Self-Direction Technical Requirement Frequently Asked Questions

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Self-Direction Technical Requirement and Implementation Guide, Effective 3/1/2024

Self-Direction Technical Requirement Implementation Guide (Michigan.gov)

This FAQ has been developed based on questions and feedback received from stakeholders administering and utilizing self-direction in Michigan.

**FAQ will be updated as needed.*

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A. Requirements

The decision to implement self-determination as a matter of policy for the public mental health system has already been made.

- Self-Determination and self-directed arrangements is a contractual requirement.
- All currently available models of Self-Direction must be made available to all population and age groups.
- With recognition that all PIHPs and their affiliates are not in the same place with their implementation efforts, there should be observable progress being made toward accomplishment of the Technical Requirement and Implementation Guide.
- MDHHS expects and will help facilitate a good-faith local effort to pursue and achieve implementation. Training and Technical Assistance is available and will be provided on and individual basis, as requested.
- Local implementation efforts need to include significant involvement of people using services, family members and advocates in the process of design, participation and evaluation of these efforts.

See Self-Direction Technical Requirement for additional contractual requirements

B. General Questions

1. Is there a recommended arrangement to provide supports through self-determination?

There is no one option or arrangement that will work for everyone at any given point in time. Effort should be made to ensure people understand the available models and the responsibility and control unique to each model. Considerations should include:

a. Arrangements should best fit best the person's goals and preferences, flowing from the policy and the elements of the practice guideline.

b. Arrangements must be easily navigated by the person (or, as applicable, his/her chosen representative).

c. Care should be taken to ensure the needed level of support exists for the person to be successful in the chosen arrangement.

d. There is a range of options that can provide greater control and direction for a person. Someone may utilize more than one model at the same time.

The 3 models currently available:

1. **Direct employment**
2. **Purchase of service**
3. **Provider with choice**

2. What responsibility do PIHP/CMHSPs have in Self-Directed Arrangements?

PIHP/CMHSPs must assure that:

- Medicaid funds are expended for services and supports that are necessary to accomplish the goals, objectives and/or outcomes in the person's IPOS.
- Funds are paid to a qualified provider of the Medicaid covered or alternative services/supports.
- Transactions are based upon purchase of service or employment agreements.

Since these are Medicaid funds, the Center for Medicaid & Medicare Services (CMS) has required that a separate "provider agreement" between the provider furnishing services and the PHP/CMHSP be in place.

See SD Technical Requirement Implementation Guide for additional specifics on roles and responsibilities.

3. Can the person be the employer of record?

The person who is using the services should be the employer of record.

Employer of record is the person who is legally responsibility for the tax aspects of employment; it is the person in whose name the tax identification number is obtained. That person is legally responsible, meaning that if something does wrong, his or her assets are at risk. In practice, the FI/FMS handles these responsibilities on behalf of the individual and the financial liability is minimized. However, if a guardian or representative is the employer of record (meaning the tax identification number is obtained in guardian's name), then that liability extends to his or her assets.

As a best practice, it is strongly discouraged for a guardian or representative to become the EOR.

A distinction should be made between an **Employer of Record** and a **Managing Employer**.

Someone may choose to have a representative act as the managing employer. In cases where the person has a legal guardian with authority over contracts, the guardian should be the managing employer.

4. If the person is to be the employer, are there any required criteria to determine competence as an employer?

No. The presumption is that an adult person is competent unless a court has deemed otherwise.

See SD Technical Requirement Implementation Guide for additional specifics on support, information and assistance.

5. Can someone use SD in a segregated setting, such as an AFC or Day Program?

No

A. Can a self-directed arrangement be combined with Day Programming? For instance, an individual who wants to participate in community activity with program but requires a level of assistance that the day program cannot

accommodate - Could the person bring SD staffing and bill for both SD CLS and Program CLS?

As the question is posed, the answer is NO. Not only can those services not be billed concurrently, **segregated settings are identified as settings where SD arrangements cannot be utilized** as the person has zero control of budget, schedule or staff.

However, if the person wanted to hire staff using a self-directed arrangement to access the community- separate from the day program - then yes. If the person wants to reduce the day program hours and replace those with staff through a SD arrangement for the same goals, also yes.

B. Can someone living in a contracted specialized residential (where CMH funds the CLS and PC in the home but the staffing at the home is minimal), use SD to access the community more fully? (not specifically to work on moving to a more independent setting).

Individuals who are living in a Specialized Residential Setting are not able to self-direct their budget, however they are able to access additional CLS services through a separate provider. The individual plan of service should reflect goals and objectives related community access through this CLS service and the CLS service must be provided in the community.

6. Is there one MDHHS approved "SD Handbook"?

There is not currently one approved SD Handbook.

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C. Provider Qualifications

***** *For an inclusive list of Provider Qualifications, please see Self-Direction Technical Requirement and Implementation Guide.*

1. Can a person hire any provider he or she chooses?

All providers must meet the minimum Medicaid Provider Requirements for the service(s) they are providing. There are specific Medicaid limitation on who cannot be paid to provide services (such as guardians).

2. Can a family member, other relative, or someone who shares the same home as the person be an employee for the person?

Yes, a relative or someone who resides with the person may be hired through a self-directed arrangement. Medicaid-funded services cannot be provided by the parent or guardian of a minor or the spouse or guardian of an adult.

3. Can a landlord also be service provider?

When the same person or entity provides room and board as well as 24-hour personal care and supervision for compensation to someone unrelated to him or her, the definition of foster care is met and the arrangement must be licensed pursuant to the Adult Foster Care licensing rules. These issues also arise when the same person is the landlord and the provider or the landlord and managing employer (such as the guardian). See Factsheet: The Use of Arrangements that Support Self-Determination in Shared Living Arrangements.

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D. Individual Budget

1. What rate is used to develop the isb?

In order to establish the maximum amount of Medicaid funds to possibly utilize in the individual budget, **the service cost must not be less than the contracted, provider rate for the same service for the same level of need for that individual.** For example, the PIHP/CMHSP's contracted provider rate for Community Living Service is $20 per hour. If an individual's budget includes the delivery of Community Living Service, then the hourly amount allocated in the individual budget for this service is $20 per hour.

2. What **MUST** be included in the Individual Service Budget?

- Staff pay rate (range), which cannot be determined by the CMHSP/PIHP
- Employment taxes
- Worker's compensation
- Cost of FMS (cannot reduce amount available for services)

3. What **CAN** be included in the Individual Service Budget?

While there is not an exhaustive list, some examples are:

- Mileage
- Paid training
- Meeting attendance (staff)
- Holiday pay
- Paid Time Off
- Built in overtime
- Insurance
- Cost of activities
- Staff Bonus

4. Can someone move money from one line of the Budget to another line?

Yes. If a person directing their budget chooses to move funding between budget lines they can do so. The plan and authorizations will also need to be updated to reflect any changes prior to the change being implemented. Any needed Notice of Advanced Benefits Determination must also be completed.

5. Do all services need to be in an ISB or just those being self-directed?

Only services the person chooses to self-direct should be included in the ISB. The cost of the FMS should also be included, but cannot reduce the amount available for other services.

6. Can time sheets be changed to reflect services with remaining funds in the budget? For example, budget reporting shows CLS is out of funds, but Respite dollars remain at the end of a plan of service/budget year. Can the CLS service code be changed to Respite to accommodate the hours worked by the employee?

   If the service has already been provided as CLS, NO. The service provided cannot be reported as a different service (i.e. CLS to Respite). If services have not yet been provided, adjustments can be made to the budget to move money from the under-utilized line to another.

7. Are there limitations on who can be paid mileage/transportation reimbursement? For example, can a parent be paid for staff to use the parent's accessible vehicle?

   Mileage reimbursement should be paid to whoever is paying the cost of the mileage/gas. At this time the travel line item cannot be used to reimburse parents.

8. From the Technical Guidance regarding budget development: *"The line item would be calculated by multiplying the number of units by the cost per unit. (units vary, some are 15-minute units, while other may be per encounter). Begin with the allowable contracted provider rate, then deduct the employee's benefits from that rate. This will establish a range of pay for the employee wages."*

   A. Is this just the method to determine the budget developed for Michigan CMH/PIHP or is this method directed by CMS to be used for all Medicaid funded self-directed services?

   Yes, this is the method for Michigan, however, it is quite common across the country

   B. What would be "employee benefits" that need to be deducted?

   Employee benefits are any benefits outside of a pay rate. Some examples: bonuses, paid time off, health insurance, sick leave, mileage, raises, stipends for work related expenses if needed, etc. There are other costs that need to be factored into the total budget amount, such as paid training, taxes, worker's comp, etc.

   C. Is the CMH/PIHP required to disclose the provider rate information to participants when developing the budget?

   There is no mandate that the CMH provide the provider rate, however the provider rate should be used to develop the budget, so should be evident through budget development process, including often being reflected on the Estimated Cost of Service.

   D. If the contracted provider is paid $25/hr is the top rate available to SD staff $25/hr?

No. The provider rate is used to develop a budget amount and does not equate to pay rates, which are determined through a process after the budget amount has been established.

E. If approved for 39 hours/week of CLS, then the yearly budget would be $50,700? And that is budget amt. just for CLS?

Yes. The top of the budget differs from the available wage/benefits an employer can afford to pay staff within that budget. Determination of what is included within the budget should occur during planning with the person.
The expectation is that the system (CMH and/or FMS) engages in a transparent budget development process that ensures the employer is educated on what can be included in the budget and how choices will impact the current and future budget - with thoughtfulness about future raises/rewards for longevity and or excellent performance, turnover, and the type and intensity of work the employees will be performing.

9. Are overtime wages required for family members who provide care?

The Fair Labor Standards Act (FLSA) defines overtime wage requirements and any exceptions to those. In general, overtime must be paid unless the worker is determined exempt.

10. Can employees be paid mileage for travel to the employer's home (place of work)?

The rate for CLS workers can include reimbursement for mileage for the cost of traveling to and from work.

11. Technical Budgeting Questions:

A. To add a health insurance supplement, do I subtract that from total units after the budget is calculated thereby reducing hours of service or wage?

The cost of PTO or insurance would need to be factored into the overall allowed budget cost – preferably at the beginning, though it can be added in later. It should not reduce the amount of hours available, but would reduce the amount available for hourly wage and other benefits like mileage or paid training.

B. The FMS is NOT a self-directed service and its costs are NOT included in the individual budget. Should this be subtracted from the budget? Or separated so the cost is shown, but reflected as the CMH cost, not the budget amount?

The FMS should be included in the budget as a cost related to the SD Arrangement, but since those dollars cannot be controlled by the individual they should not be included in the budget as a controllable amount.

C. Cost for administrative activities (background checks, credentialing) must NOT reduce the available funding for services". How does that get added to the budget?

This applies only in cases where a separate fee is paid to the FMS for these services (on top of FMS fee). This cost would be budgeted separately, just as the FMS fee. This only includes administrative functions such as background checks and does not include typical overhead costs (workers comp, taxes, mileage, etc).

D. "…MAXIMUM AMOUNT OF Medicaid funds used in the budget" – this is per individual budget, not a maximum we won't exceed of any budget, correct?

Correct – This is not an arbitrary 'max SD budget' amount and must be based on the contracted rate for the same service. Since every budget is developed individually, each person's max budget amount may be different.

E. We have to use the contract provider rate for the budget. What rate do we use if we have multiple provider rates for the same service? Do we have to use the highest rate?

As a general rule, the highest average provider rate should be used. However, a higher rate may be requested, if, based on assessed need it is identified that a higher rate is appropriate to meet the individual's needs.

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E. Training

Training Requirements

I. Blood Borne Pathogens:
   a. needed once per employment episode.

II. First Aid:
   a. Good for 2 years and evidence can be simple testing
   b. First Aid training evidence – a training document that reflects date/content name of person trained, and who trained, *we have also accepted tests that confirm passing grade and name or signature of trainer, as evidence.*
   c. CPR was never required as a qualification, nor is it foreseen to be in the future.

III. Individualized IPOS Training:
   a. Annually and as needed, must be trained before working with individual (employer of record can train but must first be trained by SC/CM)

IV. Recipient Rights:
   a. Required every 2 years and is NOT required to be face-to-face. Per "The ORR Investigative Authority Memo" dated 12.11.20: Although employees hired directly by the recipient within a participant-directed arrangement are not considered contracted employees of the CMHSP, they are providing specialty mental health supports and services and utilizing public mental health funding. Therefore, the CMHSP shall ensure that employees directly hired by participants have access to and have completed recipient rights training within 30 days of hire".

V. Emergency Procedures and Preparedness:
   a. Procedures: Beneficiary-specific
   b. Preparedness: Required for all populations. Needed every 2 years.

VI. Ability to communicate expressively and receptively (MPM)
   a. The employer of record will decide if the worker can communicate in a way that allows them to do their job effectively.

VII. Additional Training
Employer of Record must determine any training requirement above those stated.

1. The Self-Direction Technical requirements states:

The CMHSPs/PIHPs must provide education and training to ensure a common understanding of Self-Directed Services is made available throughout its network, including:

- Administrators
- Case Managers/Supports Coordinators
- Direct Support Professionals
- Supports Brokers
- Individuals and their Families
- Agency-based Staff
- Others

Is the requirement that the Self-Direction training is made available as an option or that it is required?

At this point the most important part of the requirement is to "ensure a common understanding of Self-Directed Services". This may require the PIHP to have some requirements to help the field orient to what the focus of self-determination and self-directed services are and how to best implement oversight for each arrangement.

2. What approach should be taken when the CMHSP feels training is needed that is in addition to basic MA required training (due to health and safety reasons)?

The Implementation Guide pages 18-19 states that the CMH staff can "Assist the employer, if desired, to develop a training plan." While MA sets minimum training requirements for providers of a service, the CMHSP should provide information on all available training and can, through the planning process, make recommendations for training. Health and safety concerns should be addressed in the planning process and documented in the IPOS.

3. For a self-directed arrangement, is Emergency Preparedness required for a provider for just the SED Children's Waiver participants or for all children on a choice voucher?

Emergency preparedness is required for all population and age groups utilizing a self-directed arrangement

4. What is a Rapid Training?

A way of getting someone trained quickly – for example, a CMH requires their contracted staff to do face to face only recipient rights training, but only hold a training every 6 months. A rapid training would be online or paper training that gets someone a basic understanding and knowledge of the subject so they can start work with the understanding that they will need to complete the full training in the future.

5. What training or qualifications must be met BEFORE staff can begin working?

- Training in IPOS
- Approved Background Check
- Employment Verification Complete (I9)
- ORR: within 30 days of employment
- All other training requirements can be met using a Rapid Training within 30 days, with any needed full training within 90 days of employment.

6. Non-compliant training issues. To pay or not to pay? Employer schedules a provider that has not completed training or has expired training.

There must be a system in place between the FMS and Employer to ensure training is being tracked and outreach to the employer/employee completed with enough notice to allow ample time to complete.

- Reasonable efforts must be made to coordinate with the employer about their staff's compliance/non-compliance with training requirements.
- Support should be provided for the employer to effectively manage these employee expectations.
- Language in the Medicaid Provider Agreement should address training and provider requirements that reflect staff qualifications and timelines for these.
- Best practice is to proactively engage with the employer and employee to ensure training is completed within the identified timeframe. As a last resort, the cmhsp can utilize the Medicaid Provider Agreement to suspend Medicaid payments to non-compliant employees.

7. CMH's who are not in compliance with new training guidance. How does the FMS respond?

The training requirements must be followed as established in the Technical Requirement and Medicaid Provider Qualifications.

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F. FMS

1. Is the FMS provided a copy of a participant's person-centered plan so they can verify if a support or service has been approved in the plan?

The FMS is provided with a copy of the ISB and spending plan, which includes services and supports approved within the budget that support the goals in the Plan of Service.

2. How does the FMS pay for CLS activity costs such as movie tickets, museum tickets, & other activities where an invoice cannot be obtained?

If there is an activity or cost line in the budget, a receipt can be submitted and the FMS will reimburse.

3. Does the FMS review clinical documentation before paying timesheets?

No. The FMS is not responsible for reviewing supporting Medicaid documentation or making determinations for appropriateness of this documentation.

4. How should FMS process timesheets submitted that are in excess of the budget or authorization?

While prevention should be the approach, there may be times of overlapping timesheets or budget over-utilization.

a. Are they required to pay them due to Labor Laws?

   The employer may be responsible for payment of employees. The employer agrees to stay within the approved budget for the SD arrangement. The FMS cannot be expected to pay funds that the CMH will not reimburse within the arrangement.

b. We won't be able to bill for them so this will affect their overall budget and may cause the employees wages or another area in the budget to be reduced to cover the difference.

   A system should be developed to address any budget overage concerns. This could include reduction of other funds within budget, use of GF, reductions extended to future budgets, etc.

5. Does the FMS still pay staff if the budget is current and approved, but the authorization is late?

Yes. The FMS has a responsibility to pay staff for services approved by the employer and include within the budget. The CMH should not refuse payment to the FMS in these instances.

"Resolving Claims Issues: CMHSPs should follow claims guidance in their contract to work with FMS provider to fix any claim issues. Claim issues should not impact payment of employees." (Page 31 of Self-Direction Technical Requirement Implementation Guide).

6. Does the FMS pay overlapping timesheets?

The CMHSP and FMS should have an established process to handle overlapping timesheets. Only hours in question should be withheld from payment and the issue should be resolved by the next pay period.

"Overlapping timesheets: FMS contacts EOR. EOR is responsible for reviewing and approving all timesheets and documentation. EOR is responsible for ensuring accuracy in all documentation submitted for payment. EOR is expected to provide staff supervision to ensure timely and accurate submission of timesheets and Medicaid documentation." (Page 32 of Self-Direction Technical Requirement Implementation Guide) The EOR may need additional support, training, or tools to better manage employees and checking timesheets for accuracy. It is the responsibility of the CMHSP to support the individual/families to make SD arrangement successful.

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G. MA Documentation Requirements

1. What are the documentation responsibilities of the employer?

The employer has the authority to review and approve employee timesheets and documentation. The employer will decide through the person-centered planning process how their staff will document services provided. The employer will review supporting Medicaid documentation to ensure it meets their standard.

2. Do people who use arrangements that support self-determination have to comply with Medicaid documentation requirements and share records with the PIHP/CMHSP?

Yes, Medicaid documentation requirements do not differ between traditional and self-directed arrangements.

3. Can CMH REQUIRE person document on their form?

No. The employer may choose to use the CMH form, but may also choose their own documentation method, as long as it meets MA requirements. The EOR cannot choose a method of documentation that does not meet Medicaid rules.

"*The employer will decide through the person-centered planning process how their staff will document services provided." "The employer determines how documentation is organized, as long as the documentation:*

Meets Michigan's Medicaid rules

- *Is complete, concise, and accurate, including the face-to-face time spent providing services*
- *Is legible, signed, and dated "*
-

4. Is it appropriate for paid staff to help employer review documentation?

The employer can appoint a 'Lead Staff', whose role can include assisting in managing schedules, back-ups, and reviewing timesheets. The staff cannot do this without the involvement of the employer. If the employer is not able to participate in this process, there should be discussion of the appropriateness of the lead staff, or the use of an unpaid support (such as a representative) or support broker to act in this role (if needed).

5. The person does not want to separate the timesheet from the support note and would prefer to send everything to the CMH and the FMS, is that ok?

While Best Practice is to avoid sending the FMS clinical documentation, the person can choose to keep the timesheet and documentation together. However, in these instances the presence of the documentation must not impact payment of approved timesheets. The FMS must also not have a role in reviewing or monitoring clinical documentation. The person's preference should be documented in the IPOS/SD Agreement.

6. CMH can't deny payment to Employees, but can we make them redo their documentation? And if we can, do they have to be paid for redoing those notes?

Documentation must meet Medicaid documentation standards. If submitted documentation is determined to not meet the standards, best practice would be to coordinate with the employer to have the documentation corrected in a reasonable time frame. CMH also has the ability to require additional trainig in documentation standards as needed. Staff do not need to be paid for time to redo the note, but would need to be paid for the training.

7. Where is documentation housed?

Based on employer preference:

a. Employer may keep
b. Employer may delegate to cmhsp
c. FMS may NOT house clinical documentation.

Decisions about where documentation will be kept and how cmhsp can access as needed will be agreed upon by the employer and cmhsp. The agreed to process should be included in writing in the SD Agreement.

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H. Compliance & Oversight

1. Can CMH require staff to correct documentation that does not meet Medicaid requirements?

The CMH should work with the employer to ensure staff understand MA documentation requirements. The MA Provider Agreement lays out the expectation that staff will ensure documentation meets the MA requirement. The CMH and employer should work collaboratively to ensure documentation that does not meet requirements is corrected.

2. What recourse does CMH have if SD employees refuse to meet MA requirements? (I.e. late training, poor or no documentation, etc)

The MA Provider Agreement reflects requirements staff hired through self-directed arrangements. If staff do not meet these requirements, the CMH should work with the employer to address the concerns.

3. How does the CMHSP assure there is proper documentation of funds expended in the budget for non-service items?

It is the responsibility of the FMS to only reimburse/fund services and supports (costs) that are included in the ISB and Spending Plan. It is the responsibility of the FMS to maintain all records reflecting payments made within these arrangements.

Oversight of this role can be accomplished through internal FMS compliance reviews.

4. Are there reporting responsibilities of the PIHP/CMSHP staff, especially a Supports Coordinator, regarding poor quality of care or failure to provide care as specified in the plan or budget?

The CMHSP has a responsibility to monitor the delivery of services/supports, regardless of the service delivery model (SD vs traditional). The CMHSP's role in a self-directed services arrangement is to support the individual as an employer and provide oversight – monitoring health and safety, responsible budget management and proper use of Medicaid funds.

Concerns related to health and safety, delivery of services, MA requirements, etc do not differ for self-directed arrangements.

5. What actions can a PIHP/CMHSP take when fraud/abuse of funds is occurring by workers directly employed by the person?

During investigations of Suspected fraud, waste, or abuse by an EOR or the individual, the CMHSP must takes steps to ensure medically necessary services continue without interruption. This may include increased oversight and monitoring of service delivery, temporary addition of provider-controlled services, or temporarily suspending the arrangement and replacing with provider-controlled services.

The least restrictive option must be utilized during the investigation.

6. What actions may a PIHP/CMHSP take when a person or his or her guardian knowingly overspends the funds in the individual budget?

Support and utilization of existing tools, such as the Monthly Budget Report, should be utilized to ensure budget utilization is being monitored in a consistent and ongoing manner.

Costs outside of the approved budget should not be expected to be paid using MA funds. (A clear and transparent process must exist to address these instances, should they occur). Examples could include reducing the future budget to address current overages, additional oversight and monitoring of budget within planning team, etc.

The Self Determination Agreement should outline responsibility and expectations for all parties within the arrangement, including budget oversight and utilization. This agreement can be leveraged if ongoing support and problem-solving do not successfully address concerns related to budget over-utilization.

7. What can CMH do if staff through SD arrangements are not meeting timesheet deadlines and documentation requirements?

Staff must submit timesheets within established timeframes to be paid as expected. The SD Agreement and MA Provider Agreement should include language about documentation responsibilities and requirements.

People utilizing SD Arrangements agree to the Responsibility of managing the arrangement, which includes ensuring their chosen providers meet necessary requirements (training, documentation, etc). Support should be provided to an employer if needed to ensure the arrangement is successful.

If an employer/employee are consistently non-compliant, the employer/employee must be made aware that continued non-compliance could put their arrangement at risk. If support and training are unsuccessful, the SD Agreement and MA Provider Agreement language can be leveraged.

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I. ORR

1. Do ORR rights and rules apply to SD Arrangements?

   Yes

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