Attachment B

Guidance to Service Coordination Entities (SCE) When Converting Service Coordination Service from an Hourly, Weekly, or Monthly Unit to a Quarter Hour Unit

Converting Service Coordination Service (effective July 1, 2012)

The purpose of Attachment B is to provide guidance to Service Coordination Entities (SCE) when converting Service Coordination Service from an hourly, weekly, or monthly unit to a quarter hour unit. In addition, Attachment B provides guidance to SCE when requesting additional units.

Service Coordination

Services that will assist individuals who receive Office of Long-Term Living (OLTL) services in gaining access to needed waiver services and other State Medicaid Plan services, as well as medical, social and other services regardless of the funding source. Service Coordination is working with the participant whenever possible to identify, coordinate, and facilitate all necessary services.

HCBS Waivers are the payor of last resort. Funding from other sources, if applicable, are to be used for services such as information and referral.

- Service Coordination also includes: completion of needs assessment, advocacy, arranging for services from local resources, and coordination of services so a participant can realize his/her identified goals for living independently in the community.

- Activities of a Service Coordinator (SC) include:

    - performing level of care re-determinations annually, or more frequently if needed (Please note that this does NOT apply to service coordination in the Aging Waiver where Level of Care Assessments and re-determinations are a Title XIX administrative function);

    - maintaining current documentation of the participant's eligibility for waiver services, copies of the participant's individual service plan (ISP) and service plan addendum, financial data and related information;

    - providing information and assistance to participants regarding self-direction;

    - informing participants of rights, responsibilities and liabilities when choosing a service model;

- monitoring the health and welfare of the participant and the quality of services provided to the participant through personal visits at a minimum of twice per year, telephone calls at least quarterly or as defined in the service plan – monitoring can be more frequent, but not less frequent than specified in this definition

- providing notice of amount and frequency of waiver services;

- working with the participant to develop a comprehensive service plan – including risk identification – that meets their needs, preferences and goals;

- reviewing the service plan at least once a year or more frequently, if the needs of the participant change;

- ensuring that services are provided as planned and delivered appropriately to meet the participant's needs;

- facilitating the comprehensive ISP development process;

- gaining access to needed State Plan and HCBS services, as well as needed medical, social, educational and other services, regardless of the funding source;

- tracking and conducting ongoing review of service delivery; and

- documenting and recordkeeping including contacts with individuals, families and providers.

Examples of what Service Coordination does not include:

- Nurse (RN) review of each service plan (nurse consultation is to be provided only if an assessed need is documented by the SC)
- RN home visits as a component of the service coordination service
- Serving as a representative payee
- Health promotion and prevention services
- Services that are directed to primarily support the needs of participant family members

Frequency of Service Coordination Contact

§ 52.26. Service coordination services.

(a) To be paid for rendering service coordination services, an SCE shall meet all of the following:

4) Review the participant need, the participant goal and participant outcome with the participant, and other persons that the participant requests to be part of the review as required by conducting all of the following: (i) At least one telephone call or face-to-face visit per calendar quarter. At least two face-to-face visits are required per calendar year.

Documentation of Services Delivered

In order to fulfill that responsibility and to be compliant with **§ 52.26. Service coordination services,** the service coordinator shall document in the designated areas of Home and Community Services Information System (HCSIS) or Social Assistance Management System (SAMS) at a minimum the following information captured during participant contacts:

- Whether a contact was a home visit, telephone call or email contact;
- Whether the participant reported receiving the amount of goods and services specified in the ISP;
- Whether the participant reported receiving the frequency of services that are in ISP;
- Whether the participant reported receiving the authorized services specified in the ISP;
- Whether the participant confirmed that and/or SC concluded that the services indicated in the ISP are appropriate in supporting the participant with reaching his/her goals;
- Whether the participant confirmed that and/or SC concluded that the duration of services in the ISP needs to be continued, extended or concluded;
- Whether the participant reported any change in health status or other events (such as a hospitalization, scheduled surgery, etc.) or changes that might impact his/her ability to perform activities of daily living that prompt a need for temporary or permanent changes to service delivery or other follow-up to identify what discharge services are and are not being provided through the participant's health insurance;
- Whether the SC had contacts with participants, families or providers;
- Any communication regarding service plan changes to the participant and the appropriate service provider(s);
- Any reminders or prompts given to the participant of "next steps" and/or his/her responsibilities; and
- The amount of times a participant has utilized his/her individualized back-up plan and if it is effective.

What constitutes a unit?

15 minutes equals one unit. Agencies are able to round up from 7½ minutes of a billable activity with proper documentation to constitute a unit.

Number of units

The number of units after the conversion will fluctuate based on participant utilization and individual needs. Additional units may be requested through your regional Bureau of Individual Support (BIS) representative.

Process to Request Additional Units

Service Coordinators have the flexibility of scheduling the hours that meet the individual needs of each participant. For example, a participant that is new to waiver services may require more hours of service coordination at the beginning of services, and fewer hours several months later.

If a participant is unable to have their needs for service coordination met with 144 units per year, OLTL will consider requests for additional units. Requests for additional service coordination units cannot be submitted until 75% of the original authorized units have been used. The service coordinator should submit a request for additional units through the regional BIS representative.

Requests for additional units must be submitted through HCSIS and SAMS. Requests must include justification of why the initial amount was not enough and how the additional units will meet the needs of the participant. Specifically, this includes:

- Identify the changes in the participant's condition, circumstances, informal supports, or any other changes that warrant the request; and
- Provide justification related to the identified changes and how additional service coordination units will meet the identified needs.

This information must be entered on the Service Notes screen or Journal Notes. The Service Coordinator will assess the need for service coordination and adjust the service plan as necessary throughout the year and annually.

Billable vs. non billable activity

	Billable	Non-Billable
Facilitate and participate in needs assessment	x	
Development of service plan	x	
Coordination of service plan services	x	
Coordination of service plan services with providers	x	
Coordination of service plan services with others as necessary to meet participant's needs	x	
Participant assistance	x	
Inform participants about services	x	
Assist participants in accessing services	x	
Inform participants about hearing and appeal rights	x	
Assist participants in exercising hearing and appeal rights	x	
Ongoing management of service plan	x	
Documentation supporting management of service plan	x	
Face-to-face visits (at least the minimum number required by the program and based on changes in participant's needs)	x	
Review of the service plan (at least annually and based on changes in participant's needs)	x	
Facilitate the resolution of barriers	x	
Disseminate relevant information necessary for service delivery	x	
Exchange information with the participant's family when relevant to the service plans and service delivery	x	
Respond to emergency situations and assist in meeting the needs of the participant	x	
Respond to and assess incidents and assure appropriate actions are being taken	x	
Evaluate participant progress	x	
Monitor participant and/ or representative satisfaction with services	x	
Arrange for modifications in service and service delivery	x	
HCSIS and SAMS documentation	x	
Obtain service authorizations	x	
Communicating relevant authorization information to service providers	x	
Assisting and obtaining participant required information	x	
Provide participant and/ or representative with information on participant directed options	x	

Assist with transition to participant direction if chosen	x	
Assistance to participant in directing their services	x	
Conducting program eligibility determination or redeterminations	x	
Assisting participant employers in managing personal assistants	x	
Service plan development prior to service plan approval	x	
Other services available under the waiver or state plan		x
General educational activities – (such as training, meetings, have been factored into the Service Coordination rate)		x
Transportation for participants not directly related to service coordination		x
General information not related to specific participant services		x
Coordination or outreach prior to participant enrollment in the waiver		x
Payee or other financial management services		x
Conducting Medicaid financial eligibility determinations or redeterminations		x
General program outreach – (such as community education programs)		x
Coordinating any burial or funeral arrangements		x
Travel – (travel time and expenses, such as mileage and tolls, have been factored into the Service Coordination rate)		x
Billing OLTL		x