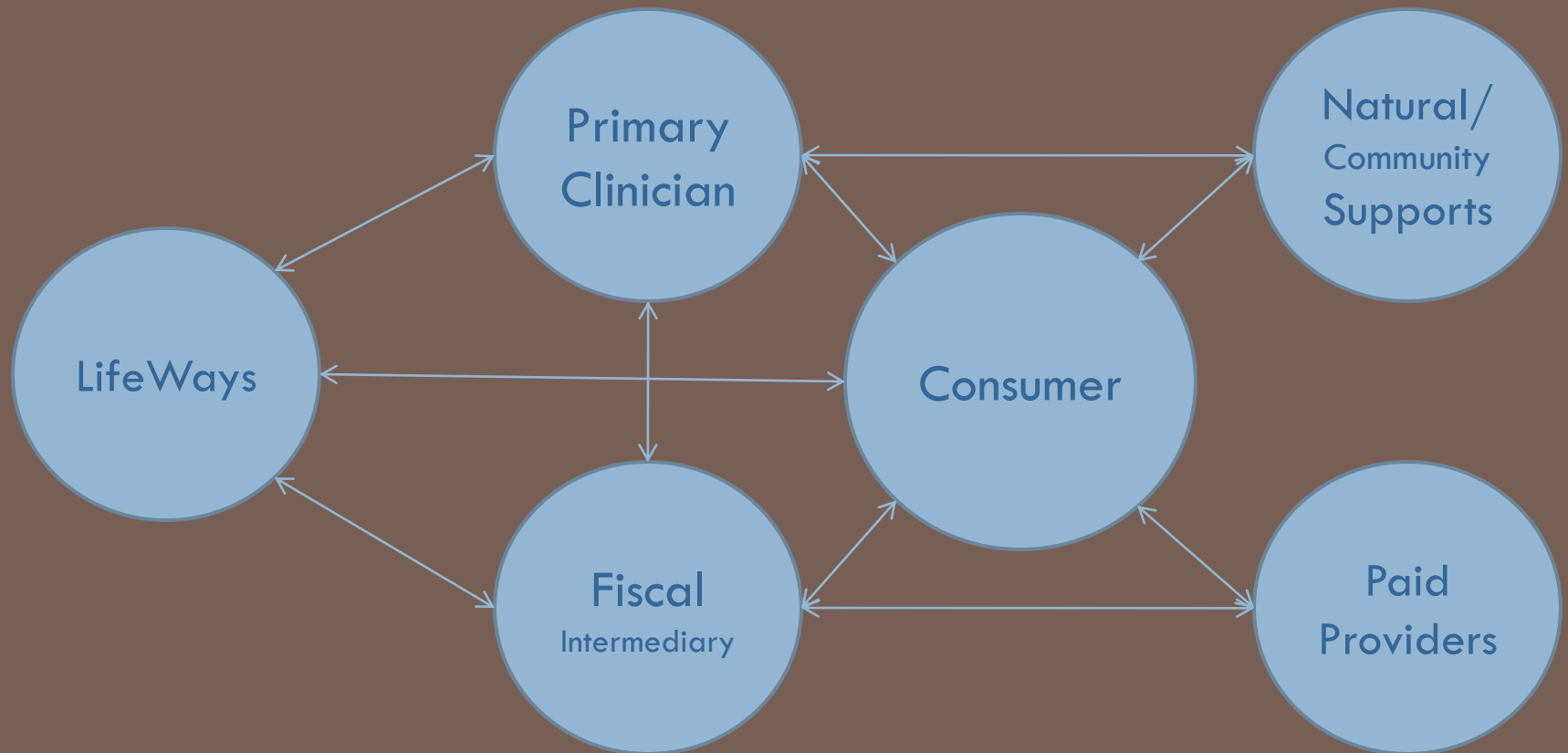


SELF-DETERMINATION



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Self-Determination is . . .

- A philosophy that people with disabilities have the right to control their own lives. Under a Self-Determination arrangement, consumers can hire their own workers and manage their services within a set budget.
- Four main principles:
 1. Freedom: to live the life they want and to have choice (of qualified providers and eligible services)
 2. Authority: to control the way they receive their authorized services and supports within a budget (based on Individual Plan of Service)
 3. Support: is provided to foster success
 4. Responsibility: to follow State and Federal laws, to control a *set amount* of money to purchase support services based on their Individual Plan of Service, and to use public funds wisely



Funding & Supports

□ Public Dollars

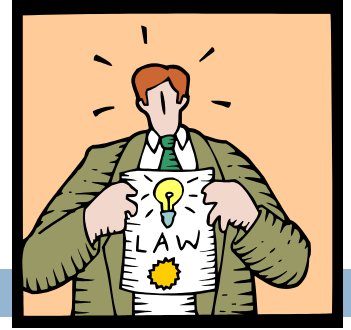
- SSI/SSDI/Social Security/Medicaid rules still apply
 - Must use resources within published guidelines
 - CMS (Centers for Medicaid Services)
 - DHS (Department of Human Services)
 - SSA (Social Security Administration)
 - DCH (Department of Community Health)
 - LifeWays

□ Private Dollars

- From employment
- Family contributions



Medicaid Basics



- Medicaid pays for services that are medically necessary:
 - To screen and assess the presence of mental illness, developmental disability or substance abuse
 - To assist with attaining or maintaining sufficient functioning level to achieve goals
 - Encourages community inclusion and participation
 - Based upon personal and clinical information
 - Provided by trained professionals (or staff supervised by trained professionals as appropriate)
 - Based upon person-centered planning
 - Provided within standards of timeliness
 - Sufficient in amount, scope and duration to achieve identified purpose (goals)

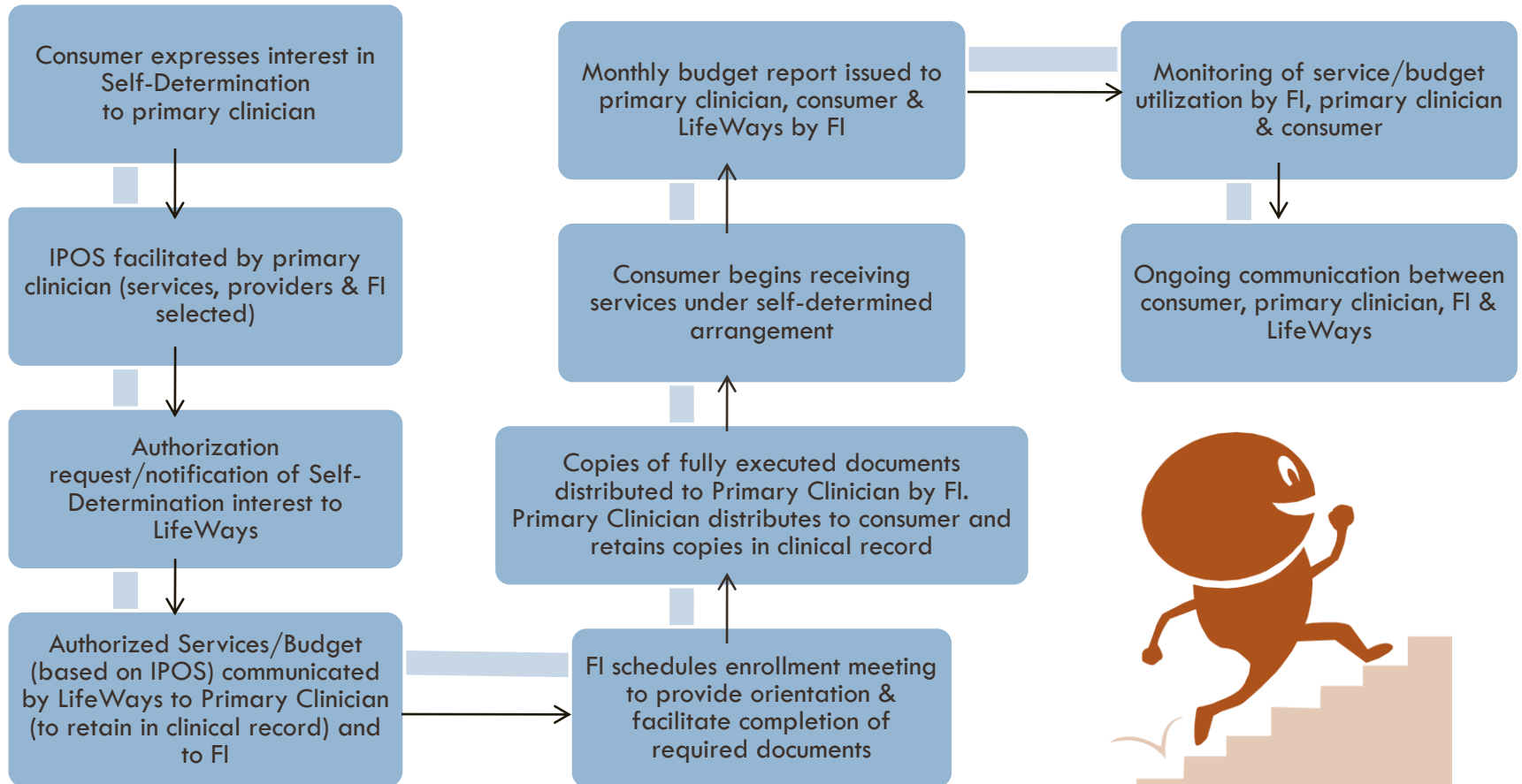


Medicaid Basics

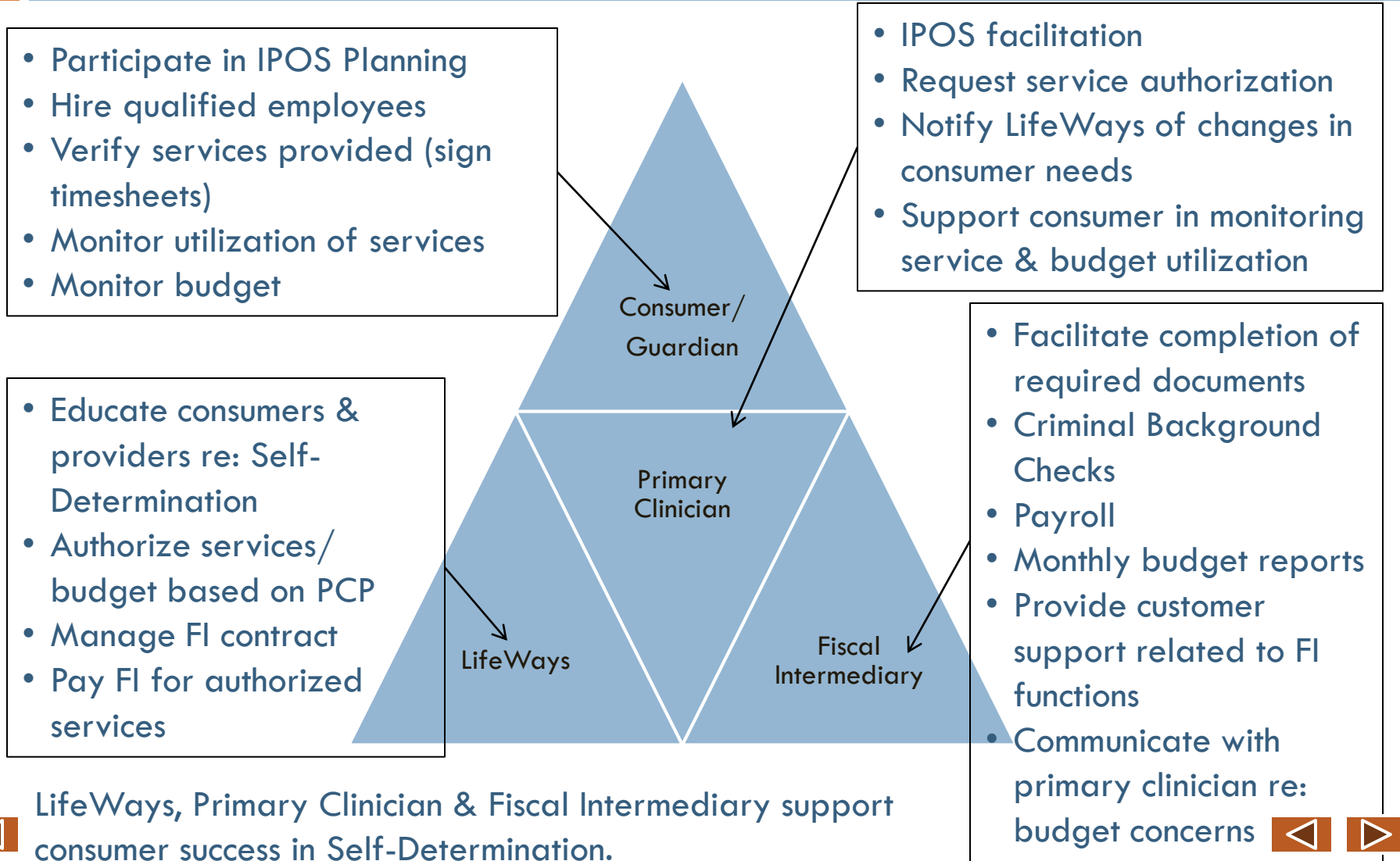


- Medicaid is the “payer of last resort”. That means all other natural and community supports must be used before Medicaid will pay for a service.
- Services are defined in Section 3 of the Mental Health/Substance Abuse chapter of the [Medicaid Provider Manual](#).
- Specialty services and supports cannot supplant (be used instead of) State plan services.
 - For example: Home Help (State Plan) must be used before Community Living Supports (Specialty Service)
- The Individual Plan of Service (IPOS) that results from person-centered planning specifies the amount (how much & how often), scope (what kind) and duration (for how long) of each service needed to support the achievement of those goals.

Process



Roles & Responsibilities



LifeWays, Primary Clinician & Fiscal Intermediary support consumer success in Self-Determination.



Roles & Responsibilities: Employee

- Provide services according to IPOS
- Document services provided in a timely and accurate manner
- Provide documentation and consumer progress updates to primary clinician
- Submit accurate time sheets (signed by consumer/guardian) to Fiscal Intermediary
- Complete Employment Agreement or Staffing Agency Agreement (with consumer/guardian)
- Complete Medicaid provider agreement



Authorization Requests

- Individual Plan of Service submitted to LifeWays Utilization Management for review, including:
 - Per diem service request form (if applicable)
 - Any supporting documentation not included in IPOS
 - IEP (if applicable) – Medicaid cannot supplant school services
- Utilization Management reviews within two business days of receipt
 - If pended, Utilization Manager sends information request to provider (provider has 5 business days to respond or request will be denied)
 - When authorized, Utilization Manager completes Budget Determination Summary/Authorization Letter and denial letter if necessary
- Common reasons for denial
 - Lack of response to information request
 - Intensity not supported in IPOS (medical necessity)
 - Duplication of services (across providers – poor care coordination)
 - Consumer ineligible



Authorizations

- Budget Determination Summary (should be reviewed with consumer/guardian by primary clinician):
 - Consumer name & case number
 - Diagnosis
 - IPOS end date
 - Primary Clinician
 - Fiscal Intermediary
 - Services authorized, LifeWays authorized rate, effective/end dates and authorization number
 - Authorized budget amount per service type
 - Total authorized budget for treatment period. Note: non-service related costs such as employment costs (like training and workers' compensation) & Fiscal Intermediary costs are not part of the calculated budget.
- Sent to Fiscal Intermediary and Primary Clinician by LifeWays Utilization Management
- Must be maintained in the clinical record and Fiscal Intermediary records



Self-Determination Budget



- Developed by Fiscal Intermediary based on services authorized by LifeWays
- Sent to consumer (or guardian), primary clinician and LifeWays
- Must be retained in consumer's clinical record by primary clinician

Sample Budget Report

Sent each month to:

- Consumer or guardian
- Case Manager or Supports Coordinator
- LifeWays

Individual Report For **For Month of:**

CONSUMER NAME **Your Budget is OK**

Authorization Period: _____

Item	Units Budgeted	Actual Units	Difference	Budgeted Cost	Month Cost	Difference
CLS (Hrs)	18	20	(2)	\$368	\$267	\$101
Fiscal Intermediary Fee				\$125	\$125	\$0
Skill Building (Hrs)	18	16	2	\$368	\$213	\$154

Authorization to Date

Item	Units Budgeted	Actual Units	Difference	Budgeted Cost	YTD Cost	Difference
CLS (Hrs)	61	36	25	\$1,269	\$480	\$788
Fiscal Intermediary Fee				\$500	\$500	\$0
Skill Building (Hrs)	61	28	33	\$1,269	\$373	\$895
Workers Comp				\$387	\$387	\$0
<i>Difference</i>						\$1,684

Remaining Until: _____

Item	Starting Units	Actual Units	Remaining	Total Budget	Spent To Date	Remaining
CLS (Hrs)	88	36	52	\$1,838	\$480	\$1,358
Fiscal Intermediary Fee				\$637	\$500	\$137
Skill Building (Hrs)	88	28	60	\$1,838	\$373	\$1,464
Workers Comp				\$387	\$387	\$0

Remaining Units: 114 Remaining Dollars: \$2,959

Your Supports Coordinator/Case Manager is: _____ Phone _____

This report was sent to the following people:

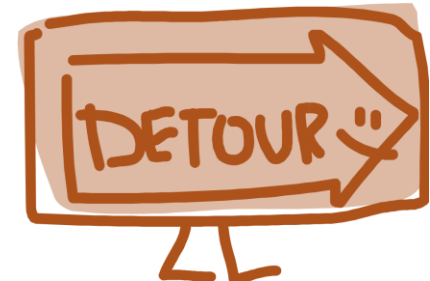
GT Financial Services ♦ 215 Broadus, Sturgis, MI 49091 ♦ 1-877-659-4500 ♦ support@gtfinancialservices.com

BudgetID: _____ If you have any questions, please feel free to call us! For Date Range Between: 12/1/2010 and 12/31/2010



Amendments to IPOS

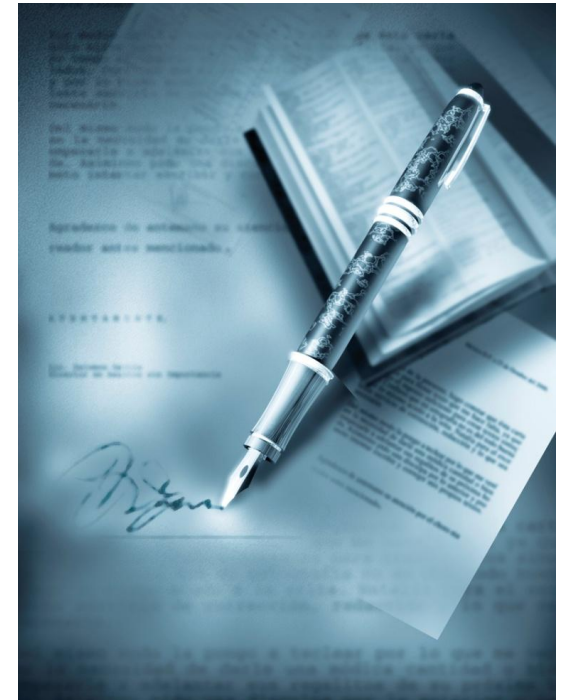
- Primary Clinician communicates changes to LifeWays Utilization Management (UM)
 - Monitor for fluctuations in usage
 - Document consumer involvement in any requests for changes
- Initiate communication to UM when a change in needs is identified (significant increase/decrease, temporary need, long-term need)
 - Provide UM with a formal addendum to the IPOS
 - If approved, a new Budget Determination Summary is completed



Required Agreements

Should all be in place BEFORE consumer begins receiving services through Self-Determination

- ❑ Self-Determination Agreement (a.k.a. Choice Voucher Agreement)
 - ❑ Between LifeWays & Consumer
 - ❑ Outlines purpose of Self-Determination & defines responsibilities of parties
- ❑ Employment Agreement or Staffing Agency Agreement
 - ❑ Between consumer and chosen provider/employee
 - ❑ Outlines services to be provided, rate of reimbursement, employee/employer responsibilities (must be updated when there are changes)
- ❑ Job Description
 - ❑ Signed by employee
 - ❑ Describes services to be provided, standard requirements of employment & essential job functions
- ❑ Medicaid Provider Agreement
 - ❑ Between LifeWays and provider/employee
 - ❑ Outlines provider responsibilities per Medicaid regulations & LifeWays standards
- ❑ Ethical Standards for Self-Determination Providers
 - ❑ Attestation of agreement with LifeWays defined ethical standards



Service Documentation Requirements

All documentation is subject to review by auditing bodies and must be made available, upon request, to LifeWays, the State Medicaid agency, the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

Basic service documentation forms:

- IPOS
- Progress Note
- PC/CLS Chart & Individual Consumer Log



Documentation: IPOS

- The IPOS is developed through a person-centered planning process.
- It is the basis for all services being provided.

INDIVIDUALIZED PLAN OF SERVICE			
Consumer Name (First, MI, Last)			Consumer No.
Date of Psychosocial Assessment:	Date of Pre-Planning:	Date of PCP Meeting:	<input type="checkbox"/> INITIAL Start Date: <input type="checkbox"/> ANNUAL End Date:
Integrated Treatment and Care Coordination			
Others involved in the consumer's treatment:		Method of Communication:	Frequency of Communication:
<input type="checkbox"/> LifeWays Physician's Unit, Physician Name:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Primary Care Physician, Physician Name:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Other Service Providers, Please list Name and Service:		<input type="checkbox"/> Fax <input type="checkbox"/> Letter <input type="checkbox"/> Telephone Call	
<input type="checkbox"/> Other, Please list:			
Comments:			
Preferences and Accommodations			
<input type="checkbox"/> Not applicable to consumer			
Preferences as indicated in assessment and/or the person centered planning process (include non-verbal needs):			
Accommodations made to meet preferences (include non-verbal accommodations):			
Health and Safety			
<input type="checkbox"/> Not applicable to consumer			
Summary of health and safety risks as indicated in assessment and/or the person centered planning process:			
Supports to address health and safety needs:			
Transportation safeguards:			
Formal Review of Effectiveness of Treatment Plan			
Consumer/guardian/family will provide ongoing feedback regarding their treatment plan using the following method:		<input type="checkbox"/> Consumer self report as needed <input type="checkbox"/> Scheduled face to face contacts <input type="checkbox"/> Telephone calls	
Staff will document consumer's satisfaction and progress towards outcomes using the following method:		<input type="checkbox"/> Progress Notes <input type="checkbox"/> Formal Review of Treatment	
Staff will conduct formal reviews of the treatment plan at this frequency:		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other:	
Consumer has Crisis Plan on file: <input type="checkbox"/> Yes <input type="checkbox"/> No			



Documentation: Progress Note

- The Individual Progress Note is used to document the provision of services when staff are *teaching and training* (regardless of location) and there is an expectation of progress.
- It must minimally include:
 - Consumer name & case number
 - Date of service
 - Start/Stop time of service
 - Place of service
 - Type of service (note: “self-determination” is not a service). Examples of services are: CLS, skill building, respite
 - Goal & Objective being worked on
 - Interventions provided (what staff did) & consumer’s response (what consumer did)
 - Statement of progress toward goal/objective (whether or not there was progress, how progress or lack thereof was observed)
 - Staff signature/date
- Additional notes may be written on the back of the form or on an attached piece of paper that includes the consumer’s name & case number

INDIVIDUAL PROGRESS NOTE	
Consumer Name (First, MI, Last)	Consumer No.
Start Time: _____ End Time: _____ Total Units Used (optional): _____	Date of Contact
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Community <input type="checkbox"/> Office <input type="checkbox"/> Other: _____	
Type of Service <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Case Management/Supports Coordination <input type="checkbox"/> IDDT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Family Counseling <input type="checkbox"/> ACT <input type="checkbox"/> Homebased	
Non-Billable Service (complete if applicable) <input type="checkbox"/> Telephone Call <input type="checkbox"/> Consumer Cancelled <input type="checkbox"/> Appointment Was: <input type="checkbox"/> Consumer No-Show/DNKA <input type="checkbox"/> Staff Cancelled <input type="checkbox"/> Scheduled/Routine <input type="checkbox"/> Unable to Locate <input type="checkbox"/> Other: _____ <input type="checkbox"/> Follow-Up/Random <input type="checkbox"/> Other: _____ <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> Unforeseen Need Requested by Consumer	
Comments:	
<input type="checkbox"/> Not a face-to-face contact (skip section) Consumer Presentation	
Orientation <input type="checkbox"/> Person <input type="checkbox"/> Place <input type="checkbox"/> Time Affect <input type="checkbox"/> Appropriate <input type="checkbox"/> Restricted <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other: _____ Mood <input type="checkbox"/> Dysthymic <input type="checkbox"/> Euthymic <input type="checkbox"/> Elated <input type="checkbox"/> Anger <input type="checkbox"/> Anxious <input type="checkbox"/> Manic <input type="checkbox"/> Other: _____ Thought Content <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Grandiose <input type="checkbox"/> Illusions <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____ Risk <input type="checkbox"/> Suicidal Ideations <input type="checkbox"/> Homicidal Ideations <input type="checkbox"/> Acute Psychosis <input type="checkbox"/> N/A <input type="checkbox"/> Other: _____ If Risk involved, please check as appropriate: <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Attempt <input type="checkbox"/> Other: _____	
Comments:	
New Health/Welfare/Safety concerns reported by the consumer or observed since the last contact? <input type="checkbox"/> No <input type="checkbox"/> Yes, Action taken: _____	
Goal/Objective addressed from Individualized Plan of Service (IPOS):	
Stressors and/or new issues presented today:	
Interventions provided and consumer's response: (i.e. motivational enhancing interventions, stage wise treatment)	
Natural/community support in achieving goal since last contact: (Indicate if present during contact, how staff is working to engage supports) <input type="checkbox"/> No support <input type="checkbox"/> Some support <input type="checkbox"/> Great support	
Comments:	
Progress towards goal/objective: <input type="checkbox"/> Not Rated <input type="checkbox"/> No Progress <input type="checkbox"/> Some Progress <input type="checkbox"/> Good Progress Comments:	
Satisfaction reported by consumer:	
Consumer's Rating of Their Progress: <input type="checkbox"/> I am happy with my progress <input type="checkbox"/> I am not happy with my progress Comments:	
Consumer Signature (optional)	Date
Staff Signature/Credentials	Date
Supervisor Signature/Credentials (if applicable)	Date



Documentation: PC/CLS Chart

- Used to document services provided in the home
- Completed in addition to Individual Consumer Log

NAME: _____ CASE# _____ MONTH/YR: _____

PC CLS	#Units		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
PC CLS		Eat/Feed																															
PC CLS		Meal Prep																															
PC CLS		Toileting																															
PC CLS		Bathing																															
PC CLS		Grooming																															
PC CLS		Dressing																															
PC CLS		Transfers																															
PC CLS		Ambulate																															
PC CLS		Housekeep																															
CLS		Laundry																															
CLS		Individual goals																															
CLS		Individual goals																															
CLS		Individual goals																															
CLS		Individual goals																															

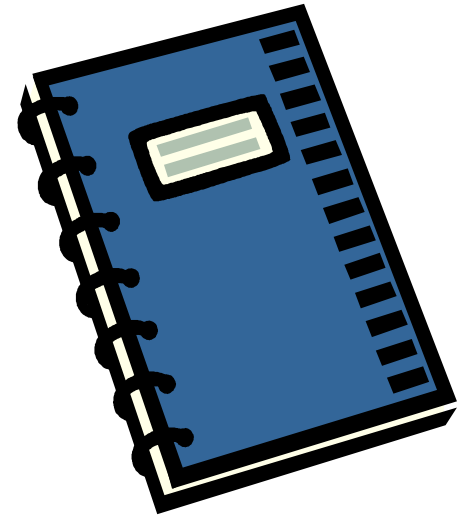
Circle PC or CLS being provided Enter # Units provided per day in each category Staff initial in box corresponding with the day of the month provided.
Staff Providing Care enter initials and signature below. If additional staff, add on back of the sheet.

1. _____ 4. _____ 7. _____
2. _____ 5. _____ 8. _____
3. _____ 6. _____ 9. _____



Documentation: Individual Consumer Log

- Individual Consumer Log
 - Used to document services provided in the home
 - Completed in addition to the PC/CLS Chart
 - Maintain separate log for each consumer
 - Make available for primary clinician review
 - Document the following:
 - Consumer Name
 - Date
 - Notes from each shift for that date, including:
 - Time period (ex. 8:00 a.m. – 12:00 noon)
 - Consumer response and progress toward goal
 - Anything staff did that is not recorded in PC/CLS Chart
 - Any behaviors/interventions*
 - Any medical issues/interventions*
 - Staff signature



*May require an incident report (explained in Recipient Rights training provided by LifeWays)



Documentation: Time Sheets

- Time sheets for directly employed staff
 - Must be signed by consumer/guardian
 - Must indicate service provided (ex., Community Living Supports, Skill Building)
 - Must include date and time OR date and number of hours provided (depending on type of service)
 - In-Home CLS (per diem service – include date and number of hours)
 - Out of home CLS & Skill Building – include date and time (ex. 9:00 a.m. – 11:00 a.m.)
 - When multiple consumers are served during the same timeframe, time must be divided among those served to reflect active treatment provided for each consumer. (ex. if served two consumers from 10:00 a.m. – noon, do not bill for two hours for each consumer)
 - Must be accompanied by progress notes that provide evidence of service delivery when submitted to the Fiscal Intermediary



Employee Eligibility

- ❑ Proof of appropriate licensure/degree (and/or supervision)
- ❑ Completion of training required by LifeWays (see Job Description or Staffing Agency Agreement and [Required Training & Resources Chart](#))
- ❑ At least 18 years of age at time of hire
- ❑ Not excluded from program participation (Medicaid, Medicare, LifeWays)
- ❑ Able to prevent transmission of communicable diseases
- ❑ Able to perform basic first aid procedures
- ❑ Felony Convictions:
 - ❑ The Medicaid Provider Manual allows past felony convictions for employees of adults, BUT that person must “not be a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing”. So, a person with a past felony conviction could be hired to work for with an adult IF they meet this additional criteria AND if the consumer/guardian employer signs the Criminal Background Check Waiver Letter available from the FI prior to hire.
 - ❑ Any felony conviction excludes a potential employee from working with a child.
- ❑ Able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and report on activities performed
- ❑ Refer to Job Description or Staffing Agency Agreement for requirements specific to services to be provided



Required Training & Resources

- ❑ [Click here to view Required & Resources Training Chart](#)
- ❑ Other training (depending on the type of service being provided and the consumer-employer's needs – see job description or staffing agency agreement)
- ❑ Employee must provide written proof of training to the consumer-employer and/or Fiscal Intermediary.
- ❑ Costs for training come from the consumer's self-determination budget.



Monitoring

□ Service Utilization

- Monitored by Primary Clinician & Consumer/Guardian
- Over/Under (medical necessity)
- Should be in alignment with IPOS
- Some fluctuations are expected, but dramatic fluctuations or changes in usage that are expected to continue require communication to Utilization Management



□ Budget

- Monitored by FI, Primary Clinician and Consumer/Guardian
- FI provides monthly reports
- Rates paid for services must agree with Employment Agreement or Staffing Agency Agreement AND cannot exceed LifeWays authorized rate (included in Budget Determination Summary)
- Important to consider employment costs (training, fiscal intermediary fees, worker's compensation) which are not included in budget calculations when determining rates of payment



Medicaid Fraud & Abuse



- As a person coordinating services that are paid for by Medicaid, you have a responsibility to protect against fraud/abuse. The following are examples of Medicaid fraud/abuse:
 - Falsified time sheets
 - Billing for services that were not provided
 - Poor or no documentation to support services delivered
 - Forging a signature
 - Recommending/referring to another provider or service and receiving a kickback for the referral
 - Providing and billing for services that are not medically necessary
 - Using Medicaid dollars to purchase, repair or maintain an asset (like a vehicle)



Medicaid Fraud & Abuse Continued

- Consequences
 - Repayment of funds
 - No future Medicaid reimbursement
 - Criminal charges
- Reporting fraud & abuse
 - LifeWays Corporate Compliance
Hotline: 1-866-630-3690



Conflict of Interest

- ⊘ A parent cannot be reimbursed by Medicaid to provide Community Living Supports for their child.
- ⊘ Employees cannot approve their own time sheet.
- ⊘ Dual/exploitative relationships with consumers/guardians must be avoided.



Code of Ethics



Providers who accept a contract or employment with a LifeWays consumer/guardian under self-determination, imply agreement with:

- LifeWays defined Ethical Standards. Signature attesting to understanding and acceptance of the defined ethical standards is required *prior to employment* under a self-determination arrangement. ([Click here to print and sign attestation](#))
- LifeWays Standards and Best Practice Guidelines which are linked to the Ethical Standards attestation above and can also be found on the LifeWays website at www.lifewayscmh.org.



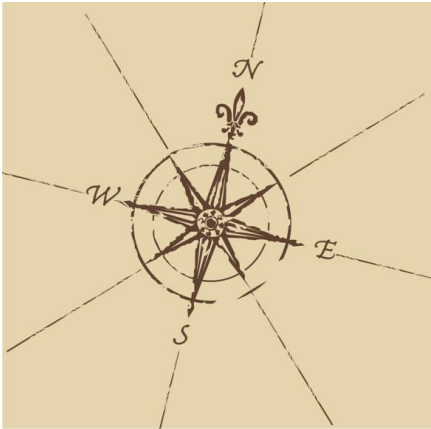
Resources

STATE:

- ❑ Medicaid Provider Manual:
<http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>
- ❑ Center for Self-Determination: www.self-determination.com
- ❑ Michigan Department of Community Health: <http://www.michigan.gov/mdch>
- ❑ Department of Human Services: www.michigan.gov/fia
- ❑ Centers for Medicare and Medicaid Services: www.cms.hhs.gov
- ❑ Social Security Administration: www.ssa.gov

LOCAL:

- ❑ LifeWays: (517) 780-3332 or (866) 630-3690
www.lifewayscmh.org
 - Shannan Clevenger, Self-Determination Coordinator
(517) 796-4574
 - Annette Friday, Self-Determination Contract Manager
(517) 780-3353
- ❑ ARE: Jackson (517) 788-9147; Hillsdale (517) 439-5210
www.dropincenters.org
 - Certified Peer Support Specialists
 - Independent Facilitation



Provider Training Confirmation

By my signature below, I acknowledge that I have completed the LifeWays *SELF-DETERMINATION SELF-STUDY TRAINING*. I understand that I will be accountable for the information contained in this training. If I have questions I may contact LifeWays or my employer for clarification.

I also understand that this signed training acknowledgement must be provided to my employer *PRIOR* to my providing any services and that it will be maintained as evidence of my completion of Self-Determination Training.

Name (please print): _____

My signature below indicates that I:

- ✓ Completed the Self-Determination Training on ____/____/_____.
- ✓ Understand that if I have any questions regarding the training subject matter I may contact LifeWays or my employer for clarification.
- ✓ Have achieved functional competency in the training subject matter.

Provider/Employee Signature: _____ Date: _____

