Frequently Asked Questions about Self-Direction in Managed Care

Self-Direction Overview

1. What is self-direction?

Self-direction is a service delivery model available under Medicaid that supports individuals who need home and community-based services (HCBS) to help maintain their independence. In a self-directed model, individuals direct many or all of their own HCBS. Individuals can decide what mix of personal care services and supports works best for them within the parameters of their service plan. This likely includes selecting and managing direct service workers and developing a schedule for workers based on the number of available hours. Individuals' choices about workers' hours and items purchased are subject to caps. Like traditional Medicaid-funded HCBS, all Medicaid-funded services or items to be purchased in a self-directed model must be listed in the individual's service plan.

All state Medicaid programs allow self-direction in one or more HCBS program.[1] Whenever a self-direction model is offered, individuals may choose to participate in either: (1) the traditional agency model, in which a qualified agency hires, pays, and trains personal care attendants to provide services to an individual; or (2) the self-directed model, in which the individual directs many or all of her/his own HCBS, to include selecting and managing direct service workers in the provision of services to the beneficiary. In some self-directed programs, states may allow individuals to combine the traditional agency-directed model with self-directed model for the same services. Examples of this are using agency-based services during the week with self-directed services on a weekend, and purchasing agency-based services through a self-directed model.

2. Why is self-direction an important option?

As of 2016, over one million individuals receiving Medicaid HCBS had elected to participate in optional self-directed models. There are a number of reasons why participation in self-direction has grown over the last decade. Several national studies reported that self-direction has a positive influence on individuals' quality of life. For example, services are reported to be more accessible and flexible. Further, individuals are able to hire workers who have experience or skills specific to their unique needs, such as familiarity with cultural expectations. Because individuals know who is coming into their homes, their feelings of safety are enhanced. The flexibility of self-direction can also improve individuals' ability to continue to live in community-based settings rather than move to facility-based care.

3. Why are managed care plans supporting the use of self-direction?

Self-direction helps to expand an individual's level of choice and control, thus improving his or her experiences with HCBS. Support for this program model among managed care plans demonstrates to the community that the plan is committed to developing opportunities for individuals to increase their

[1] Self-direction can be made available under a variety of Medicaid HCBS state plan and waiver options, including the Home and Community-Based Services state plan option - 1915(i); Community First Choice - 1915(k); Self-Directed Personal Assistance Services state option - 1915(j); and Home and Community-Based Services waiver programs - 1915(c).

autonomy. Promoting self-direction also gives individuals more tools to achieve the goals of their person-centered service plan.

4. Is self-direction right for everyone?

Individuals who would like to self-direct must have the ability to make appropriate decisions as the employer or co-employer; manage employees to ensure provision of all required services; and support their own well-being. Some individuals may feel uncomfortable taking on employer-related duties or may have cognitive issues that prevent them from having the ability to make personal decisions. In these situations, a case manager will recommend the designation of a representative to do these activities on the individual's behalf (see definitions of commonly used terms below). Case managers assess the need for a representative through an assessment with several questions for the individual to determine the best path forward.

5. What if an individual choses self-direction and later desires to return to traditional services?

An individual may elect to return to a traditional agency model at any time. Participation in self-direction under Medicaid is voluntary. Case managers should make necessary adjustments to service plans and supports systems to ensure services remain continuously in place throughout the transition period with no gaps in care.

6. What is the case manager's role in self-direction?

The initial role of case managers is to introduce the self-direction model to individuals and their family members, and provide more detail if they are interested. If an individual selects self-direction, the case manager will either: (1) refer the individual to a self-direction counselor, enrollment specialist, or support broker to implement the self-direction model; or (2) personally support self-direction implementation.

The latter role can be a time-consuming responsibility for case managers, particularly in the beginning during orientation and enrollment activities, when individuals often have frequent questions during the initial phases. Managed care plans may consider reducing case managers' caseloads if many individuals decide to self-direct their services.

7. What are the key support functions of case managers in a self-directed model?

If case managers assist with the implementation of self-direction, they must perform several tasks for the self-directed model to be successful and meet federal requirements. New duties of a case manager include: [**STATES CAN CUSTOMIZE THIS LIST OF CASE MANAGER RESPONSIBILITIES IN THEIR SELF-DIRECTION PROGRAMS**]

- Clearly explaining the roles and responsibilities that individuals who self-direct must assume to manage their own services;
- Determining if the individual needs assistance to self-direct;
- Working with an individual who wishes to self-direct HCBS services who requires assistance to do in finding an available representative;
- Discussing how individuals can access assistance with recruiting, interviewing, selecting, managing and evaluating staff;
- Describing how personal care attendants can access additional training opportunities;
- Assisting the individual to create a back-up plan for emergency situations; and,

- Clarifying the role of the financial management service entity (see question 13) and its responsibility in supporting the individual.

Service Planning in Self-Directed Models

8. What is an assessment?

An assessment identifies the medical, functional, social, and behavioral health needs of the individual. States and managed care plans use different processes to obtain information about an individual's condition, personal goals and preferences, functional status, health status, and other factors that are relevant to the authorization and provision of services and development of a service plan. The assessment determines the individual's medical eligibility and is conducted either every 12 months or when the individual's condition changes. The assessment becomes the basis for service planning in both traditional and self-directed service delivery models.

9. What is a service plan (also known as "plan of care")?

The service plan outlines the approach to meet individuals' assessed needs, preferences, and self-care abilities. It is the written document that specifies which care, services, and supports are needed by an individual to remain in the community, regardless of funding source. At a minimum, the service plan must contain the types of services to be furnished; the amount, frequency, duration of each service; and the type of provider furnishing each service. Only those services listed in the service plan can be included in the set of self-directed services.

10. Why is person-centered planning a key component of self-direction?

Person-centered planning involves the art of discovering what is important to the individual. It places the individual at the center of all decisions. There is a significant reliance on individual input to identify and develop the service plan to meet an individual's care needs. The approach is personalized to each individual. Since March, 2014, the Centers for Medicare & Medicaid Services (CMS) has required person-centeredness to be part of every facet of service planning and implementation for long-term services and supports covered by Medicaid.[2]

To illustrate, a case manager might ask the following questions to engage the individual in a self-directed, person-centered planning process:

- What is important to you?
- Describe a really good day and a really bad day for you.
- Do you like where you live? If yes, why? If no, why?
- What do you need help with?
- Are there things you wish you could do more or less of?
- What supports do you need to be happy, healthy, and safe?

[2] 42 CFR Part 430, 431 et al. Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule. 2014.

11. How is a self-directed individual budget used?

Under self-directed models, an individual's self-direction budget may be used to furnish a wide range of goods and services to support community living. Individuals may apply the capped amounts available under a budget (which may also be referred to as a service cost maximum) to hire an attendant and, in some cases, purchase items, to reduce human reliance or promote independence. Budgets are often calculated based on the value of the full range of services and items identified in the person-centered care plan. Budgets may be determined in a variety of ways, but whatever method is employed, they must be applied consistently to each participant who self-directs and must facilitate adequate access to needed care. (See Definitions of Commonly Used Terms below for additional information about budgets).

12. How much flexibility does an individual have in developing and spending his/her individualized budget?

[**IN STATES THAT DO NOT OFFER THIS AUTHORITY, THIS QUESTION MAY BE DELETED**]. An individual has choice and control over what goods and services to purchase as long as such services are included in his or her service plan and on the program list of eligible self-direction services. Individuals also have decision-making authority regarding who will provide a service, when the service will be provided, and how the service will be provided consistent with the program's service specifications and other rules. Individuals typically may choose to make changes to how funds are allocated among services included in their individual budget (i.e., within the maximum amount or cap). Case managers may work with individuals to ensure that any changes are synchronized with service plans. In [**INSERT STATE NAME**], individuals have authority over how to spend money for the following goods and services: [**STATE PROVIDES LIST**]

13. What supports does CMS require be made available for all individuals who choose to self-direct services?

CMS requires two supports be made available to those self-directing.

- **Information and Assistance.** These support services assist an individual in directing and managing his or her services. Activities include assisting an individual in carrying out employer responsibilities, locating sources of permissible goods and services, and managing the individual budget. Most commonly, these services are provided by case managers. Models also exist that delegate these duties to a contracted entity or establish these tasks as a waiver service. Sometimes these services are referred to as support brokers or service facilitators. In [**INSERT STATE NAME**], the Information and Assistance function is delegated to [**FILL IN RESPONSIBLE ENTITY**].

- **Financial Management Services (FMS).**[3] When used in conjunction with Employer Authority (see Definitions section), this support includes enrolling attendants, operating a payroll service, handling complaints, and making required payroll withholdings. When used in conjunction with Budget Authority, this support includes paying invoices for eligible goods and services and tracking expenditures against the budgeted amount for the service plan. **[INSERT STATE NAME]** contracts with **[INSERT NAME OF FMS VENDOR(S) AND CONTACT INFORMATION]**. Some states manage these activities within their state agencies and do not contract with an FMS vendor. **[INSERT NAME OF STATE**

[3] In some states, the FMS function may be performed by Medicaid agency staff or a case manager, rather than a contracted vendor. Information and assistance may be performed as an addition to the case management tasks, as a waiver service, or by a contracted entity including the FMS.

DEPARTMENT] handles **[LIST ALL TASKS THE STATE CONDUCTS TO SUPPORT FINANCIAL MANAGEMENT ACTIVITIES]**.

Definitions of Commonly Used Terms

Back-up plan. CMS requires a back-up plan for each individual receiving self-directed services. A back-up plan arranges for another worker to be "on call." This plan should address contingencies such as emergencies, including failure of an attendant to appear when scheduled when the absence of that service would present a risk to the individual's health and safety.

A common back-up plan strategy is to identify a person to serve as a direct care attendant if the primary attendant is unavailable. It is helpful for the potential back-up person to have completed all the employment paperwork through the Financial Management Services provider. In some instances, a traditional agency provider serves as a back-up.

Self-directing individuals and case managers should discuss back-up plans with either the provider agency or the individual's family, friends, or neighbors prior to the launch of self-directed services.

Individual budgets (or service cost maximum). Budget authority means that an individual can determine how Medicaid funds in his or her self-directed individual allotment are spent on attendant hours or other appropriate goods and services. A self-directed individual budget or service cost maximum is the amount of Medicaid funds under the control and direction of the individual, and the capped amount is determined by an individual's service plan. While specific state methods used to calculate the amount of funds available to an individual vary, the amount is typically determined by calculating the cost of traditional services that an individual is assessed to need, then deducting the cost of the self-directed services and Financial Management Services. Amounts can be adjusted if changes are made to an individual's service plan.[4]

Employer authority. Employer authority means that an individual can directly recruit and hire attendants of his or her choice and will train, supervise, schedule and dismiss attendants. Under employer authority, the individual may function as the co-employer (managing employer) or the employer of record of the attendant who furnishes *direct services and supports to the individual.*

Enrollment specialist. An enrollment specialist is a trained individual who provides detailed information to individuals about self-direction. Enrollment specialists explain the program to interested individuals, and ensure that all relevant forms are completed by the individual and his or her direct service attendant. Employment specialists also continue to support the individual as he or she directs his or her services and supports. Programs have the option of creating this new role or assigning the functions listed above to the case manager.

Legally responsible relative. A legally responsible relative is a person who has a legal obligation under the provisions of state law to care for another person. Legal responsibility is defined by state law, and generally includes the parents (natural or adoptive) of minor children, legally-assigned caretaker relatives of minor children, and spouses.

[4] See CMS guidance to states on the Medicaid.gov website, accessed April 16, 2017. "Individualized Budget: An individualized budget is the amount of funds that is under the control and direction of the individual. The budget plan is developed using a person-centered planning process and is individually tailored in accordance with the individual's needs and preferences as established in the service plan. States must describe the method for calculating the dollar values of individual budgets based on reliable costs and service utilization, define a process for making adjustments to the budget when changes in participants' person-centered service plans occur and define a procedure to evaluate participants' expenditures." Available at, https://www.medicaid.gov/medicaid/ltss/self-directed/index.html.

Representative. If an individual feels uncomfortable with the responsibilities of self-direction or requires assistance with making decisions, he or she may designate a representative who may act on his or her behalf. A representative may be: (a) a legal representative (a court-appointed guardian, a parent of a minor child, or a spouse); or (b) an individual (e.g., family member or friend) selected by an adult to speak for and/or act on his/her behalf.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided by the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.