SELF-DIRECTED SUPPORTS

Report of:

**The Wisconsin Self-Directed Supports
Cross Unit Functional Team**

and

**The Wisconsin Self-Directed Supports
Stakeholder Committee**

Prepared by:

The Management Group

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Issue: What should be Wisconsin's approach towards participant self-direction in community-based long-term care?

This paper contains recommendations for participant self-direction in community based long-term care programs serving elders, persons with physical disabilities, and persons with developmental disabilities. It is the result of an intensive discussion and development process carried out by the Self-Directed Supports (SDS) Cross Unit Functional Team with a broad-based SDS Stakeholder Committee.

The recommendations in this report do not constitute state policy. State policy development is a complex process involving many considerations. This report is intended as input for the DDES Joint Steering Committee, which will be setting SDS policy.

The paper starts by providing background on self-direction—what it is, what federal Center for Medicare and Medicaid Services (CMS) policy is, and why it is important. It outlines a suggested approach to SDS in Wisconsin. Finally, it identifies key issues and challenges with respect to participant self-direction and recommends next steps for the SDS initiative.

DHFS has recognized the need for a clear policy on participant self-direction. While all Family Care Care Management Organizations (CMOs) and many county Community Options Program Waiver (COP-W) and Community Integration Program (CIP) programs offer some form of SDS, there is not a consistent approach statewide or among the COP-W or CIP waiver counties. SDS currently is not a part of the Wisconsin Partnership model. Furthermore, Wisconsin is embarking on a long-term care reform process that will result in long-term care being delivered by nine to fifteen regional CMOs. It is anticipated that contracts between CMOs and DHFS will require CMOs to offer SDS to their members; therefore, it is important that DHFS expectations for SDS be clearly defined.

Representatives of Mental Health/Substance Abuse programs and Children's programs also participated in the development of this report. These programs are working on incorporating SDS into their programs, and the same general principles and approaches developed for long-term care would be applicable. Though there are important programmatic and client differences that may result in some variation in how SDS is applied in these programs, some level of consistency in the application of SDS across long-term care, mental health/substance abuse, and children's programs would be desirable.

To date this initiative has considered SDS only for long-term care services, not primary and acute medical services. Currently, the Wisconsin Partnership Programs are the only long-term care programs in Wisconsin that integrate long-term care services with medical (primary and acute care) services, though additional programs integrating long-term care with primary and acute care services are under development as part of long-term care reform. This initiative has not to date considered the application of SDS to medical services. However, fully integrated programs could adopt this approach to SDS for the long-term care components of their programs.

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In addition, this paper outlines an approach for fully operational SDS programs. It is recognized that it will take time for local programs to fully achieve all of the program features outlined in this report.

This paper represents the first phase of the larger effort to improve and expand SDS throughout the state. Upon approval of this paper, the initiative will focus on developing specific tools, training and approaches to support implementation of SDS programs.

A complete list of persons who participated in the development of this paper is included as Attachment A.

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Part 1: Background

What are Self-Directed Supports, and why are they important?

Although the terms self-determination and self-directed supports are often used interchangeably, they are actually two distinct concepts with unique implications. *Self-determination*, being the broader of the two elements, refers to the individual having control over all aspects of his or her life, and exercising basic rights such as citizenship, liberty, and the pursuit of happiness. This definition impacts activities beyond the scope of long-term care services.

Self-directed supports are a facet of the larger self-determination philosophy. Stated simply, participants in long-term care programs actively direct the supports and services being provided. For the purposes of this report, the term self-directed supports refers to a wide range of approaches designed to maximize choice and control for people who use long-term care services and supports. People who self-direct are able to hire, supervise, and fire their own direct care workers. But SDS involves many other elements as well, including control of one's own budget for services, choice of services and supports, and decision-making authority. Though frequently used for in-home care, SDS can be used outside of the home as well for services such as transportation and supported employment. Elements of SDS will be thoroughly discussed in this paper.

SDS is consistent with the RESPECT values that guide Wisconsin long-term care programs:

- **Relationships**. *Relationships between participants, care managers and providers are based on caring, respect, continuity over time, and a sense of partnership.*[1] By making the option available for participants to select and oversee the persons who provide their care, SDS respects and promotes the participants ability to build on relationships that are meaningful and productive for their lives.
- **Empowerment to make choices**. *Individual choice is the foundation of ethical home and community-based long-term support services.* SDS is grounded in participant choice. Participants choose whether, and what services to self direct. For services that they self direct, they have considerable latitude to choose who is providing the service and how and when it is provided.
- **Services to meet individual need**. *Individuals want prompt and easy access to services that are tailored to their unique circumstances*. Individuals who are self-directing services can tailor them to their specific needs.
- **Physical and mental health services**. *Intended to help people achieve their best level of health and functioning.* SDS recognizes that most people are capable of selecting and directing long-term care services in a way that is consistent with their physical and mental health needs. Involving the participant in a careful care planning process helps ensure that SDS supports the best level of physical and mental functioning.

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[1] The term "care manager" is used throughout this paper to describe a range of similar positions also referred to as "case manager" or "support services coordinator." Also, while it is recognized that Interdisciplinary Teams (IDT) often provide care management, the paper does not specifically refer to IDTs. For the purpose of this paper, the term IDT can be substituted as appropriate for care manager.

- **Enhancement of participant reputation**. *Services maintain and enhance participants' sense of self-worth and community recognition of their value in every way possible.* Through SDS, participants have increased control over their own lives and increased ability to interact with the community in ways that they value.
- **Community and family participation**. *Participants are supported to maintain and develop friendships to participate in their families and communities.* SDS promotes the use of community resources and informal supports to meet participant outcomes.
- **Tools for independence**. *People are supported to achieve maximum self-sufficiency and independence.* SDS enables participants to exercise self-sufficiency and independence to the degree that they choose to do so.

The Recovery Oriented Systems Assessment (ROSA) used by the Bureau of Mental Health and Substance Abuse Services (BMHSAS), involves talking with participants about personal outcomes related to recovery. The general idea of recovery is that people with mental illness can get better, and live happy, full and productive lives. The basic tenets of recovery emphasize the importance of recognizing that participants are people and not simply a list of diagnoses or disabilities. People are empowered to take risks and make the decisions they believe will be best for them.

SDS is consistent with the recovery values incorporated in the ROSA tool:

- **Personal Life and Direction.** A person exercises autonomy, courage, and responsibility when making decisions about his or her life and in turn achieves a sense of mastery and purpose.
- **Community, Affiliation, and Connection.** In order to create a sense of belonging, people need supportive, meaningful, and respectful connections with others. People should be free to fulfill social roles and to be as involved in their communities as they prefer.
- **Health, Wellness, and Safety.** The ability to participate fully in life can be impacted by a person's physical, emotional and safety concerns. The person determines when and how these concerns are addressed.
- **Treatment and Services.** Successful treatment is done with people, not to them. People should have the opportunity to choose the type of service they believe will best meet their needs, and facilitate their personal recovery.
- **Empowerment and Self-Determination.** In order to make decisions about things that are important to them, people need information about their options and the opportunity to exercise their decision-making power. Having this sense of control encourages people to reach their personal goals and achieve their desired level of recovery.

How is Wisconsin currently using SDS?

Use of SDS varies across local long-term care programs:

- Family Care Program CMOs are required by administrative rule and in their contracts with DHFS to offer self-direction options to members. The nature of self-direction varies with member needs and preferences.

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- Many, but not all, of Wisconsin's 1915(c) waiver programs serving Elderly and Physically Disabled populations (COP-W and CIPII) and Developmentally Disabled populations (CIP 1A and1B) offer SDS to some degree. According to a survey of Wisconsin Counties published in September 2004, 35 out of 66 counties responding to the survey offer some of their participants the option of directly employing their own providers, with the assistance of the county and a fiscal agent. According to this survey 3,197 consumers were utilizing this option in 2004.[2]

  SDS under COP and CIP waiver programs typically provides consumers or guardians with the ability to hire their own supportive home care worker (using a fiscal agent for related financial transactions.) Counties have varying criteria for determining participant eligibility to self-direct.

  The most notable application of SDS among CIP 1A and 1B programs is Dane County's program for people with developmental disabilities, which has offered SDS to most consumers for 10 years. Consumers are provided with a budget, and work with support brokers to access needed services.

- Currently, the Wisconsin Partnership programs (WPP) do not formally use SDS, although WPP provides a consumer-centered planning and service delivery model that results in a generally high degree of consumer input. Beginning in 2007, SDS will be contractually required in Partnership programs.

- BMHSAS has submitted an application for a new Community Opportunities and Recovery (COR) waiver to CMS. The COR waiver will fund relocation of nursing home residents with mental illness into the community. SDS would be an important component of the COR waiver. In addition, the Comprehensive Community Services (CCS) program integrates consumer self-direction into its recovery model, and BMHSAS is interested in considering the applicability of SDS to Community Support Program (CSP) services.

- Wisconsin's Children's Long-Term Support (CLTS) Waivers contain provisions for offering SDS as a service option.

What are federal CMS expectations with respect to SDS?

CMS strongly encourages, but does not mandate, expansion of SDS. Its support for SDS is demonstrated in a number of programs and initiatives, including:

- The Cash and Counseling Pilots in three states, co-sponsored by the federal Department of Health and Human Services (DHHS) and the Robert Wood Johnson Foundation;
- The Independence Plus initiative, based on the Cash and Counseling and Self-Determination projects, offers assistance to states to implement programs to support self-direction, either through a 1915(c) or 1115 Waiver;

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[2] *Long-Term Support Direct Care Arrangements in Wisconsin Counties; Survey Results, 2004. DHFS/DDES*

- CMS requires considerable detail on whether and how the state will provide for participant direction of services in both 1915(c) and 1915(b) Waiver applications;
- CMS audits of waiver programs check for provision of consumer directed services. For example, a 2004 CMS audit of the COP-W and CIP II Waivers expressed concern that the waivers were not including consumer directed services as an approved service. [3]

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[3] The DHFS response notes that COP and the COP-Waiver require consumer choice as part of the care plan development and throughout the service determination process. The response further notes that consumer direction occurs through the use of fiscal agents or intermediaries, and appears under the supportive home care service category.

Part 2: SDS Recommendations

This section of the paper recommends a comprehensive approach for self-directed supports. The paper primarily addresses SDS for long-term care services for elderly adults and adults with physical or developmental disabilities. However, with certain modifications, these recommendations may also be applicable to mental health/substance abuse programs and programs serving children.

The recommendations address the following key areas:
- A. Who is eligible to self-direct services?
- B. How does SDS apply to residential settings?
- C. What limitations can be placed on participant self-direction?
- D. What is the scope of consumer self-direction?
- E. What are the roles and responsibilities of persons and organizations involved with SDS?
- F. How does care planning take place under SDS?
- G. What training needs are associated with implementation of SDS?

Each of these key areas is discussed below.

A) Eligibility for self-direction

All participants receiving long-term care services would have the opportunity to participate in the self-direction of their supports. No person would be excluded based solely on target group or characteristics, such as cognitive deficits or the need for guardianship. Local programs would inform all parties of their right to self-direct.

Persons with guardians are eligible to self-direct. Guardians, parents of minor children, and other alternate decision-makers would be considered active partners in the self-direction process. These alternate decision makers would act as the participants' voices, and help the participants navigate the self-direction option. If a participant is not able to select the self-direction option on his or her own, and the decision maker believes it to be in the participant's best interest, the alternate decision maker may choose the self-direction option for the participant.

Whether guardians, parents of minor children, and other legally responsible adults would be paid for their services would need to be consistent with waiver regulations. To avoid a conflict of interest (defined here as existing when a person or any other entity involved in operating any part of the local program has an interest in or the potential to benefit from a particular decision, outcome or expenditure), the local program would have written policies and procedures to ensure decisions can be made without any undue influence.

B) SDS and residential setting

Choice of where and with whom to live, and who will provide needed supports and services is fundamental to self-direction.

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SDS would be an option for all participants living in private homes. They would have the option of self-directing supports that come into their homes, such as supportive home care workers, as well as services received outside of the home.

SDS for participants residing in substitute care poses more complex issues. First, there is a question of definition of substitute care. For example, does a 1-2 bed adult family home created especially for a participant constitute substitute care, or is it a private residence? Second, in larger congregate settings, complete participant self-direction may be inconsistent with the staffing and operational requirements. The following principles would apply to self-direction for participants residing in substitute care:

- For all participants living in substitute care, it would be determined that a substitute care setting is truly the least restrictive environment for a participant, and that the residence was chosen by the participant and/or the decision maker.
- At a minimum, participants living in substitute care may self-direct services unrelated to their living arrangements. Under this approach, a person living in a Community Based Residential Facility (CBRF) would not be able to hire or fire residential staff, but would be able to self-direct (hire, supervise, fire) transportation providers, day treatment program, and employment services. The local program would contract with the facility for services directly related to care and supervision of the participant, and the facility would only bill the local program for actual care and supervision costs. Costs related to services that may be self-directed (i.e. transportation, attendant care, day treatment, etc.) would be carved out of the care and supervision rate.
- As an option, local programs may work with interested participants, facilities and the Bureau of Quality Assurance (BQA) to develop options for participant self-direction of residential services in substitute care. Participants could perform limited self-direction in substitute care, consistent with Bureau of Quality Assurance (BQA) regulations and the operational needs of the facility. The concept of choice would be written into local program contracts with facilities. For example, the participant could choose when and what to eat, could direct his or her sleeping schedule, and could participate in hiring direct support staff. Local programs and facilities would work together to ensure that substitute care employees understand the philosophy of self-direction and assist participants to employ these practices.

C) Restrictions on a participant's ability to self-direct
The local program would have written policies and procedures, shared with participants who are self-directing, outlining conditions under which the program may either:
- Forbid a participant from self-directing;
- Restrict the level of self-direction exercised by a participant; or
- Increase the level of involvement of the care management team.

Restrictions on a participant's ability to self-direct would be uniform statewide and across waiver programs. They would be limited to the following circumstances:
- The health and safety of the participant or another person is threatened;
- The participant's expenditures are inconsistent with the budget and the plan;

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- The conflicting interests of another person are taking precedence over the desires and interests of the participant;
- Funds have been used for illegal purposes.

If a local program restricts or terminates a participant's ability to self direct, it would provide the participant with information about what specific steps he/she would take in order for the restrictions or termination to be withdrawn. The local program would also inform the participant whose level of self-direction is restricted about his or her right to file a grievance, request DHFS review, or request a fair hearing if he or she disagrees with any limit on the level of self-direction. The local program would have written policies and procedures in place as to how it would assist participants in attaining or regaining self-direction authority.

The local program would have written policies and procedures in place related to self-direction that include periodic re-assessment of participants' competency to exercise their right to self-direct without assistance from an alternative decision maker.

D) Scope of self-direction
The scope of SDS involves a number of components:
1. The participant's authority to employ workers and manage a budget
2. The services that are available for self-direction
3. Participant's ability to determine the extent of self-direction
4. Participant's ability to obtain independent advise and support

Each of these components is described below.

1. Participant authority to employ workers and manage a budget
CMS recognizes two broad categories of self-direction: *Employer Authority* and *Budget Authority*. State SDS programs may offer either or both of these authorities to participants. This approach would provide both employer and budget authority in Wisconsin's SDS program.

It is important to note that under the self-direction model described here, participants will never directly be provided with funds to pay for services. A fiscal agent or co-employment agency will always be responsible for actually carrying out financial transactions.

Employer authority
In programs offering employer authority, participants employ their own service providers. Employment entails the full range of employer rights, including the right to recruit and hire service providers, to supervise their work, to set their wages and to terminate their employment.

There are two variants of employer authority: "*employer of record*" or "*co-employment*" *(also known as "agency with choice*.") Depending on the availability of area resources, local programs would be encouraged to offer both alternatives, but would at least present participants with the "employer of record" option. Under each of these variants, the participant functions as the employer of the worker.

a. Employer of record – When a participant is the employer of record, he or she has the authority to hire, supervise, and fire his or her own workers. The participant is also responsible for payroll and completing the paperwork required for taxes and social security withholdings. Typically, the local program contracts with a fiscal agent to issue paychecks to workers and handle withholdings. Participants submit necessary information about their employees/service providers, including wage rate and timesheets, to the fiscal agent.

b. Co-employment/agency with choice – Under the co-employment/agency with choice model, the co-employment agency and the individual enter into a dual employment relationship. The agency is typically the common law employer and the participant is the managing employer. Duties of an agency with choice may include invoicing the local program for public funds, conducting human resource activities, managing all aspects of payroll, providing a variety of support services, and monitoring worker's performance in conjunction with the managing employer. The participant is responsible for choosing providers from the worker pool available to the agency. Participants may also locate their own workers and request that the co-employment agency hire them.

Budget authority
Participants would also have budget authority. Budget authority is the authority to select the types and amounts of services received, within a given budget, as long as the services relate to the person's long-term care needs.

The local program would be responsible for developing methodologies and standards for budget development to ensure cost effective budgets adequately meet participant needs.

2. *Services available for self-direction*
Most services would be eligible for self-direction, with the exception of a few that are carved out and funded separately on an as-needed basis. Services related to health and safety (e.g. acute mental health services) would be provided without penalty to the participant's budget.

Within the budget and the service plan, the participant may purchase any service or support consistent with his or her goals. In order to offer as many service choices as possible for participants, local programs would work to increase provider capacity. Participants would also be encouraged to draw on informal and community supports to provide needed services.

For supportive home care and other supports provided in the home, the participant would typically submit a signed timesheet to the fiscal agent, who would issue payment to the provider. For services provided outside of the home, the participant would typically purchase services and supports by using a voucher supplied by the fiscal agent. Through use of the voucher, the participant directly authorizes payment to the vendor. However, at no point is the participant actually given funds to purchase services or supports. There are

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many different funding models available which provide the participant with control of the money without actually giving them cash.

3. *Participant ability to determine extent of self-direction*

Subject to any restrictions, the participant may choose which long-term care supports to self- direct, as well as which services and supports would be managed in a traditional manner by the local agency. A participant may choose to self-direct one service, several services or all services. Alternatively, a participant may also forego self-direction if that is his or her preference. Regardless of the level of self-direction a participant chooses, he or she will not be required to navigate the system without assistance. Each participant will be offered the services of a care manager to aid in the management of his or her personal budget and supports.

4. *Participant's ability to obtain independent advice and support*

Self-direction programs may provide participants with the opportunity to seek and receive independent advice and support regarding services available, provider networks, and budgetary decisions. This could range from targeted services provided by an agency under contract to the program (similar to the "counseling" component of the Cash and Counseling model) to the option of utilizing support brokers either exclusively or in conjunction with traditional care management services. Support brokers are contracted participant representatives who perform duties similar to those of care managers, but who work independently of the local program, representing participant interests independent of the risk-bearing entity or administrative agency. Support brokers are discussed in more detail in Section E, below, and in Part 3 of this document.

E) <u>Roles and responsibilities of persons and organizations involved with SDS</u>

Successful implementation of SDS programs requires full and knowledgeable involvement from participants, care managers, local program administrators and providers, fiscal agents, and sometimes Aging and Disability Resource Centers (ADRC) and support brokers. This section outlines the primary responsibilities of each of these parties.

Party	Major Responsibilities
Participant	- Indicate whether he/she wants to self-direct and what services to self-direct. - Serve as employer of workers. This entails recruitment, supervision, hiring and firing. - Conduct required criminal background checks on potential workers. - Develop clear descriptions of worker responsibilities; assure that workers are adequately trained. - Develop a back-up plan for worker absences or other unexpected occurrences. - Assure that all required state, federal and program paperwork is completed promptly and accurately. This could be done using a fiscal agent, a fiscal intermediary, a co-employment

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Party	Major Responsibilities
	• agency, or the participant could do it independently. • Manage self-directed services within the allotted budget.
Aging and Disability Resource Center (ADRC)	• Where an ADRC exists, it is responsible for educating persons applying for programs about options to self-direct.
Care manager (or service planning team where applicable)	• Make sure that all participants are informed of the opportunity to self-direct. • Facilitate person-centered planning meetings and assist the participant with the development of the service plan • Support the participant's self-direction activities as needed. As appropriate, identify community resources to support the participant in self-direction. • Assure that there are adequate back-up plans to ensure the participant's health and safety should problems arise with self-directed services. • Monitor outcomes for self-directing participants. Work with participants to address issues that arise.
Support broker	• Support brokers represent the participant's interest independent of the risk-bearing entity or the local administrative agency. • Whether and how support brokers will be part of Wisconsin's self-direction model is still under consideration. • Typically, in self direction programs using support brokers, support broker roles include the following: participating in the service planning process; assisting in identifying and locating services; negotiating with service vendors and providers; advocating for the participant with the local program; serving as a resource about community and neighborhood supports; facilitating team meetings; assisting in the development and monitoring of the participant's emergency back up plan including arranging for the provision of back up providers; coordinating services with fiscal agents/intermediaries and the local program care managers. • See Part 3 for a discussion of the role of the support broker and its relationship to the care manager.
Local program administration	• Assure that clear policies on self-direction are in place, and that they are communicated to participants and program staff. • Assure adequate training and support on self-direction and its components are available to participants and staff. These include training and support on the Resource Allocation Decision-making Method (RAD), budgeting, utilizing informal supports, and related topics. • Local programs would ensure that the decisions made by the staff and participants would be honored, as long as they posed

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Party	Major Responsibilities
	no health or safety risk, and were within the scope of the care plan and budget. • Make sure that training requirements of funding sources are met and documented. • Set budgets for participants who are self-directing. • Take appropriate steps to minimize liability associated with SDS. • Establish and maintain guidelines and procedures for restricting SDS for participants who violate policies or who are otherwise unable to self-direct. Assure appropriate procedures for appeals and reinstatement of SDS authority. • Contract with fiscal agents or intermediaries and co-employment agencies to provide fiscal and/or co-employment services to self-directing participants. • Assure that workers not associated with a provider agency do not have criminal records that would preclude them from providing direct client care.
Fiscal agent or fiscal intermediary	• When participants hire workers not affiliated with an agency, fiscal agents or fiscal intermediaries would typically be utilized. • The distinction between fiscal agent and fiscal intermediary is as follows: The fiscal agent handles employee payroll when the participant is the employer of record. The fiscal intermediary can perform the functions of the fiscal agent, and in addition, can purchase other supplies and services on behalf of the participant. • Specific fiscal agent and intermediary duties include: the payment of service providers; completing fiscal accounting functions and expenditure reports; withholding federal, state, and local taxes from payment to service providers; ensuring compliance with federal state and local tax laws; ensuring compliance with employment and wage laws; verifying that payment is made only for services identified and authorized in the participant's ISP; maintain an audit trail of disbursement of funds; and develop and maintain service agreements with each provider employed by the participant.
Workers/Providers	• Carry out work assignments as specified by the participant/employer. • Record time on timesheets and complete all other required paperwork in a timely manner.

Managing for self-direction differs in a number of respects from managing for traditionally delivered services. Some of the key areas where SDS presents different challenges are described below:

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- <u>Advising participants of the right to self-direct</u>. Local programs would be required to have written plans detailing how they will disseminate self-direction information to participants. The plan would include how the local program can ensure that the people participating in the self-directed supports option understand and are agreeing to utilize this option. The information would be presented to the participants both verbally and in a written format in the participant's primary language.

  Local programs, including ADRCs, would be required to discuss the self-directed option with all new participants and at six-month reviews with participants already enrolled in the programs. Local programs would be responsible for presenting the self-direction option to school-age participants moving from children's to adult's programs.

- <u>Care management</u>. The SDS option may require more front-end time than a traditional care management model, and it may also be time-intensive if the participant requires substantial assistance. That acknowledged, care managers may also utilize other community resources and training opportunities to scale back their involvement and time commitment. Co-employment agencies, independent living centers, or support brokers, for example, may be able to provide some of the necessary assistance that care managers would otherwise provide. In order for self-direction to be successful, it may be necessary for care managers to relinquish some of the control present in traditional care management models.

  Local programs may find it effective to designate certain care managers as "specialists" in SDS. These care managers could receive special training and would become experts in self-direction. They would directly serve as care managers for self-directing participants, and as coaches and advisors to care managers who are not SDS specialists.

- <u>Determining individual budgets</u>. The local program would have a methodology in place for establishing and modifying an individualized budget amount or range available to the participant to pay for the services and supports to be self-directed. Methodologies for creating SDS budgets are being developed as part of the SDS initiative and will be made available to local programs. (See discussion of budgets in Part 3.)

- <u>Supporting participants in self-direction.</u> The local program would be responsible for ensuring a person is able to participate in self-direction if the person expresses a preference to self-direct, notwithstanding his or her capabilities. Regardless of the local program's level of involvement, there would be a clear distinction between the role of the program as facilitator and that of the participant as primary employer or purchaser of services. Both the participant or representative and the local program would sign a letter of agreement that clearly delineates the roles and responsibilities of both parties. Local programs would assume the role of "consultant," helping all involved parties (participants, guardians, care managers, brokers) understand SDS rules and regulations, while clearly sidestepping actual employer duties.

Local programs would have written policies and procedures that include mechanisms for assuring compliance with requirements for the deduction and payment of payroll taxes and for providing legally mandated fringe benefits for individuals employed by the participant. The local program would make assistance available to the participant for all of the following employment-related tasks: recruiting; screening; interviewing; hiring and firing; setting the level of wages; setting workers tasks and hours; authorizing and making payment for services delivered; setting the level of benefits, if any, to be provided in addition to requisite state and federal payroll benefits (these could include benefits such as vacation, sick leave or health insurance); assistance in procuring additional optional employee benefits; training workers; assessing participant liability; supervision and disciplining workers; arranging back-up workers or services.

The local program would have in place written policies and procedures under which the participant can make or authorize payments to providers and receive timely information on expenditures and budget status.

- Use of support brokers. Support brokers are contracted participant representatives who perform duties similar to those of care managers, but who work independently of the local program. For some individuals who may not be fully capable of carrying out all aspects of SDS, hiring an independent broker compliments the philosophy of self-direction by creating another means for the participant to establish and maintain control over his or her service plan independent of the local program.

    Whether and how support brokers would be part of Wisconsin's self-direction model is still under consideration. If support brokers are part of the model, there are a number of ways in which their role could be defined. Under one approach, participants choosing to self-direct would have the option of utilizing support brokers in conjunction with care managers. See the above table for a summary of support broker responsibilities and Part 3 for a discussion of support brokers.

- Use of a fiscal agent and fiscal intermediary. SDS involves the use of a fiscal agent or intermediary to carry out the payroll and purchasing responsibilities associated with SDS arrangements. (See table above for summary of fiscal agent/intermediary responsibilities.) While presently some local programs directly handle payroll, withholding, etc. for self-directing participants, local programs would be required to contract with a professional fiscal agent. Having a third party fiscal agent is beneficial in that it distances the local program from the SDS relationship. It is also more efficient to have a fiscal agent who specializes in payroll functions and who can devote the time to staying up-to-date on IRS requirements and applicable regulatory changes.

F) Care planning under SDS

While participant centered care planning is an essential component of SDS, it is important to understand that SDS goes beyond just participant centered care planning. SDS allows participants to actually control and direct the services they receive on a daily basis. If support brokers are used, SDS can also provide independent advocacy and support for participants.

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The actual creation of the plan could happen several different ways depending on the structure of the local program and the preferences of the participant. The development of the participant's plan would be person centered and based on the guiding principles of individual and family involvement and participant choice and control. The process would be individualized, interactive and ongoing. The participant would formally review his or her care plan at least every six months. A copy of the participant's plan would be kept in his or her file.

Participants would have the option to use the services of an advocate, independent from the local program to assist with the development of the care plan. The advocate could be a formal or informal support, and would have been chosen by the participant. Participants work with their care planning team to develop plans for self-direction of funding for the supports or services they choose to manage directly. The local program reviews the plans to ensure that the plans do not jeopardize the participants' health and safety, and that expenditures are within the budgets agreed to by the local program. The plans would also meet any other conditions approved by the department, such as the requirement for emergency back-up plans and how they are developed. If a participant's service plan is safe and within the stated budget, then the local program should not change the plan without input from the participant.

G) Training and support needs for successful implementation of SDS
Successful implementation of SDS would require ongoing training and support of participants and their guardians, for providers, and for care managers and other local program staff.

Care management organizations would be responsible for providing needed training, either directly or by purchasing training from qualified vendors. DHFS would provide standards and expectations for training, and would make training materials and curriculums available (through a web-based format) to support local training efforts.

Existing county COP and CIP waiver programs would not typically be expected to have the resources to purchase needed training. DHFS would work with these counties to assure access to needed training to support SDS programs.

The following table briefly describes training and support needs for SDS:

Category of persons needing training	Training needs
Participants and guardians	Training would be designed around the needs of individual participants – individuals would not be required to take training that is not relevant to their needs. Training topics for participants could include: - Philosophy/guiding principles of the self-direction option - Participant rights and responsibilities - Participation requirements

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Category of persons needing training	Training needs
	• Budget management • Billing and reporting requirements • Scheduling • How to recruit, interview, hire and fire direct support staff • Liability and reducing risk • Training for guardians to assist them in learning and respecting participants preferences and goals
Workers/Providers	Provider training needs would be based on the needs of the participant. It is expected that in many cases, the participant would directly train the provider. There may also be a need to develop specific skills requiring outside training (for example, transferring skills.) Expectations would be incorporated into provider contracts with participants and local programs. There would be mechanisms developed to assess provider performance, and to assure that the local program and participant are immediately informed of problems with providers.
Care managers	Care manager training needs would focus mainly on the changes to their roles and responsibilities as compared to the traditional care management model. Emphasis would be placed on developing person-centered care plans, understanding personal outcomes, and exploring service and support options. To ensure that care managers and service planning teams are able to work in the best interest of the participant, these staff members could be given training on issues that impact self-direction, such as the RAD, budgeting skills, and utilizing informal supports. Once DHFS or the local program has provided this training, the care managers, in conjunction with participants, could make safe and appropriate decisions about services and providers. As long as these decisions address health or safety issues and are relevant the participant's assessed needs, the local program would respect the choices made. SDS is required under current waiver guidelines, and is expected of waiver care managers. The option will also be mandatory under the upcoming managed care rules. Therefore, if care managers have more exposure to the model and the opportunity to incorporate the practice into their current duties, the transition to the managed care

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Category of persons needing training	Training needs
	standards may be smoother for staff as well as participants.
Support brokers	Because support brokers are not employees of the local program, their levels of familiarity with various programmatic funding sources may vary. They may benefit from training on balancing the preferences of the participant with the policies of the local program. They would also require orientation to the relationship between their responsibilities and those of the fiscal agent/intermediary, the local program care manager, and the participant.

Support brokers would also need to understand person-centered care planning, use of personal outcomes, and exploring service and support options. |
| Local program managers | Training needs of local program managers would focus on the development of quality assurance and quality management processes to ensure the successful implementation and delivery of SDS. Additionally, program managers may require training on participant budget determination, cost effectiveness, and provider networks.

To ensure that participants are truly directing their own services and care, local program managers may benefit from training aimed at helping them strike a balance of control between their management duties and participant and his/her service planning team responsibilities. |

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Part 3 – Implementation Issues

There are a number of important areas that will require further development as part of SDS system design. While the SDS Initiative has commenced work in these areas, more work is needed to clarify issues and develop policy. These areas include:

A) Balancing choice and risk
B) Liability
C) Incompatibility of funding streams
D) SDS in a managed care environment
E) Use of support brokers/outside care managers
F) Individual budget development, savings, and managing institutional stays
G) Assessing cost effectiveness of SDS
H) Assuring quality of SDS
I) Developing expectations for implementing SDS, both for new CMOs and for existing c-waiver COP and CIP programs
J) Applicability of SDS to mental health/substance abuse and the children's waivers.

Each of these issues is discussed briefly below.

A) <u>Balancing choice and risk</u>
  SDS involves increased participant choice about their services and how they are delivered. Sometimes, participants may make choices that involve a level of risk. At the same time, care plans under home and community based waiver programs must be safe. Concerns have been expressed about balancing choice and risk in SDS situations.

  Careful care planning is key to addressing this concern. The care manager needs to work closely with the participant to discuss alternative approaches and their risks. It is within the authority of the local program to deny funds for services or activities that it considers unacceptably risky. However, consistent with the philosophy of SDS, this authority would be exercised only in extreme circumstances. The local program would have a clear policy regarding what is considered acceptable and unacceptable risk, including how the care plan development process addresses emergency back-up plans and the arrangements utilized in these situations. That policy would be distributed to and discussed with self-directing participants both at the time the initial care plan is created as well as at six-month reviews. The local program would have a process in place to ensure that the care manager can document the steps taken to evaluate the risk to the participant. Care managers would be trained in this process. At a minimum, the process would include an assessment of the source of risk, what harm may result from it, the level of seriousness, and the likelihood that the risk will result in a negative consequence for the participant.[4] The care manager would document conversations with the participant or the participant's legal representative regarding the participant's decisional capacity, their reasons for making this choice, how this choice relates to their desired personal outcomes, and whether the participant was aware of all available options.

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[4] Information taken from Ann Pooler, RN, PhD. "Consumer Safety, Risk and Risk-Taking: A Guide for Community Long-Term Care," and La Crosse County Care Management Organization, "Risk Assessment."

Risk assessments can also be used to minimize risk or, at least, minimize harm by creating opportunities for the participant and the care manager to openly discuss all possible options. These discussions would result in the outcome that will best balance the participant's safety and preferences.

All parties involved in the risk assessment process would sign off on the final decision. While the document is a useful mechanism for ensuring participant preferences for care, it cannot override existing State or Federal laws, nor is it established whether a risk assessment will actually protect providers or local agencies from liability claims. The local program would have an appeal process in place, about which the participant would be given information and any needed direction.

B) Liability
While there is potential liability in all forms of long-term care delivery, both local programs and participants may have particular concern about liability in SDS. Several factors contribute to these concerns. First, there is not a corporate provider entity (such as a supportive home care agency) to incur liability. Second, participants are serving directly as employers. Finally, participants are making more independent decisions than under standard service delivery situations. These concerns would need to be proactively addressed for a successful statewide implementation of SDS.

Fundamentally, careful care planning to assure a safe plan, combined with ongoing monitoring, provide the best protection against future liability. Risk for participants (and indirectly for local programs) may also be reduced if workers compensation insurance policies are purchased either for or by the participants. If a participant has such a policy and his/her worker is injured on the job, the policy would pay. This would reduce the chance that the injured worker would sue either the participant or the local program in an injury situation.

However, it is recognized that participants, local programs and providers all need additional information on liability in SDS. This information would be reflective of Wisconsin law, and presented in a manner that is clear and accessible to all parties needing the information. A subcommittee of the SDS Cross Unit Functional Team and Steering Committee is working on researching liability issues and developing appropriate informational materials.

To guard against situations that potentially could result in liability, the plan for each participant using self-direction would include a written strategy for how the local agency would ensure and monitor all of the following:
- The health and safety of the participant and other people are not significantly threatened;
- Relevant legal and building code regulations are met.
- The participant's expenditures are consistent with the budget and the service plan;
- Safeguards are in place to ensure that the conflicting interests of other people are not taking precedence over the desires and interests of the participant;
- The plan meets all legal requirements for the applicable waiver program.

Attachment B outlines potential sources of liability under SDS and steps that can be taken to mitigate them.

C) <u>Incompatibility of programs and funding streams</u>

SDS is sometimes incompatible with the specific requirements of particular funding streams. For example, people participating in this initiative have raised concerns about Medicaid Personal Care (MAPC), which is very prescriptive about the types of services that MAPC workers can provide. This mix of services is not necessarily consistent with participant preferences for supports. Consideration would be given to a state plan amendment to include a self-directed personal care benefit.

Wisconsin's coming transition to care management organizations as providers of long-term care will be helpful in addressing this concern since there will be a single capitated rate, rather than multiple funding streams as is often the case in fee for service long-term care programs.

D) <u>SDS in a managed care environment</u>

There is relatively little experience nationwide implementing SDS in managed care environments, particularly in managed care programs that combine long-term care with acute and primary care services.

Concern has been expressed that a high degree of participant choice is incompatible with managing within a capitated rate. The CMO is at risk in the managed care environment; this raises the question of how much control the CMO can afford to relinquish. Concern has also been raised that participant choice about long-term care services under SDS could adversely impact their health, and therefore costs, in programs that integrate long-term care and primary and acute care services.

This concern can be addressed through careful planning, development of realistic, and cost-conscious budgets for SDS participants, and careful monitoring of costs and budgets. Both Family Care and Michigan's managed care system for persons with developmental disabilities and mental illness, have demonstrated that this is possible.[5] However, additional work is needed to consider the specific challenges involved with integration of SDS into managed care. The SDS Cross Unit Functional Team proposes to work closely with representatives of Family Care, Partnership and new managed care consortiums to develop workable solutions to SDS issues specific to managed care.

E) <u>Use of support brokers or care managers outside of the LTC funding agency</u>

Wisconsin's long-term care system currently allows individuals to receive assistance in planning, arranging and monitoring services from outside of the funding agency. For example,

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[5] Michigan provides "specialty services" to persons with mental illness and persons with developmental disabilities through a s.1915(b)(c) managed care waiver. Michigan's program, which began in 2002, makes self-determination available to all participants. Participating programs would assure at a minimum that:

- Within an individual budget based upon needs, participants are able to choose or design their own support and services;
- Participants are not required to utilize network operated or contracted services or programs;
- Participants have access to third-party fiscal intermediaries that participants may select if they choose to employ and direct their own support personnel;
- Participants have the option to select an independent supports broker to serve as personal agent and perform supports coordinator functions.

within HFS 10.44, Family Care administrative rules allow for the use of a broker or care manager outside of the agency for an enrollee who "takes full responsibility for managing the funding for all or part of his or her services," where the "Primary differences from the usual Family Care model are: (1) the ability to purchase services from outside the CMO network for providers; (2) the ability to receive assistance in planning, arranging and monitoring services from a broker or care manager outside the CMO."

Outside brokers would typically perform duties similar to those of traditional care managers, but would be hired by the participant. While they would work independently of the local program, they would be integrated into the participant's care planning team that includes LTC agency care management, the participant, and other members of the participant's support network. The option of hiring an outside broker/care manager compliments the philosophy of self-direction by creating another means for the participant to establish and maintain control over his or her service plan and budget.

The SDS Cross-Unit Team and Stakeholder Committee recognize that there are a number of issues that the system must address to ensure that the use of an outside broker/care manager: 1) is complementary to agency care management, 2) is an efficient use of resources, and 3) addresses financial and personal risk. There are numerous examples across the country where those criteria are met, and thus a number of technical assistance resources available to local programs as they explore how this option can be applied most effectively.

The team/committee's recommendation sets out the following guiding principles as agencies work on developing the structure to support outside brokers/care managers:

- As currently allowed in Family Care, the participant would have the option to choose an outside broker/care manger with whom he or she would work.
- Outside brokers/care managers would have a collaborative, non-adversarial relationship with the local program, the care manager, and the participant. The broker would be a member of the participant's interdisciplinary team.
- The roles of the care manager and the outside broker/care manager could be divided in a number of ways. For example, the care manager could focus on formal services routinely funded by local programs. Outside brokers/care managers, who would not be direct employees of the local program, could help the participant develop informal or community resources, and could help with activities that might require less skill and experience than care managers possess.
- Local programs could offer a continuum ranging from the exclusive use of agency care management to total utilization of outside broker/care management, although it would be expected that few people would choose the latter option. More likely, outside brokers/care managers could be used to facilitate a limited number of specified services and informal supports, while care mangers would assist the participant with all other aspects of services provision and budgeting.[6]

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[6] Budget approval would remain the responsibility of the participant and the rest of the members of his or her care planning team. The outside broker/care manager would not assume sole responsibility for that task.

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- Care must be taken to avoid the duplication of services and costs. The outside broker's/care manager's responsibilities and costs can be planned for by carving them out of the duties and costs of the care manager, or they may be paid for separately as part of the funding available within an individual's allocation for services.
- Participants could choose to limit or expand the assistance the outside broker/care manager provides. For example, the broker could focus initially on the development of the service plan and getting the services, both formal and informal up and running. As the plan comes together, the participant could choose to reduce the involvement of the outside broker/care manager and work primarily with the care manager. The outside broker/care manager's responsibilities would increase or decrease depending on the preferences and needs of the participant.
- If interest in this option increase over time, the local program could contract with agencies that provide qualified brokers. Participants could interview and hire outside brokers/care managers from these agencies. Alternatively, participants could choose to utilize an outside broker/care manager who is a family member, friend, or another trusted adult with knowledge of the funding program. This could be a paid or unpaid support, however, parents, guardians, payees or other legal representatives of the participant would not be appropriate candidates for a paid broker position.

F) Individual budget development, savings, and managing institutional stays
This paper recommends that participants be offered budget authority for SDS, in addition to employer authority. Please see Part 2.D.1. for an explanation of budget and employer authority.

Attachment C provides a set of broad recommendations for developing a budget methodology. The recommendations are based on a review of SDS budget methodologies employed in several long-term care programs, including Wisconsin's Family Care.

Typically, approaches for budget development in SDS either use historical data to derive a dollar amount (basing the budget on what services for the participant or similar participants cost under traditional service provision arrangements), or use assessment information to determine what the participant's needs are, and then allocate an amount of funds sufficient to meet those needs in a cost effective manner. There are examples of each approach in Attachment C. Note that instead of recommending one over the other, Attachment C makes a distinction between an individual *allocation*, which is the dollar amount available to a participant using SDS, and an individual *budget*, which is a plan of services and supports that describes how the allocated dollars will be utilized. Regardless of which comes first, any SDS methodology must explicitly consider both the individual allocation and the individual budget.

A question typically raised when considering SDS budgets is "What to do with savings if a participant under-spends the budget?" Given the existence of waiting lists and the move toward managed long-term care, this question might better be phrased as "How to create incentives for cost-effective individual budgeting?" This component of individual budgeting is addressed in Attachment C.

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Finally, a budget methodology may need to consider how institutional stays are handled in SDS programs. If the participant's workers are not paid during a short-term nursing home or hospital stay, the participant may well lose his or her provider network and thus have difficulty returning to the community. However, paying workers when they are not needed results in duplicative, non-productive program costs. This is similar to "bed-hold" issues faced by nursing homes and substitute care facilities. It is possible that, similar to a vacancy factor built in to a residential care rate, an individual allocation methodology could take into account the participant's health history and build in an expectation for a certain number of days when home care workers will not be needed. Efforts are still needed to develop cost-effective approaches that comply with waiver standards for addressing this issue.

G) Assessing cost effectiveness of SDS

The use of the self-direction option should not significantly increase service provision costs, or inflate administrative expenses. The cost of services being provided under self-direction would typically be comparable to those provided in a traditional care management model. For example, instead of receiving home delivered meals through a network provider, participants could use a pre-paid credit card loaded with the dollar amount normally spent on a month's worth of home delivered meals. The participants could then use the card to order meals they prefer with the understanding that they need to stay within a budgeted dollar amount per meal. The local program would have spent the same amount of money per month in each option, but by using the credit card, the participants exercise much more autonomy and purchase the meals that they prefer.

Costs can be controlled through well-designed individual allocation and budget methods, utilizing tools such as the RAD to support creative, cost-effective approaches to service needs. Systems would be developed for ongoing monitoring of costs to make sure they are staying within budget. Timely identification and response to increasing service utilization and costs can help bring expenditures under control and ensure that the changing needs of the participant are being adequately addressed.

Evaluating the cost effectiveness of SDS over time will be an important component of quality management. Existing research on the costs of SDS programs in other states, including the Cash and Counseling research completed by Mathematica Policy Research, Inc., provide some potential evaluation models for Wisconsin. Please note, however, that the Cash and Counseling demonstrations themselves may be significantly different from Wisconsin's SDS approach, in that a Waiver and/or Medicaid Personal Care benefit is "cashed out" directly to participants. This approach introduces variables that may affect the cost of the program, and which may not be present in Wisconsin's program.

Research on the Cash and Counseling programs shows that higher Personal Care service costs for SDS participants (where they exist) are caused by an increase in utilization over non-SDS participants. In other words, non-SDS participants in these states typically use fewer of the hours authorized for personal care than their SDS counterparts. Cash and Counseling states have addressed this effect by applying a discount to the SDS plans, so that the amount of the individual allocations is more consistent with the amount that non-SDS participants would use. This effect also may be exacerbated by the way the Cash and Counseling benefit is

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administered, and seems less likely to occur in Wisconsin, where participant spending will likely be more closely tied to a well-developed service plan based on participant outcomes and assessed needs.

Research on Cash and Counseling and the state of Texas SDS program also suggests that while the cost of Waiver services (primarily home care, including personal care) may increase for SDS participants, these increases are offset by decreases in Medicaid costs for acute care and prescription drugs.

As Wisconsin develops its quality management plan, it should plan to collect and analyze data that will support comparisons of costs between participants using the SDS option and those in traditional Waiver programs. It could track differences in the cost of long-term care services both within and outside of the SDS allocation and budget. It could also track differences in other Medicaid costs, including prescription drugs and acute health care.

A quality management plan should also consider the impact of SDS on other variables indirectly related to cost. It could track differences in utilization, particularly for personal care and supportive home care. It could attempt to measure the impact of SDS on participants' access to workers, particularly in areas where there may be a shortage of provider agencies. Additionally, the quality management plan could attempt to identify the long-term impact of SDS on participant outcomes that may indirectly influence costs, such as physical and mental health status and longevity.

H) <u>Assuring quality of SDS</u>
Each local program would have a quality management plan that outlines its overall approach to assuring quality of services, including those available for self-direction.

Typically, a local program's quality management plan would involve a number of components, including:
- Participant outcomes measurement, using interviews or another technique
- Satisfaction surveys
- Quality indicators (quantitative measures of program performance)
- Analysis of complaints and grievances
- Analysis of critical incidents

Local programs use information from these discovery techniques as a basis for targeting areas for quality improvement.

These quality management discovery approaches apply equally to self-directing participants and participants receiving standard services. For example, self-directing participants can engage in outcomes interviews and respond to satisfaction surveys, with appropriate follow-up for problems that are identified. However, it may be more challenging for local programs to undertake quality improvement initiatives in response to findings of quality problems in SDS, since the local program may not control all service providers like it does in traditionally delivered services. To the extent that quality problems involve care planning, training or other

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elements in control of the local program, quality improvement for SDS is more readily achievable.

The SDS Cross Unit Functional Team should work closely with the Quality Close to Home (QCTH) Initiative, which is developing an overall quality management strategy for home and community based long-term care services. This will ensure that SDS is an integral part of the QCTH initiative, and that the recommended quality management strategy accounts for the unique characteristics of SDS that could present challenges to quality measurement and improvement efforts.

I) Developing expectations for implementing SDS
Requirements for SDS will be included in the RFP that will be issued for new CMOs as part of the long-term care redesign initiative. It would be expected that new CMOs implement SDS programs.

Recognizing that development of fully functioning SDS programs takes time, and that new CMOs will be simultaneously developing and implementing all aspects of their programs, it is recommended that expectations for SDS programs be phased in over time. For example, it may not be required that CMOs offer SDS budget authority to participants during their first year of operation – employer authority may be sufficient. Requirements to offer support brokers also may be phased in. Contracts between DHFS and CMOs would specify phase-in requirements.

Counties administering COP-W and CIP programs are expected to offer SDS to participants; however, the extent to which they are doing this varies substantially. It is very important that waiver counties continue and expand their SDS programs during the period of transition to managed care, to better serve participants, to meet CMS expectations, and to develop their capacity to meet requirements of the managed care environment.

J) Applicability of SDS to mental health/substance abuse and the children's waivers.
This paper has focused on SDS in long-term care. However, representatives of the mental health/substance abuse and children's systems have also participated in the SDS initiative.

The BMHSAS supports a recovery-based approach to services. A key component of recovery is consumer ability to make choices about their lives and services. As illustrated in Part I of this paper, this philosophy is compatible with SDS. Work is currently taking place on developing recovery-based CSP and CCS services. Self-direction as outlined in this paper may be appropriate for some clients of these services.

It is particularly appropriate to consider SDS for mental health/substance abuse services along with SDS for long-term care, due to the high level of overlap between the two programs. Many participants in long-term care programs also have mental health or substance abuse issues. Therefore SDS policies need to be crafted to fit both systems.

Children's waivers will likely continue to operate on a fee-for-service basis for the foreseeable future; there are no current plans to migrate them to managed care.

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Part 4 –Next Steps

This report has provided an overview of SDS and how it could be implemented. It is intended to offer guidance to existing long-term care programs and new managed care organizations as they design or expand their approach to SDS. The report is advisory only; requirements for SDS programs will be determined by DHFS policy and resulting contract language.

With the preliminary phase of the initiative completed, the SDS Cross Unit Team has identified the following areas for further research and development:

- Collaborating with DHFS to produce models for quality management in SDS that will be consistent with quality management strategies for long-term care programs, including assuring compatibility between SDS and managed care systems.
- Creating a website housing a comprehensive library of SDS resources, guides, and tools. The information will be geared towards participants, care managers, local program administrators and providers, and will build on the wealth of resources on self-direction that is available nationally. All material will be reviewed and edited to ensure that it is compatible with Wisconsin law and policies.
- Recommending SDS contract language for new managed care organizations.

Finally, representatives of the SDS initiative will educate county waiver programs, Family Care CMOs, Wisconsin Partnership programs and managed care planning consortiums about SDS approaches, and will familiarize them with resources that have been made available to support design and implementation of local SDS programs.

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Attachment A
Description of the SDS recommendation development process

The SDS Stakeholder Committee developed the recommendations in this report in consultation with the Cross-Unit Team. TMG provided staffing and facilitation to the SDS Stakeholder Committee. Dan Johnson of the Bureau of Aging and Disability Resources chairs the SDS Cross-Unit Team

The SDS Cross-Unit Functional Team meets at least monthly. It is responsible for coordinating SDS efforts in the Division of Disability and Elder Services. Its membership includes:

Cecilia Chathas	BLTS – PACE and Partnership
Stuart Gilkison	BADR
Jennifer Gillespie	DDES – Administrator's Office
Pam Groeschl	BLTS – Children's Section
Dennis Harkins	Pathways Consultant
Chris Hess	Community Care – Milwaukee
Dan Johnson	BADR
Charlie Jones	BLTS – Managed Care Section
Cheryl Lofton	BMHSAS
Jenny Neugart	Pathways
John O'Keefe	BLTS – DD Section
Gail Propsom	BLTS – COP Section
Sharon Ryan	DHFS
Ann Sievert	Pathways
Eva Williams	Pathways Intern
Deb Wisniewski	Pathways Consultant

The SDS Stakeholder Committee is a broad-based group including consumers and representatives of county long-term care programs, Family Care CMOs, Independent Living Centers, fiscal agent organizations, and mental health CSPs. The Committee has met several times, both in person and by conference call. Members of the SDS Cross Unit Functional Team also participated in these meetings. The SDS Stakeholder Committee was created to provide advice to the SDS Cross-Unit Team. Its membership includes:

Nancy Austin	Villa Hope CSP
Joyce Binder	Independent Care
Kathi Cauley	Jefferson County CSP
Dennis Ciesielski	Dunn County DHS
Tiffany Dorst	Waupaca County DHS
Jenny Fasula	Mid-State Independent Living Consultants
Pam Frary	North Central Health Care

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Mary Hofland	St. Croix County DHS
Pat Keefer	Milwaukee Center for Independence
Kathie Knoble-Iverson	Independent Living Resources Services
Ron Lockwood	St. Croix County DHS
Karol McKormick	Jefferson County CSP
Mark Morrison	Door County Dept. of Community Programs
Roxanne Price	La Crosse County CMO
Ginger Reimer	Independence First
Dan Rossiter	Dane County DHS
Jean Rumachik	Society's Assets
Tim Sheehan	Center for Independent Living – West Wis.
Naomi Silver	Consumer Advocate
Sally Sprenger	Anew Home Healthcare
Steve Stanek	DD Council
Matt Strittmater	La Crosse County DHS
Andrea Summers	North Central Health Care
Chris Thomas-Cramer	WCDD
Dee Truhn	North Country Independent Living
Kari Vinopal	CCP Community Services
Tom Wirth	Eau Claire County DHS
Deanna Yost	Consumer Advocate
Lisa Zaspel	CCP Community Services

The Management Group, Inc. (TMG) provides staffing for this initiative. TMG staff includes Gail Nordheim, Shanna Jensen, Dave Verban and Theresa Hobbs.

Liability Risk	Party Potentially at Risk	Mitigation Action or Strategy	Action Detail	What it does:
Employment and Tax Regulations	Consumer	Use of Fiscal Agent	(Sometimes called a fiscal conduit) Consumer is employer of record	Provides basic support to help consumer manage payroll responsibilities
			FA issues paychecks and handles tax withholdings	
		Co-Employment (or Agency with Choice)	Agency is employer of record; consumer is managing employer	Advise and support consumer to assure that tax and employment obligations are met;
				Provide key employer functions, to assure compliance with tax and employment regs
		Workers Compensation	Workers Comp must be in consumer's name for consumer to be consider employer by WI DWD	Not required by State employment law, but protects consumer from possible claim in case of worker injury
		Consumer Training	Employment Law/Legal responsibilities of Employer	Assures Consumer able to meet obligations as employer
			Risks associated with employer role	Assures consumer understands, and can make reasonable judgments about their ability to meet obligations as employer
		Employment Agreements (Written)	Written agreement between consumer and worker, describing responsibilities of each and reinforcing employment at will. (Reference samples)	Reduces risk that consumer will need to fire or take other action in the case of an unsatisfactory worker
		Documented Worker Screening and Training Protocols (including background checks)		Reduces risk that consumer will need to fire or take other action in the case of an unsatisfactory worker
		Independent Case Manager	May assist consumer to make decisions about whether to assume employer responsibility, and to acquire adequate training and support	Possible additional level of protection for consumer; May help consumer make best decision about whether to assume employer responsibility and how much support will be needed
	Worker	Worker Training	Essential Competencies	Increases likelihood that worker will understand and be able to meet their obligations
			Tax and Employment responsibilities	
			Adult Protective Services (APS) Laws	
	County (Funder)	Use of Fiscal Agent or Intermediary	Contract with Fiscal Entity delineating responsibilities and obligations	Insulates county against responsibilities for complying with tax and other employment regulations
		Consumer Training	Employment Law/Legal responsibilities of Employer	Reduces risk of county being found liable as employer by reducing risk of any criminal or civil actions against a consumer
			Risks associated with employer role	
Risk of Harm or injury	Consumer	Documented Worker Screening and Training Protocols (including background checks)		Minimize risk of incompetent care that could lead to harm

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Liability Risk	Party Potentially at Risk	Mitigation Action or Strategy	Action Detail	What it does:
		Maintain registry of qualified workers (based on some standard and relevant criteria)		
		Documented process for service and spending plan approval, including criteria for approval		Minimize risk of a service plan that does not meet basic health and safety needs
		Written emergency back-up plans	(Note: Include examples of Dane's approach, contracting for a pool of available back-ups)	Minimize risk to consumer's well-being in case of emergency
		Documented process for designating Authorized Rep		Provides protection by assuring an authorized rep is qualified to advise and support the consumer
		Risk assessment and negotiated risk management plan (written) between county and consumer		Minimize risk of a service plan that does not meet basic health and safety needs
	Worker	Worker training	Best practices for safety and risk mitigation	Minimize risk to worker's health arising from work-related injuries
		Workers Comp Insurance		Provides remedy in case of injury
Risk of Civil action, due to negligence; (e.g. failing to provide expected standard of care)	Consumer	Personal Liability Insurance	Note: May include some mechanism to address 3rd Party liability, in case of injury caused by consumer or worker to a 3rd party.	Protects consumer's assets, if applicable
		Property Insurance		Possible protection against injury to worker on premises, not directly related to job functions
	Worker	Worker training	APS training	Minimize Worker exposure to claim for failure to report possible abuse or neglect
			Essential Competencies and expectations	Minimize risk of negligence due to inability to provide adequate care
		How to protect worker against claim if they injure a consumer?	The best strategy for avoiding liability for negligent care giving is to provide adequate training and oversight	
		Routine performance evaluations		
Risk of Civil action, due to negligence; (e.g. failing to provide	County (funder)	Informed and voluntary written consumer consent to participate in CDS		Increases assurance that consumer understand their obligations and risks under CDS, and may provide protection for funder against claim arising from either injury to consumer or consumer failure to follow tax or employment regulations

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Liability Risk	Party Potentially at Risk	Mitigation Action or Strategy	Action Detail	What it does:
expected standard of care)		Review existing liabilities, in contracts, regulations, protocols		Allows funder to identify liabilities that already exist, and to determine whether they change under CDS
		Contracts with providers and fiscal agents delineating expected outcomes, responsibilities; specifically addressing liability risks		Outcome-based contracting improves ability of funder to provide oversight, and increases likelihood of satisfactory outcomes; May limit funder's liability in cases where provider or fiscal agent fails to meet their obligations.
		Documented worker screening and training protocols		Minimize risk of incompetent care, which could lead to consumer harm, and claim against funder
		Documented process for service and spending plan approval, including criteria for approval		Minimize risk of a service plan that does not meet basic health and safety needs
		Written emergency back-up plans		Minimize risk to consumer's well-being in case of emergency
		Documented process for designating Authorized Rep		Provides protection by assuring an authorized rep is qualified to advise and support the consumer
		Risk assessment and negotiated risk management plan (written) between county and consumer		Minimize risk of a service plan that does not meet basic health and safety needs

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	Definitions:
	Individual Allocation: Amount of money made available to an individual consumer
	Individual Budget: Plan of services and supports, and the associated costs, that describes how the individual allocation will be utilized

Guiding Principles:
- Budget based on real information about individual
- Funding is portable, attaches to person, not providers
- Person sets priorities (outcomes), and people with greatest needs get greatest dollars
- Method is well defined, predictable, transparent, and understood

	Method for Setting Individual Allocation	Method for Setting Individual Budget	Ind. Allocation Adjustments	Ind. Budget Adjustments	Fit with Managed Care Principles	Services included in SDS Budget	Incentives for Cost Effective Service Planning	General Controls and Protections
Recommendations	• Include Person-centered planning process • Allocation method should be uniform across all consumers • If allocation is set before budget, there should be a data-based method for determining the individual amount • Allocation method should result in an equitable distribution of available funds across all clients	• Tool or criteria for developing the budget – linking services to individualized consumer outcomes • Allow consumer to negotiate own provider rates, if desired.	• Emergency or back-up funding mechanism • Consumer or team should have the ability to request modified allocation • Well-defined process for monitoring spending and flagging overruns.	• Clear policy on what happens if consumer spends under budget. • Allow consumer to modify budget within allocation with minimal constraints.	• Provide information – the cost of the plan should be transparent to consumers and case management team • Operational protocols that are flexible enough to allow consumers to choose from the broadest possible menu of services • Retain some independence between the process of setting provider rates and setting individual allocations.	• All long-term care services	• Avoid practices that may inadvertently encourage consumers to spend all their budget (e.g. the "use it or lose it" mentality) • Create a clear policy for allocation of unspent individual budget funds • Assure that consumer is aware of service costs	• Adequate funding available • Minimize implementation costs • Leverage existing data and systems • System-wide implementation • Strong leadership • Support for staff to learn and implement SDS • Availability of independent case coordination • Rigorous and uniform methodology

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	Method for Setting Individual Allocation	Method for Setting Individual Budget	Ind. Allocation Adjustments	Ind. Budget Adjustments	Fit with Managed Care Principles	Services included in SDS Budget	Incentives for Cost Effective Service Planning	General Controls and Protections
Family Care	• Interdisciplinary Teams (IDT) develop the budget, based on multiple factors, including: comprehensive assessment, desired member outcomes, RAD, and reasonable estimate of service cost outside SDS • RAD: process for balancing desired outcomes with costs • Allocation (cost) based on the supports in plan • Providers chosen from within and outside CMO provider network • Rates established by CMO network developers act as a baseline for cost determination		• Change in member needs or desired outcomes may result in re-visiting Member Centered Planning process to establish new plan/budget based no RAD • Member can make changes within allocation, with support from IDT; new services are subject to RAD process.		• Experience to date suggests that SDS option fits well with the FC approach • Members know the cost of their plan, and this seems to have both empowering and an effective cost management impact.	• Any service that is part of the FC benefit package that emerges from the individual RAD process		• FC teams work with member to develop and implement all plans • RAD assures consistent methodology; emphasis is on achievement of member outcomes

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	Method for Setting Individual Allocation	**Method for Setting Individual Budget**	**Ind. Allocation Adjustments**	**Ind. Budget Adjustments**	**Fit with Managed Care Principles**	**Services included in SDS Budget**	**Incentives for Cost Effective Service Planning**	**General Controls and Protections**
Dane County	• Budget amount had been based on historical expense data • Currently, process to setting base rate, that can be adjusted up or down based on comparative review of individuals with similar needs. • Budget broken out into 3 components: residential, vocational/day service, and misc.	• Consumer receives the budget amount first – constructs a service plan within the dollar limits • No pre-set provider rates. consumer/broker negotiate their own package with providers	• Multiple steps for addressing budget shortfall/overspending: • Informal Review • Formal Request • One-Time Exceptional Expense Requests • Process for capturing under spending which is returned quarterly, unless plan includes the expense. • Increases are subject to availability of funds except for health and safety needs, or; • Potential cost-savings as a result of investment	• County Manager receives monthly statement on all individual expenditures. • Individuals may transfer payments to different providers or to different programs without seeking permission of County as long as the Individual Allocation is not exceeded	• Provider rates are not pre-determined (across the board provider rates are average rates for average individual need and do not allow for individual program design) and are set at the consumer/broker level • De facto capitation (i.e. limited program budget) managed via individual budget setting process • The Individual Allocation may be adjusted annually to reflect County's total system allocation. • Participant chooses all team members including the Care Manager (Support Broker)	• Includes all Waiver services; County acts as MAPC provider and includes these funds in the Individual Allocations • Can include virtually any support, service, or good directly related to the individual's disability • Excludes Licensed or Certified Residential Care Settings		• Consumer chooses Support Broker • Support Brokers are independent; first line of quality assurance • Fiscal agent authorizes payment only up to amount on ISP. • Administrative Contract with providers, requiring notice to the County if Support Broker is not functioning in the best interest of the individual • Also requires Providers to adhere to the County's Abuse & Neglect guidelines and the County's Health and Safety Guidelines • County Manager receives monthly statement on all individual expenditures

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Other WI Waivers	• Occurs after and corresponds directly to budget setting. • All budget items unable to be funded (no money available) are wait listed except for those meeting needs of health or safety, which are funded immediately.	• SSC/CM completes comprehensive person centered assessment; service plan is built to meet assessed needs individual outcomes. • Natural and no cost services and supports are identified, are neutral ingredients of budget calculation. • Maximize MA first Waiver rule is followed: MA Card costs are not included in the budget setting calculations • Agency rate serves as the basis for non-agency service/item. • Typical provider rate may be exceeded for cause. • Provider sets rates	• Allocation adjustment occurs after and corresponds directly to budget adjustment. • Increases are subject to availability of funds except for health and safety needs. • Increase also occurs when wait list movement allows for reallocation to budget.	• Re-assessment on an at least annual basis may determine change in need, or the team may determine a more cost effective manner to meet needs and outcomes. • Increases are subject to availability of funds. • Unanticipated "under-spending" is used for wait list. • Some counties are flexible in allowing participant to shift expense between services without additional approval/review • Cost share may fluctuate	• Participant is at the center of a team. • Services authorized without regard to the slot value or state reimbursement. • Participant receives only what they need to achieve outcomes, have needs met. • Rate setting is generally based on the county/provider-contracted rate. • Risk balancing plays part in service authorization.	• Increasingly budgets are including MA Card Costs		• Fiscal agent authorizes payment only up to amount on ISP. • SSC/CM fiscal staff monitors spending according to individual service plan. • Additional diligence from SSC/CM in areas otherwise handled by agency.

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Wyoming (DOORS)	• Derived from data – statistical analysis • ICAP, and other, factors • Applied uniformly across consumers • Works as an "equitable allocation" of available funds (across entire state)	• Budget amount derived independently – sent to ISC (CM) • ISC convenes planning team with consumer (and others) • Team determines services, providers, and sets/negotiates rates		• Reserve Fund (state level) • Local planning team	• Rate-setting (or negotiation) at consumer team level			• Independent Support Coordinator (ISC) – each consumer chooses one. • Some ISCs work for provider agencies, some are free agents • State staff does assessments • Independent contractor calculates budgets • Cost factors are masked in assessment • Independent Service Coordinator

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Michigan Managed Care	• Flexibility across CMOs (they refer to them as PIHPs) was negotiated with CMS, with the bottom line being: 1) A person-centered Individual Services Plan must be created that meets the individuals & 2) the funding for that plan must be adequate to meet the identified needs. • PIHPs typically start with historical data, AND /OR create a person-centered plan without a budget target and then cost it out.	• Same as allocation, since the allocation is actually derived from creating a budget based upon a person-centered plan. • Some PIHPs "discount" the budget by 10-15% for people who employ their own staff, the rationale being that administrative costs will typically be reduced by that amount.	• Allows for contingency authorizations by PHIP in response to request.	• Allows for changes in budget by individual so long as changes stay within approved allocation and are allowed goods or services.	• Person-centered planning was mandated by statute and self-determination had begun as a pilot prior to managed care planning. Both were accepted as requirements within the managed care "specialty plan" that now provides services to people with developmental disabilities and people with mental illness.	• Extensive and flexible list. In practice, licensed group homes are not included within the budget that a person directs, although there is not state prohibition for doing so.		• There is a strong emphasis on cost considerations and "value purchasing" at all levels of the system, including the individual. • Budgets monitored monthly through fiscal intermediary and/or PHIP • Individuals have the option to have independent support brokers to assist with different aspects of initial and ongoing planning.

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