to discover the existence (or lack of) these informal supports in each person’s life and to document if and how these people can support participants in fulfilling service plans.

### Community Supports

In addition to the federal and state programs that support Home and Community-Based services, you should be aware of the available resources in a person’s local community.

Community resources could include formal and informal services and supports, such as:

* Religious group programs,
* Senior community center programs,
* Local transportation programs,
* County based programs, and
* Nonprofit organization programs.

The availability and type of community supports vary widely across Pennsylvania. If there are no community services available to meet specific needs and goals . . . that is okay. Service Coordinators must document that they checked for specific services and that none are available.

To assist you in identifying local resources, call 211 and check with the local PA Link to Aging and Disability Resources. 211 and the PA Link compile and maintain lists of resources in their local areas. Links to 211, the PA Link, and other resource organizations are available in the Resources Document.

## HCBS Waivers & Programs

What are waiver and other public programs? Prior to waivers, people could only receive long-term care in nursing or other specialized facilities.

“Waiver” means that the federal government “waives” the Medicaid/Medical Assistance rules for institutional care in order for Pennsylvania to use the same funds to provide services and supports for people in their own communities. The federal government matches Pennsylvania’s spending for covered waiver services.

Waiver programs offer services not traditionally covered under health insurance programs.

HCBS waiver programs can include “extended” State Plan services. Extended State Plan services are provided to participants whose needs exceed the scope and duration of what is in the MA State Plan.

### Program Services

Now, let’s take a look at services that programs may include and services and supports that are not included; these are not comprehensive lists. Make sure you check the participant’s specific program and waiver to verify which services are included.

As a reminder, state plan and third-party liability services must be accessed and exhausted before using program services.

Act 150 program services may include:

* Personal Assistance Services (PAS)
* Personal Emergency Response Systems (PERS)
* Service coordination

OBRA program services may include:

* Adult Daily Living
* Employment Skills Development
* Job Coaching (Intensive and Extended Follow-along)
* Personal Assistance Services
* Residential Habilitation Services
* Respite
* Service Coordination
* Structured Day Habilitation Services
* Behavior Therapy Services
* Nursing Services
* Occupational Therapy Services
* Physical Therapy Services
* Specialized Medical Equipment and Supplies
* Speech and Language Therapy Services
* Community Integration
* Community Transition Services
* Counseling Services
* Home Adaptations
* Job Finding
* Non-Medical Transportation
* Nutritional Consultation
* Personal Emergency Response System
* Prevocational Services
* Supported Employment
* Vehicle Modifications

Make sure you check the participant’s specific program and waiver to verify which services are included.

Services and supports that are not covered are:

* Room and board
* Non-emergency medical transportation or NEMT (People use the Medical Assistance Transportation Program, MATP, for this.)
* The same services covered by the State Plan, unless those services are exhausted
* Vocational rehabilitation
* Services for which the public schools are expected to fund or pay
* Recreation
* Guardianship
* Institutional services
* Home modifications for the purpose of increasing the living space of a home
* General home repairs/home modifications that add value to the home and do not aid in providing independence
* Companionship services
* Services for people who don’t meet the waiver and program eligibility requirements

Previously, there was a classification of “chore or homemaker services.” These are not service definitions in Act 150 or OBRA. Please use the current service definitions for the scope of each service to be provided. Service definitions are included in program documentation.

To review the most current information on each program’s requirements, services, and other specifics, always check the individual program online. The link to online information can be found in the Resources Document.

## Freedom of Choice

Freedom of choice is an essential component of waiver services. Participant choice is a requirement for states to receive federal funding for waivers. Not only must the participant have choice at all steps in the process, but the Service Coordinator must also document that the participant was offered choice at each step in the process.

Each HCBS program participant has the freedom to:

* Select an institutional or community-based setting in which to receive services.
* Choose among OLTL programs for which the participant is eligible.
* Choose a Service Coordination Entity to provide planning services.
* Choose among available service providers.
* Request an assignment or change in Service Coordinator or Service Coordination Entity.
* Participate in all decisions related to services and plan development.

## Lesson 1 Knowledge Check

Now check your understanding by answering these review questions.

1. True or False? Medicare covers most long-term care services for people over age 65.

Please pause.

The correct answer is False. Medicare does not cover most long-term care services, only a few specific services.

2. True or False? If a participant has a family member living in the home, the family member is required to provide at least 10 hours of care per week if he or she is physically able.

Please pause.

The correct answer is False. Family members or other household members are not forced to provide care for program participants.

3. True or False? "Waiver" means that the federal government waives the requirement for Medicare and Medicaid funding to be accessed and exhausted first.

Please pause.

The correct answer is False. "Waiver" means that the federal government waives the Medicaid/Medicare rules for institutional care so that people can receive services at home.

4. True or False? The best place to research program eligibility and services is in the OLTL Home and Community-Based Services Program Manual.

Please pause.

The correct answer is False. The best place to research program eligibility and services is in the individual OLTL program online. Links to each program are listed in the Resources Document for this module.

5. True or False? Once a participant selects a Service Coordination Entity, they must work with that agency for one plan year.

Please pause.

The correct answer is False. Participants are free to change SCEs and Service Providers as they see fit.

6. Where are Medical Assistance services are listed?

Medicaid Assurance Portal

State Plan

Medical Assistance Site

Please pause.

The correct answer is that Medical Assistance services are listed in the State Plan.

7. If a 27-year-old participant with traumatic brain injury requires physical therapy, which funding source is primary?

Medical Assistance

Medicare

Act 150

OBRA

Please pause.

The correct answer is Medical Assistance. Medical Assistance would be the primary funding source. Service Coordinators should always access the state plan when developing service plans. Waiver and other OLTL program services can only be used if a needed and justified service has been denied by the Medical Assistance providers.

8. True or False? Waiver programs are "payers of last resort" because all other funding sources, programs, and resources must be accessed and exhausted first.

Please pause.

The correct answer is True. State plan and third-party liability services must be accessed and exhausted before using waiver services.

## Service Delivery Models

Now, let’s talk about service delivery models.

A service delivery model is how a participant wishes to receive and manage their PAS and respite services. The models provide participants with a choice. Participants can choose to have an agency manage their care workers or may choose to directly manage their care workers.

There are two basic service delivery models in fee-for-service—the Agency model and the Employer Authority model. The Employer Authority model only applies to personal assistance services and respite services. Both models have benefits and potential risks. SCs must explain both delivery models as part of the service planning process. Participants choose their preferred service delivery model. The choice of model influences how SCs develop and monitor plans. This choice must be documented as part of the planning process.

As you just learned, Service Coordinators must explain both of the delivery models as part of the service planning process. Let’s explore each model in greater detail.

### Agency Model

This model is considered to have the lowest level of participant responsibility when managing their services. Participants can choose among agencies and often among staff at agencies.

#### Employer Responsibilities

Under the Agency model, the home care or home health agency is the employer of a participant’s care workers. The home care or home health agency is responsible for hiring, firing, scheduling, payroll, training, and supervisory activities for each employee.

#### Billing and Payment

Under the Agency model, the care worker wages are paid by the home care or home health agency. The home care or home health agency bills for services as authorized in the participant’s service plan. The agency is reimbursed after services are delivered.

#### Staffing

The agency is responsible for staffing the hours required on the service plan regardless of whether a specific care worker is available or not.

Agencies must prepare for, manage, and cover sick days, vacations, and other absences of primary care workers. Failure of an agency to cover shifts that results in a health or safety risk to a participant is a reportable critical incident.

### Employer Authority Model

Under the Employer Authority model, the participant is the employer of their care worker. This provides the participant with a higher level of involvement and a higher level of responsibility.

The participant is responsible for hiring, firing, scheduling, training, and supervisory activities for each employee. Care workers can be anyone who is qualified and able to perform the tasks in the service plan. Care workers cannot be spouses, legal guardians, individuals who are the participant’s assigned power of attorney, or representative payees. As such, this model requires participants or their designated common law employer to have the capacity and competence to make employment decisions and to manage, train, and supervise workers.

Under the employer authority model, the participant must follow OLTL policies and procedures when managing their care workers. Please note that when we use the word participant in the Employer Authority Model, it refers to the participant or their designated common law employer.

Let’s learn about participant responsibilities.

#### Schedule Adherence

Participants are responsible for ensuring that their care workers follow the specifics of the service plan. This includes delivering services in the type, scope, amount, duration, and frequency listed on the plan on the dates and times noted on the plan.

#### Safe Work Environment

Participants must provide a safe work environment for their direct care workers. Safe work environments may include attention to animals in the home, pest infestations, hoarding, oxygen use, etc.

#### Training

Care workers must be trained on proper procedures and safety guidelines necessary to deliver the services on the service plan. Examples include transferring, toileting, operating lifts, etc.

#### EVV

Electronic Visit Verification (EVV) is a system used statewide to capture data relevant to service delivery. Care workers must use EVV to document the services they provide each day. Participants are responsible for monitoring all components of their care workers use of EVV and ensuring improvement when necessary.

#### Employer Authority Responsibilities

Service Coordinators must monitor the participant’s supervision of their workers. Because participants are the employer, they must plan for and manage times when the primary care worker is unavailable. Back-up planning is essential, as is having multiple layers of shift coverage. If care workers do not “show up” for work and the health or safety of the participant is at risk, it is a reportable incident depending on the condition of the participant. Multiple absences can lead to health and safety issues for the participant. The model requires participants or their agents to effectively manage schedules and multiple layers of backups to cover all needed shifts.

Who pays the care workers? Medicaid law prohibits an individual or representative from receiving Medicaid funds directly. Only Medicaid providers may receive Medicaid funds directly. Due to this requirement, a Fiscal/Employer Agent (F/EA) must perform payment-related employer responsibilities on behalf of participants who use this model. The F/EA activities are called Financial Management Services (FMS).

### Interim Plans

An interim plan to receive and manage services is essential for participants who choose the Employer Authority model. Enrolling with the FMS provider takes time. It could also take time for the participant to recruit, hire, and train care workers. Participants need their services during this period.

Service Coordinators must plan for at least a 30-day window (or longer) for the Employer Authority model services to start. An interim solution could be for the participant to receive services from informal supports or from an agency. Service Coordinators must include the interim plan to address how an individual will meet their needs during the time that they are waiting to be enrolled with the FMS. OLTL may reject a service plan if Service Coordinators fail to include an interim support plan of action.

## Blending Models

Participants are not locked into one specific model. They can choose to blend service models. The breakdown of services between models is defined in the participant’s Individual Service Plan.

For example, Mrs. Smith has 40 hours per week on her service plan. She uses 30 hours Monday through Friday on ACME Home Care Agency. For 10 hours on the weekend, she employs her neighbor, Mrs. Jones. ACME Home Care would be paid for the 30 hours, and the FMS provider would pay Mrs. Jones for 10 hours.

Under both models, service coordination services are the same. Service Coordinators assist participants in gaining access to needed services.

This means working at the direction of the participant whenever possible to identify, coordinate, and facilitate services and to ensure that services are rendered in the type, scope, amount, duration, and frequency stated in the service plan.

## Ensuring Freedom of Choice

Even if the participant does not opt to direct their service delivery, Service Coordinators must ensure that participants choose their providers and services.

Service Coordinators must provide participants with information regarding choice of any willing and qualified providers, and then assist participants in filling out Participant Provider Choice and Freedom of Choice forms.

The Participant Provider Choice form designates a participant’s selection among available service providers. The form is completed at enrollment and at reevaluation.

The Freedom of Choice form designates the participant’s selection among HCBS and institutional settings. Service Coordinators must verify in writing that the participant has been informed of freedom of choice at each reevaluation. The Service Coordinator must note this in the participant’s case file and maintain the form.

## Lesson 2 Knowledge Check

Now check your understanding by answering these review questions.

1. True or False? In the Agency Model, there is no risk of an interruption in service.

Please pause.

The correct answer is False. There could be a lower risk receiving services from an agency with more than one employee than there is receiving services from an individual that the participant employs. However, in each case, back-up plans are essential in case the agency, or the individual care worker fails to deliver services.

2. True or False? In the Employer Authority Model, participants receive funds from the program to pay their care workers.

Please pause.

The correct answer is False. Medicaid law prohibits individuals from receiving funds directly. A Fiscal/Employer Agent performs payment-related activity on behalf of participants.

3. If a 67-year-old participant wants to employ her son as her care worker, which model would she use?

Agency Model

Employer Authority Model

Please pause.

The correct answer is the Employer Authority Model. It permits participants to employ care workers. Care workers can be anyone except spouses, legal guardians, power of attorney, or representative payees.

4. If a 62-year-old participant has no experience in management or finances and has no informal supports in the area, which service delivery model would pose the greatest challenges?

Agency Model

Employer Authority Model

Please pause.

The correct answer is the Employer Authority Model. It could pose challenges if the participant has no experience hiring, training, and managing staff.

5. True or False? To decrease costs, participants select one model for all of their services.

Please pause.

The correct answer is False. Participants can blend models in their service plans, receiving some services from agencies and other services from care workers who are employed directly by the participant.

6. True or False? By law, it takes thirty days or fewer to implement the Employer Authority Model for a participant.

Please pause.

The correct answer is False. Service Coordinators must develop an interim plan for at least a 30-day window (or longer) for Employer Authority Model services to start.

7. True or False? Service Coordinators are responsible for training and scheduling care workers if a participant uses the Employer Authority Model.

Please pause.

The correct answer is False. The participant is responsible for hiring, firing, scheduling, training, and supervising direct care workers in the Employer Authority Model.

8. True or False? The Agency Model requires the least responsibility on the part of the participant.

Please pause.

The correct answer is True. The Agency Model is considered to have the lowest level of participant responsibility. The service provider handles all aspects of employment (except choosing the agency and providing feedback on performance).

# Funding and Service Delivery Models Summary

In this module, we reviewed the funding sources available to pay for services and service delivery models that allow participants to choose the level of responsibility that works best for them. Please review the Resources Document for this module for additional information.

# Congratulations!

Congratulations. You’ve completed the OLTL Service Coordination Funding and Service Delivery Models training.

If you have read the contents of the entire module, register your completion of this module by going to this [webpage](https://oltl.deringconsulting.com/service-coordination-funding-and-service-models-training-completion/).