



**Office for People With
Developmental Disabilities**

Self-Direction Guidance for Providers

**Self-Direction Guidance for Providers
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Self-Direction Guidance for Providers

Part 1

Key Concepts of Self-Direction

INTRODUCTION

Purpose of the Self-Direction Guidance for Providers

NYS OPWDD is committed to helping people with Intellectual and Developmental Disabilities (I/DD) have as much control as possible over how they receive their supports and services. Self-Directed services offer the greatest amount of control in how, where and by whom services are provided. OPWDD has a broad range of options available for Self-Direction. A person can choose to develop a plan that is customized in a way that best meets their interests and needs.

The Self-Direction Guidance for Providers is predominantly meant for Providers and Brokers. This document broadly defines the policy guidance for Self-Direction and provides an overview of Self-Direction authority and staffing options, the services available to self-direct, and information on budgeting and billing for Self-Directed services. This document is technical in nature and is meant to provide detailed direction on issues that emerge for people who self-direct their services and the providers (Fiscal Intermediaries/ Brokers) who work with them to implement a self-directed plan.

The Self-Direction Guidance for Providers does not replace OPWDD Administrative Memoranda (see Attachment G) for Self-Directed services. Providers must comply with the payment standards and service documentation requirements as described in the applicable Administrative Memoranda (ADMs) for services that are self-directed.

What is Self-Direction?

Self-Determination is the philosophy that all people have the freedom to develop their own life plan. Self-Direction is based on the underlying principles of self-determination, person-centered planning and practices.

Self-Direction is the practice of empowering people with developmental disabilities to manage the supports and services they receive, determine who provides the supports, and how and where they are provided. In Self-Direction the person with developmental disabilities chooses the mix of supports and services that work best for them, how and when they are provided, and the staff and/or organizations that provide them.

The Self-Direction participant accepts responsibility for co-management of their supports and services. The amount of responsibility varies depending on the level of authority the participant chooses to exercise.

CHAPTER 1 SELF DIRECTION AUTHORITIES

Authority is a term used by the Centers for Medicaid and Medicare Services (CMS) to describe the control that a person receiving services uses when they choose to self-direct their services. Participants have a range of options for choosing the level of Self-Direction authority that they wish to have. There are two types of Self-Direction authority: Employer Authority and Budget Authority. A person may choose to have either one or both types of authority.

Employer Authority

The person hires, schedules and supervises the staff who support them. They determine the activities that will be supported and the way that support will be provided. Services are provided to the person by agency staff under a co-employment model. In a co-employment model, the person can choose to hire staff, train staff regarding their interests, monitor and provide feedback to staff, and end staff services if they are not consistent with the person's expectations. If a person chooses to self-hire their staff, they gain Budget Authority and determine the compensation of those staff.

Budget Authority

The person who is self-directing with Budget Authority must work within a Personal Resource Account (PRA) and develop a Self-Direction Budget. The person makes choices about the goods and services he/she wishes to receive and selects who is paid to provide them or how they are purchased. A person who maintains Budget Authority and works within a PRA may access needed goods or services through Individual Directed Goods and Services (IDGS). A Fiscal Intermediary (FI) works with the person to complete billing and payment for goods and services identified in the Budget. Attachment C includes a description of services that must be included in a person's Self-Direction Budget. A person who chooses to have Budget Authority can receive and budget for services that are Agency Supported, Self-Hired, or Direct Provider Purchased. **Budget types are described in Attachment A.**

CHAPTER 2 STAFF OPTIONS IN SELF-DIRECTION

A person who chooses Self-Direction has three options for selecting the staff who will work with them:

Agency Supported Self-Directed Services

The person and agency have a Memorandum of Understanding (MOU) that describes the person's authority to hire staff, train staff regarding their interests, monitor and provide feedback to staff, and end the employee's services if they are not consistent with the person's expectations. The person does not have the authority to set the staff salary in this model and the provider is paid at the provider's rate for the service, which includes the administrative and clinical components of the service. The provider bills eMedNY directly for these services. If a person chooses to have **only** Agency Supported Self-Directed Services, a Self-Direction Budget and Personal Resource Account are not needed.

Community Habilitation, Supported Employment (SEMP) and Respite can be self-directed by the participant using Employer Authority in the Agency Supported Self-Directed Services model.

Self-Hired Staffing

The person who is self-directing determines the compensation of the staff who delivers services to them. Services must be planned for and budgeted within a Personal Resource Account (PRA). A Fiscal Intermediary (FI) works with the person to implement Human Resource (HR) activities and to complete billing and payment of the services. The person and the FI have a Memorandum of Understanding (MOU) that describes the person's authority to hire staff, train staff regarding their interests, monitor and provide feedback to staff, and end the employee's services if they are not consistent with the person's expectations. The amount that is billed to eMedNY for self-hired Community Habilitation, Supported Employment and Respite cannot exceed the amount a provider would be paid for the same service or the OPWDD established rates for the service, whichever applies.

A person can choose to self-hire staff to deliver the following types of Home and Community Based Services (HCBS) waiver services: Community Habilitation, Supported Employment, and Respite.

Direct Provider Purchased Services

A person who is self-directing can choose to purchase some services directly from a provider agency. For these Direct Provider Purchased services, the person does not have the authority to set the staff salary and the person chooses to let the provider manage the staff. The provider is paid at the provider's rate for the service, which includes the administrative and clinical components of the service. The provider bills eMedNY directly for these services. If a person is self-directing other services with budget authority, the agency that provides the Direct Provider Purchased Service is responsible for ensuring that the service is utilized within the PRA, as identified in the Self-Direction Budget. This needs to be addressed during the planning process and reflected in the Budget accordingly.

Supported Employment, Community Habilitation, and Respite may be Direct Provider Purchased, Self-Hired, or Agency Supported. Group Day Habilitation Services, Prevocational Services and Pathway to Employment are available only as Direct Provider Purchased Services.

CHAPTER 3 SELF-DIRECTION BUDGET

OPWDD Issued Budget

People who self-direct with budget authority must use the OPWDD issued Self-Direction Budget. The Self-Direction Budget must be completed when a person chooses to have Budget Authority and chooses services that have Budget Authority associated with them. Only the budget issued by OPWDD will be accepted for processing and approval by OPWDD.

Personal Resource Account

The Self-Direction Budget cannot exceed a person's Personal Resource Account (PRA). Based on the OPWDD Approved Needs Assessment Tool, the PRA establishes cost parameters for individualized budgets based on need profiles and comparable costs associated with supporting similarly profiled people with developmental disabilities in other models of support. **See attachment B.**

100% State Paid Services

When a person has a Self-Direction Budget and receives the services listed below, such services must be included in the Self-Direction Budget and counted against the PRA (see Attachment C for more information):

- Family Reimbursed Respite (FRR)
- Family Support Services (FSS)
- Other Than Personal Services (OTPS)
- Housing subsidy/Individual Supports and Services (ISS)
- Assistive Supports

Budget Review Process

-See Attachment C for the Self-Direction Budget Review Procedure

Annual Effective Dates

Budget Annual Effective Dates are fixed dates that establish the year in which a person's Budget is in operation. A person's total annual expenditures for services in their Self-Direction Budget may not exceed their PRA during any year a Budget is in effect. The anniversary of the Budget Annual Effective Date is that date when this annual spending cap resets. Budget Annual Effective Dates do not change when Budgets are amended, unless the Budget type changes between "Other than Residential," "Residential Only" or "Both."

Retroactive Amendments

Self-Direction Budgets may be revised proactively to accommodate the participant's changing needs. Full Amendments to Self-Direction Budgets are not made retroactively. However, Cost Neutral Budget Amendments may be approved by the Development Disabilities Regional Office retroactive to the beginning of the month prior to the month it is approved.

Continuity of Care Provisions

Continuity of Care Provisions are not applicable to Self-Direction Budgets developed on and after 10/1/2014. On and after 10/1/2014, OPWDD will not approve increases or cost neutral changes to Continuity of Care Provisions found in existing Self-Direction Budgets; OPWDD will only approve decreases to such provisions. More information on Continuity of Care can be found in **Attachment D**.

Self-Direction Budgets for Children

Approval of a Self-Direction Budget is contingent on the participant's enrollment in the HCBS waiver. Enrollment in the waiver requires the identification of a need for ongoing waiver services that is not available through other sources.

For children under the age of four, it is expected that Early Intervention (EI) services would meet their needs and waiver services cannot be duplicative of services available through EI. Children receiving EI services would not be authorized for the HCBS waiver and, therefore, would not be eligible for self-directed services without clinical justification.

For children who are at least four years of age and younger than seven years of age, it would be unusual for Community Habilitation to be justified as typical supports come from family and school. Social skill building can often be achieved through FSS programs. This age group is typically more appropriate for respite and FSS support use. If the family, Support Broker, and Care Manager (CM) determine that Community Habilitation is appropriate for a child in this age range, clear age

appropriate habilitative goals and outcomes must be included within the child's Staff Action Plan and would be subject to audit protocols for the waiver service.

For all children who are eligible to receive service from the State Department of Education (SED), those services must be utilized before self-directed services. Self-directed services cannot be duplicative, nor can they overlap with SED services. The schedule for waiver service must not overlap with the planned schedule for educational instruction. If a child is homeschooled, the times when the homeschooling actually takes place can be considered, instead of standard school hours, as the times when SED services are occurring.

Self-Directed services are not available for children who live in a certified setting and receive SED services. As the SED services are expected to cover their service needs during the day and the certified setting is responsible for evening, nights and weekends, they are considered to have all of their service needs met.



Self-Direction Guidance for Providers

Part 2

Overview of Self-Direction Services

CHAPTER 4 SUPPORT BROKERAGE

When a person chooses to take on Budget Authority, Support Brokerage services support the person-centered planning process by assisting the person to develop a Circle of Support and complete a Self-Direction Budget for his/her services. The Broker may also provide training and support to the person to help him/her gain the skills and competencies he/she needs to manage self-directed services. If a participant has chosen self-hired Community Habilitation or Supported Employment services, Support Brokerage Services include completing and updating Staff Action plans for these services.

A person's Support Broker cannot provide them any other HCBS waiver service, and cannot be the person's Care Manager (CM). A Care Manager will assist the person participating in Self-Direction, as Self-Direction is part of the HCBS waiver.

Support Brokerage services must be established based on an agreement between the participant and the Broker. Hourly fees are negotiated between the participant and the Broker and should be commensurate with the level of training and experience of the Broker. The **maximum fee** that can be considered for delivering Support Broker services is \$40 per hour. Self-Direction participants and Brokers can agree to a fee that is less than this amount. The hourly fees reflected on the Support Broker Agreement and the Self-Direction Budget must be the same.

The participant and his/her Circle of Support make decisions about the best use of the Support Broker as a resource within the person's Self-Direction Budget to ensure appropriate support and achievement of valued outcomes.

For the Broker Training Policy, see **Attachment E**.

Start-Up Brokerage

Start-up Brokerage services are provided to assist a Self-Direction participant in developing his/her initial Self-Direction Budget, with reimbursement capped at \$2,400.

A person who received Start-Up Brokerage may budget for this again after one year has passed if the person has not received any self-directed services in that year. Self-directed services are those that would be billed by an FI, except for Community Transition Services. In this scenario, the \$2,400 cap would reset. A second Start-Up Brokerage expense is not available to participants who have received self-directed services and are changing FI agencies.

Brokerage in Settings that Prevent Enrollment in the HCBS Waiver

Home and Community Based Services (HCBS) Waiver Support Brokerage services are not available to people who reside in the following settings that are non-HCBS Waiver eligible: Intermediate Care Facilities, Nursing Homes, Residential Schools, and Developmental Centers. For people who are seeking to transition out of these settings and into self-directed services within the community, Start-Up Brokerage services up to \$2400 can be funded with 100% State funds.

OPWDD expects that these State funds are used exclusively to develop the Self-Direction Budget with Start-Up Brokerage services. The person must be enrolled into the HCBS Waiver Brokerage service in order to receive ongoing Brokerage services after completion of the Self-Direction Budget.

Support Brokerage Coverage

To maintain good continuity of care, it is best for one Broker to work with and support the participant. However, if the Broker chooses to delegate documentation to another qualified Broker or if a backup Broker is designated to attend meetings in rare circumstances when the primary Broker is unable to attend, this needs to be outlined in the agreement between the primary Broker and the participant. Any backup Broker must meet all the same qualifications as the regular Broker as described in ADMs #2019-05 and #2019-06.

Parents and Other Unpaid Support Brokers

Participants can choose to have their parent fill the role of the Support Broker, but a parent cannot be paid for Support Broker services delivered to their own child. Detailed information regarding family members delivering services can be found in Chapter 9, **Hiring Family Members** section.

When participants choose to act as their own Support Broker, or have a parent or other person fulfill the Support Broker role in an unpaid capacity, the person acting as Support Broker must complete the Initial Broker Training Requirements, as outlined in Attachment E. Self-Direction Budgets may be denied approval unless it is established that there is someone to fulfill the role of the Support Broker who has taken the required training.

A Broker Agreement should be completed when a participant chooses to have a parent or other person fulfill the Support Broker role in an unpaid capacity. A completed Broker Agreement ensures that the participant and the person they chose to act as a Broker have a clear understanding of the roles and responsibilities for the person acting as a Support Broker.

Parents and others who act as a person's Support Broker in an unpaid capacity are not generating any billing for Support Broker services. As such, they are not subject to the payment and service documentation requirements outlined in Administrative Memorandum #2019-06 regarding Service Documentation for Support Brokerage Services.

Unpaid Support Broker Services do not generate any billing and there is no impact on a participant's PRA. Therefore, the unpaid Support Broker should not be reflected on the person's Self-Direction Budget. When the Support Broker is unpaid, the Support Broker service item on the Demographics tab of the Budget should be answered as "No."

ADM #2019-06 describes the service, programmatic and payment standards and service documentation requirements for Support Brokerage Services.

ADM #2019-05 describes the Support Broker Authorization standards required to meet billing, programmatic, and documentary requirements referenced in ADM-#2019-06.

CHAPTER 5 FISCAL INTERMEDIARY

Fiscal Intermediary Services (FI Services) are HCBS Waiver services that include tasks performed by a Fiscal Intermediary (FI) which support a participant who self directs an individualized budget. Such tasks include billing and payment of approved goods and services, fiscal accounting and reporting, Medicaid and corporate compliance, and general administrative supports. The FI performs the initial review of the budgets/budget amendments, is the employer of record for staff hired by the participant, and is responsible for ensuring that applicable labor laws (including those related to minimum wage and overtime) are followed. These staff are referred to as “self-hired staff.”

Services that Require a Fiscal Intermediary

A participant must choose an FI to handle billing for any of the following services:

- Individual Directed Goods and Services (IDGS)
- Live-in Caregiver (LIC)
- Support Brokerage Services
- Community Transition Services (CTS)
- Other Than Personal Services (OTPS)
- Housing Subsidy
- Any self-hired staff for Community Habilitation (CH), Supported Employment (SEMP), and/or Respite

Reimbursement for Prepaid Goods and Services

In some circumstances, FIs may be asked to pay for an item or service before it is received or delivered. Camp deposits and pre-payments are one potential example. Annual memberships are another. FIs may elect to reimburse the participant/family, immediately, or pay for the cost of pre-paid goods and services, directly. However, the FI must wait until the service is “complete” before claiming reimbursement to Medicaid. Each FI has the right to develop policies and procedures that define and limit its financial risk regarding IDGS purchases, especially when the risk of immediately reimbursing (“floating”) a pre-paid service becomes significant or substantial. Such policies must be made known in advance to those impacted and be applied fairly and equitably across all people served by the FI. For example, the FI’s policy could require that it will accept full financial risk and that it may never subsequently receive reimbursement (if the camper does not actually attend camp).

Services Delivered by Other Agencies

When participants with Budget Authority receive Agency Supported or Direct Provider Purchased services delivered by agencies other than the FI, these services must be included in the Self-Direction Budgets, where applicable. The FI will require utilization information for services delivered by other agencies to be reflected in the person's monthly expenditure reports. Rate information can be found on the Department of Health website:

(http://health.ny.gov/health_care/medicaid/rates/mental_hygiene/index.htm)

ADM #2019-07 describes the payment standards and service documentation requirements for Fiscal Intermediary Services.

CHAPTER 6 LIVE-IN CAREGIVER

Live-in Caregiver is an HCBS Waiver service that utilizes an unrelated care provider who resides in the same household as the waiver participant and provides as-needed supports to address the participant's physical, social, or emotional needs so that the participant can live safely and successfully in his or her own home.

The Live-in Caregiver must not be related to the participant by blood or marriage to any degree.

The Live-in Caregiver must go through any required background check(s) performed by the FI before they can begin services.

Payment Standards

Payment for this service will cover the additional costs of room and board incurred by the waiver participant and reasonably attributed to the Live-in Caregiver. Room and board includes rent, utilities and food. Payment may not be made directly to the LIC. The FI will transfer the amount of reimbursement to the individual or the property owner and utility companies, as specified in the agreement between the individual and the FI.

The participant must reside in his/her own home or a leased residence. Payment will not be made when the participant lives in the caregiver's home, in a residence that is owned or leased by the provider of Medicaid services, in a Family Care home, or in any other residential arrangement where the participant is not directly responsible for the residence. **Maximum Live-in Caregiver amounts can be found in Attachment F at the end of this guidance.**

ADM #2016-03 describes the payment standards and service documentation requirements for Live-in Caregiver Services.

CHAPTER 7 INDIVIDUAL DIRECTED GOODS AND SERVICES (IDGS)

Participants who choose to self-direct their services and take on Budget Authority may receive IDGS as a waiver service. Individual Directed Goods and Services (IDGS) are services, equipment or supplies not otherwise provided through OPWDD's HCBS waiver or through the Medicaid State Plan that address an identified need in a participant's service plan. Self-Direction funds cannot be used to purchase an IDGS service that is available under the State Plan. Total IDGS expenditures are limited to \$32,000 annually or the person's PRA, whichever is less. Further detail is included in the IDGS Definitions Chart ([link found in Attachment G](#)).

Participants may manage their IDGS, as described in their Individualized Service Plan and Self-Direction Budget, to fully purchase or contribute towards the purchase of items or services which meet all of the following criteria:

1. Are related to a need or goal identified in the person-centered care plan/Individualized Service Plan;
2. Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for human assistance;
3. Promote opportunities for community living and inclusion and/or increase the participant's safety and independence in his/her home environment;
4. Are able to be accommodated without compromising the participant's health or safety;
5. Are provided to, or directed exclusively toward, the benefit of the participant.

In addition to these requirements, the IDGS chart lists additional criteria that must be met for specific categories of IDGS.

Community Classes

Self-directed supports through IDGS offer great opportunities for people with developmental disabilities to purchase community based classes that teach a subject, are open to the public, and result in active engagement and participation in **integrated** community settings.

Each of the following are excluded from being funded with the IDGS as a Community Class:

- Classes that duplicate any Medicaid State Plan or HCBS Waiver service or are conducted by an entity that delivers such services;
- Classes where participation is restricted solely to people with intellectual/developmental disabilities (I/DD);
- Classes where there are not established published fees;
- Classes that are credit bearing for matriculating students;
- Classes in a setting accessed only by people with I/DD (not including paid staff support), including all certified settings; and
- Classes that do not adhere to the standards identified in the broader IDGS rules and standards (e.g. experimental therapies).

Participation in specialized classes that take special needs, such as physical limitations or beginner level learning, into consideration are appropriate as long as those specialized classes are open to the broader public.

Private classes and lessons are allowable as long as they relate to an integration goal and the lessons are not taking place privately for the purpose of segregating the participant.

Transportation

When a person needs transportation to/from a service-related activity, IDGS can be used to reimburse service related mileage, or pay for public transportation. In order to be reimbursable under IDGS, however, transportation costs and mileage must be related to a Medicaid reimbursable service within the Self-Direction Budget. Additionally, Transportation in IDGS is only available for those services that do not have transportation built into the fee and/or are not covered by the State Plan. Transportation related to IDGS services or those delivered by Self-Hired staff would be considered allowable reimbursable costs.

Camp

For a person who has Budget Authority, Camp programs may be funded using IDGS. Reimbursement from Medicaid is not available until after a person has attended the camp. When a camp deposit or prepayment is made, but the person never attends camp, no service has been rendered to the person and, therefore, no reimbursement may be claimed from Medicaid. Medicaid does not reimburse services that are not rendered. If the FI or the family made a non-refundable deposit or prepayment, whoever made the payment to the camp accepted the financial risk.

When a camp deposit or prepayment is made, and the person arrives at camp, participates in some programs, but leaves camp early, then the terms of the camp's policy should be consulted. If there is opportunity to request a partial refund, such refund should be requested. If there is a strict no-refund policy, the full cost of the service term may be submitted to Medicaid as long as it does not exceed one month. The maximum service term Medicaid reimburses is one month. Since most camps have terms measured in weeks, it is unlikely that the FI (or family) would be left with an unreimbursed liability. However, if a participant were to enroll at a camp that demanded prepayment for a full three-month summer term (i.e., June, July, and August), it is possible that an unreimbursed liability could be generated. The FI would be forced to break up the camp term into units no greater than a month. Some service must be delivered in a given month in order to bill a service unit for that month. Therefore, if a camper were to leave in the second week of June and not return, the FI (or family) could be left with an unreimbursed liability for two-thirds of the total cost of the camp.

IDGS Camp Reimbursement is available for Camps that are not funded as Medicaid Waiver Respite Camps. Self-Direction participants can choose to attend Waiver Respite funded Camps. However, those camps must be included in their Self-Direction Budget as Direct Provider Purchased Respite.

IDGS funds may not be used for camps that are outside New York State, as these camps are not issued a permit by New York State.

Paid Neighbor

The Paid Neighbor stipend is paid to a neighbor to serve as an “on-call” support. A Paid Neighbor is someone who should be available to respond when needed. Proximity in relation to the needs of the participant should be considered when hiring a Paid Neighbor, and be based upon the participant’s likely need for a particular response time. In no case should a Paid Neighbor live with the participant nor should a Paid Neighbor be more than 30 minutes from the participant.

The Paid Neighbor cannot be a “family member” of the Self-Direction participant. See Chapter 9 “Hiring Family Members” Section for more details.

Staffing Support

Staffing Support cannot deliver services that would duplicate FI services or Broker responsibilities as related to development of the SD plan. The staffing support role can only include tasks in the spectrum of, “Assistance with scheduling self-hired staff and with assisting the person to complete staffing related paperwork.”

The person who provides Self-Directed Staffing Support through IDGS may be someone who provides self-hired CH, Respite or SEMP services to that participant or other participants, however, they cannot be otherwise employed by a not for profit agency. The billing must reflect what service is being provided. The documentation and time tracked should reflect what service the staff is providing at the time, either Community Habilitation/Respite/SEMP or Staffing Support.

Health Club/Organizational Memberships

Funding for a gym or health club may be reimbursed through IDGS in the self-directed plan for reasons of health and fitness or community integration. A person may have multiple memberships to health clubs. Memberships are for the individual only. Family or staff memberships cannot be reimbursed with IDGS funding. The club/organization must offer open enrollment to the public and the reimbursed fee must be the same as the published membership duties/fees.

A Self-Direction Participant’s activity fees, expenses (such as related supplies) and meals are explicitly prohibited from IDGS funding. The following chart is provided to assist with establishing the difference between reimbursable memberships and non-reimbursable activity fees/expenses:

Organizational Memberships (Reimbursable as Memberships)	Activity Fees/Expenses (Not Reimbursable as Memberships)
Ski club membership dues	Ski resort lift tickets and equipment rental
Museum or zoo membership	Tickets or season passes to a water park
Softball league fees	Tickets to a baseball game
Pony Club membership	Horseback riding helmet
Girl Scout/Boy Scout dues	Scout uniform and trip expenses
Membership dues for a Bowling League	Bowling shoe rental fee
Community group membership fees (e.g., 4-H, Kiwanis, Elks)	Group shopping discounts (Wholesale "club" memberships, farm shares)
	Online dating websites

IDGS Billing

For Medicaid billing purposes, the reported date of service for IDGS should be the date that funds are paid out by the Fiscal Intermediary, or the date that the good or service is actually received by the participant, whichever is later.

IDGS is a Medicaid program that reimburses costs already incurred for goods and services. For some IDGS categories (e.g., mileage reimbursement under "Transportation"), the payment is made by the FI after the service is delivered. In this scenario, the date of service would be the date that the FI issued the reimbursement. However, sometimes an FI will choose to reimburse an item or service that has not yet been delivered (for example, deposits or payments made in advance for camp). Generally, Medicaid does not reimburse services or items before they are delivered and, in terms of services, before the service is "complete." In this scenario, the date of service would be the date of the last day that the participant attended the camp.

In scenarios where a person is participating in a service funded by IDGS that spans more than one month, the FI may bill for an appropriate prorated portion of the cost, using the last day of the service month as the billing date of service. For example, a person is attending camp that runs from July 1 through August 31 and the cost of the camp is \$1,000. The FI may submit a claim for half the reimbursement on July 31 in the amount of \$500 and the remaining \$500 balance would be submitted with an August 31 date of service.

When a Self-Direction participant's IDGS service provider demands substantial "deposits" or "pre-payment" months in advance of actual service delivery, the FI should follow its own established policies as explained in Chapter 5 Fiscal Intermediary.

IDGS is billed to Medicaid in \$10 increments. Each unit must be for \$10 and there will be no rounding up. A maximum of 99 units may be billed to Medicaid on a given date of service. This limits billing to \$990 per date of service for IDGS. In instances where the FI has receipts and documentation substantiating allowable expenditures beyond the daily billing limit of \$990, eMedNY can be billed using consecutive dates of service. For example, if receipts and documentation substantiate \$1,500 in qualified IDGS reimbursement, an FI may submit one claim for 99 units totaling \$990 on a given date of service and submit an additional claim for the remaining balance of 51 units totaling \$510 on the next date of service.

ADM #2015-05 describes the payment standards and service documentation requirements for Individual Directed Goods and Services.

CHAPTER 8 OTHER THAN PERSONAL SERVICES (OTPS)

People who are self-directing their services with Budget Authority may elect to use up to \$3,000 in 100% state funding for items that are not Medicaid-fundable. This budget category is called “Other Than Personal Services” or OTPS.

For any item or service to be approved for OTPS funding in any category, it must pass ALL of the following four tests:

1. Be related to a valued outcome in the person’s plan
2. Increase the person’s independence and/or health and safety
3. Not be an OTPS excluded item (see page 29 of the SD Guidance)
4. Not be funded through any other source

Other resources (including community based and Medicaid funded) must be explored and exhausted prior to utilizing state OTPS funds for the purchase of such items. For example, cell phones are often made available to people who have Social Security eligibility.

OTPS Categories

The OTPS section of the budget is limited to the following categories of supports:

- Phone service – cell and/or land line*
- Internet* (in instances where a participant has a cable package, OTPS can be used for phone and internet only, but not the cable portion)
- Software related to the person’s disability
- Staff activity fees (self-hired staff only) to cover meals, admissions, fees, transportation or other costs incurred by staff when providing support to the self-directing person in activities that support a valued outcome
- Staff advertising/recruitment costs
- Cost associated with staff time for planning or training meetings where such costs exceed the hourly limits of the service
- Personal Use Transportation
- Clothing* (capped at \$250)
- Board Stipend* (must first request and be denied for food stamps, or approved, but not sufficient to cover needs)
- Utilities*
- Other goods and services that increase independence
- Other goods and services related to health and safety

* In general, landline, internet, clothing, utilities, and board stipend expenses are not reimbursable in OTPS for children under 18 years old where parents are responsible for these costs. Exceptions may be granted by the Developmental Disability Regional Office (DDRO) in cases where justification for a specific need is established (e.g., the family would not otherwise have internet in the home but it is necessary to support a technology system utilized by the FI and self-hired staff).

Items Excluded From OTPS

OTPS cannot be used to pay for certain excluded items. Excluded items include, but are not limited to:

- Medical visit co-pays
- Any expenses related to hospitalization or nursing home stays (including staff or respite supports or family expenses)
- Any illegal item or activity
- Cable television
- Common household supplies (e.g., paper towels, wipes, soap)
- Treatments that are experimental in nature
- Repairs, like a broken step or railing, as they should be covered under the lease or are the responsibility of the home owner
- A self-directing person's activity fees or related supplies for an activity or community class, even if funded through Individual Directed Goods and Services
- Rental cars (this OTPS exclusion does not apply to vehicles leased in the participant's name)
- Vehicle purchases, payments towards a purchased vehicle
- Legal fees
- OTPS cannot be used to apply against housing costs in excess of housing subsidies. If a person's rent is in excess of allowable housing subsidies, this will have to be reimbursed with the person's or the family's own resources.

CHAPTER 9 SUPPORTED EMPLOYMENT, COMMUNITY HABILITATION AND RESPITE

The services described in this chapter can be varied in the way in which they are self-directed. Supported Employment includes both direct and indirect activities associated with helping a person get a job and gain skills necessary to retain the job. Community Habilitation is a service delivered in the community (i.e., non-certified settings) to facilitate inclusion, integration, and relationship building. Respite is a service that provides relief to unpaid caregivers who are responsible for the primary care and support of a person with a developmental disability. The methodology for budgeting these services depends on the authorities and staffing options chosen by the participant. Other rules and considerations for these services can be found in the respective ADMs (**see Attachment G**)

Direct Provider Purchased and Agency Supported

If a person has a Self-Direction Budget and chooses to receive Direct Provider Purchased or Agency Supported Community Habilitation, Supported Employment and/or Respite services, the cost of those services are included in the Self-Direction Budget and deducted from the person's PRA.

Self-hired Staff

A person can use self-hired staff to provide Supported Employment, Community Habilitation and/or Respite with a Self-Directed Budget.

Centers for Medicare and Medicaid Services (CMS) is very clear that within Self-Direction, a person can hire their own staff to deliver services but the payment cannot exceed the rate a provider would be paid for the service. Hence:

A person can have self-hired staff persons but payment to the self-hired staff persons (including all allowable costs that comprise the total employment cost) cannot exceed the provider rate that would be paid to an agency providing the same service.

Hiring Family Members

There are specific restrictions regarding self-hired staff who are related to a Self-Direction participant. Except where specifically prohibited (e.g., relatives cannot be hired to deliver Live-In Caregiver or Paid Neighbor services), relatives may be paid as service providers as long as all of the five following criteria are met:

1. They are at least 18 years of age.
2. They are not the parents, legal guardians, spouses, or adult children (including sons and daughters-in-law) of the participant.
3. The service is a function not ordinarily performed by a family member.
4. The service is necessary and authorized and would otherwise be provided by another qualified provider of waiver services.
5. The relative does not reside in the same residence as the participant.

CHAPTER 10 FAMILY REIMBURSED RESPITE

In addition to, or in lieu of, Respite that is Direct Provider Purchased, Agency Supported, and Self-Hired, participants in Self-Direction can include Family Reimbursed Respite (FRR) in their budgets. FRR is paid for with 100% State funds and capped at \$3,000 annually.

Payment Standards

This service is designed to be used as needed, up to the amount budgeted. The FRR provider and wage do not require prior authorization or approval.

The Fiscal Intermediary may not pay the FRR provider directly. To receive reimbursement, the Self-Direction participant sends the FI an invoice or statement specifying the date, times, hours and cost for the FRR utilization.

FRR is a reimbursement service to the family for the expense they incur in being relieved of their primary caregiver responsibilities. OPWDD is not paying the person/agency that provides this relief and does not track or regulate who they may be.

A person who self-directs and receives a Housing Subsidy cannot receive Family Reimbursed Respite.

CHAPTER 11 FAMILY SUPPORT SERVICES

For people who Self-Direct with Budget Authority, Family Support Services (FSS) is a service that must be included in Self Direction Budgets under Contracted Services. FSS requires prior authorization from the DDRO and/or FSS Provider, as applicable. These services are paid for with State funds.

CHAPTER 12 HOUSING SUBSIDY

Self-Direction participants who choose to live independently, or who share a living environment and have tenancy rights, may be able to include a Housing Subsidy in their budgets, funded with 100% State funds. The amount of available Housing Subsidy is calculated based on a participant's income and Housing and Community Renewal (HCR) payment standards. Housing Subsidy follows the same rules as Individual Supports and Services (ISS).

If an individual qualifies for both Community Transition Services (CTS), and an ISS Transition Stipend, it is the expectation that the CTS funding be maximized before requesting funding through an ISS transition stipend. If an individual receives the maximum payment through CTS, they can only request the difference between the maximum ISS transition stipend and the amount reimbursed through CTS.

Restrictions

Housing Subsidy is restricted to participants in Self-Direction who are at least 18 years old. The rental lease or mortgage must be in the name of the person who is self-directing, or the person who is self-directing must have clear tenancy rights in a shared living environment.

A person who self-directs and receives a Housing Subsidy cannot receive Family Supports and Services (FSS) nor Family Reimbursed Respite (FRR).

CHAPTER 13 OUT-OF-STATE- and OUT-OF-COUNTRY-SERVICES**Out-of-State-Services Criteria**

For out-of-state services to be authorized within a Self-Direction service (e.g. IDGS, Community Habilitation, etc.), all of the following eight criteria must be met:

1. There must be a clear statement of intent indicating that the Self-Direction participant will continue to reside in NYS.
2. The situation, and the corresponding authorization, must be time limited. For example, receiving a special service, (e.g., equine therapy, out-of-state; or paying direct support staffing while the participant is attending an out-of-state college) would be approved for only the specific period under review, typically the annual period of the Self-Direction Budget. The approval is not assumed to be open-ended.
3. The FI agency must indicate that it understands the oversight requirements and agrees to provide all necessary oversight to ensure proper provision and documentation of services.
4. The people providing services must meet all the same requirements that a service provider (individual or agency) in-state needs to meet including fingerprinting, criminal background checks, driver's license check (if appropriate), training and any other requirement for employment of staff or an independent contractor providing the same or a similar service within New York State.
5. The costs funded through the Self-Direction Budget are identical to or less than the cost for the same service, or are comparable to provisions of the same service within New York State.
6. The support or service being funded must meet the criteria for that category of service (e.g. if funded through IDGS, a clinical consultant must be licensed by the NYSED Office of the Professions).
7. Medicaid service documentation requirements **MUST** be met, and the FI holds the same responsibility for Medicaid service documentation and retention as if the services were provided within New York State.
8. The OPWDD Developmental Disabilities Regional Office (DDRO) Director or their designee grants approval.

Out-of-Country-Services Criteria

1. Services outside of the United States are allowed only in the following four locations:
 - A. the Commonwealth of Puerto Rico
 - B. The Virgin Islands
 - C. Guam
 - D. Canada
2. The participant and Plan/Budget must **meet all the requirements outlined in “Out-of-State Criteria”** listed above.
3. Prior to approval of the plan containing funding to pay for services provided in allowable areas outside of the U.S., (1) a definite return date for the participant, and (2) a statement confirming that the individual is intending to remain a NYS resident upon return must be provided.



**Office for People With
Developmental Disabilities**

Self-Direction Guidance for Providers

Part 3

Self-Hired Fringe Benefit Budgeting and Billing

CHAPTER 14 FRINGE BENEFIT BUDGETING AND BILLING OVERVIEW

Part 3 provides guidance on claiming self-hired services to Medicaid. Topics discussed include distinctions between work hours and billable hours and between wage rates and reimbursement rates, types of self-hired staff, accounting for indirect costs associated with self-hired employees, and issues related to the processing logic in Medicaid for self-hired services.

Terms

Understanding the distinctions between these terms is essential to ensure correct budgeting and claiming for self-hired services.

Work Hours: The actual hours **worked** by the employee. Per federal and state labor law, employees must be paid for all hours they are "suffered or permitted to work."

Wage Rate: The standard rate of pay per hour worked as negotiated by the participant/family and the self-hired employee. Nonstandard wage rates may apply in special circumstances (e.g., "overtime" pay).

Billable Hours: The **subset of work hours** spent by the employee on billable service activities, as described and defined in OPWDD regulation and administrative memoranda.

Indirect Employment Cost: Expenses of employment other than wage costs, including the **employer-paid** portions of employee benefits, payroll taxes, etc.

Total Employment Cost: Employee wages for hours worked **plus** indirect expenses related to the employment of the self-hired worker.

Effective Reimbursement Rate: Total employment costs for the service period claimed divided by the billable service hours delivered and documented during the same service period.

Types of Self-Hired Staff

Employees: The participant and the FI share responsibilities as "co-employer" of self-hired employees. FIs should permit the participant broad leeway to negotiate the wage rates of self-hired staff, within the reimbursement restrictions described in Chapter 16. Because the FI is the legal "employer of record," benefit packages and other terms of employment typically must follow the FI's policies. In these cases, the participant may not be able to negotiate further. Nearly all true employees drive indirect costs in addition to their wage payments. These indirect costs, in addition to the direct wage costs, must be appropriately accounted and included in the fee billed to Medicaid.

Self-hired staff who perform Community Habilitation, Respite, and Supported Employment services must be employees of the participant and Fiscal Intermediary due to the nature of the work performed by such staff.

Contractors: Staff members who perform services at a negotiated payment per hour of service rendered as outlined in a formal service contract. Some examples of a self-hired contractor are a clinician, consultant and therapist. Self-hired contractors may be self-employed (i.e., an "independent contractor") or may be the formal employees of a staffing agency. In either case, the legal relationship between the participant and the self-hired contractor is "purchaser-contractor," not "employer-employee." The negotiated service rate is considered "payment-in-full" for services rendered and there are no indirect costs to be reimbursed. There are no fringe or indirect costs related to these services when self-hired as a contractor.

CHAPTER 15 ACCOUNTING INDIRECT EMPLOYMENT COSTS

In addition to wage expenses, there are "indirect" costs associated with self-hired employees. Indirect costs include mandated expenses such as the employer portion of payroll taxes, costs associated with workers compensation and unemployment insurance, and the employer's cost of providing health insurance to eligible employees. FI agencies often elect to provide additional employee benefits including life insurance, pension/retirement plan, and paid time off. Indirect employment costs are part of the total cost of delivering a service and must be properly charged on the service claim in order to be reimbursed by Medicaid. There are two basic methods for calculating and charging indirect employment costs to Medicaid:

Direct accounting method

The FI may elect to record and charge indirect employment costs in the precise month in which they are incurred for the specific self-hired employees in each Self-Direction Budget. This method is most feasible when the employee benefit package is sparse and the FI submits reimbursement claims on a monthly billing cycle.

Fringe rate method

As an alternative, the FI may create a separate pooled account to cover indirect employment expenses across all of the Self-Direction Budgets it administers. This pooled account/fund should be funded by fixed percentage surcharges on the wages of self-hired employees, so that each payment of employee wages yields a corresponding and proportionate payment into the FI's pooled fringe account. In this case, the fringe would also include shared overtime and travel costs. FIs have freedom to establish and administer their own fringe benefits programs and it is expected that these programs may differ substantially between FIs.

The following principles should be adhered to when using the Fringe Rate Method:

- 1. Uniformity:** The fringe program administered by the FI should be uniform across all Self-Direction Budgets participating within it. At their option, FIs may offer single or multiple fringe packages. When multiple packages are offered, the FI may charge differing fringe assessment rates reflecting the cost differences among the various packages offered. All benefits packages must be potentially available to all Self-Direction Budgets administered by the FI and the assessment rate charged for each benefits package offered should be the same for all participants.
- 2. Disclosure:** The participant should understand what he/she is "buying" for employees through the fringe assessment. The FI should provide participants

with a clear, concise, and complete outline of all indirect employment costs and employee benefits funded under each fringe package(s) offered and the assessment rate associated with each package.

3. Impact on permissible wage ranges: The impact of fringe assessment rates on the permissible wage rates that may be negotiated with self-hired employees should be explained to participants and their brokers.

4. Advance notice of benefit package and fringe assessment rate changes: FI agencies shall give participants with self-hired employees at least two months prior notice before adjusting benefits packages and/or fringe assessment rates. The implications of an assessment rate change on the effective budget plan should be reviewed with the participant. Assessment rates shall not be adjusted retroactively.

5. No administration charge: Costs associated with the FI's administration of the fringe benefits pool are included in the FI's monthly fee for FI services. Fringe assessment rates shall **not** include any component reimbursing the FI for its administrative cost and effort in managing the fringe pool account.

6. Management of fringe account balances: The FI is responsible for setting assessment rates that fully fund all fringe program obligations and permit timely payment of such obligations.

7. Separate Account: A separate, dedicated account or fund must be established for the self-hired fringe program. Funds in the pooled fringe account are only for use in addressing indirect employment costs outlined in the description provided to Self-Direction participants.

8. Surpluses: Surplus funds in the fringe account should not be transferred or skimmed to cover other costs, losses, or obligations of the FI agency. When account balances become excessive, surplus funds should be used to reduce the fringe assessment percentage.

9. Deficits: If the fringe account is temporarily in deficit, the FI will be expected to honor any financial obligations on behalf of participating Budgets using its own operational funds until such time it implements an increase in the fringe assessment rate.

10. Monitoring by OPWDD: OPWDD may develop procedures and protocol to monitor pooled fringe accounts for compliance with the above principles. This may include compliance with requirements for submitting Consolidated Fiscal Reports (CFRs) and compliance with auditing protocols.

CHAPTER 16 CHARGING STAFF TRAINING EXPENSES IN SELF-HIRED SERVICES

The term "training" is a broad term that describes many potential forms of instructing and teaching employees in the skills, duties, and responsibilities required of their positions. The following guidelines instruct FIs how to handle various forms of training when billing self-hired services.

On-The-Job Training: Employee training and orientation at the place of work while the employee is doing the actual job. Such training focuses on the specific tasks and responsibilities of employees at the work location and the unique needs of the particular person served. This instruction may be delivered by the person (and/or family member or designee), by an experienced employee in concert with the person (and/or family member or designee), or by a professional trainer or employee trainer.

Billable Charges: Employee time receiving employer-mandated training typically constitutes "time worked" and should be paid as such. When the person's current self-hired staff assists in the instruction, that employee must also be paid for time worked. The total employment cost of all self-hired staff (i.e., wages + fringe assessment for both trainee and self-hired employee trainer) may be included in the billed service charges for that service date. See Chapter 16 for further information on inclusion of costs in the billable fee.

Billable Service Units: Self-hired employee work time spent entirely on receiving instruction and orientation does not constitute billable time. Even while under instruction, time spent delivering respite or habilitation services, is billable. Remember, however, that a period of service time may be charged only once per person served. Therefore, when an experienced self-hired employee assists in delivering instruction to a new self-hired employee, only one of the two worker's time is countable during the period of instruction, even though the billed **charges** that day will include wages and fringe for both workers. See Chapter 16 for further information on inclusion of costs in the billable fee.

Other Costs: Costs associated with the use of professional or employee trainers (e.g., a FI employee who is not a member of the person's regular self-hired staff) should be funded from the FI's monthly administrative fee. Costs associated with developing, producing, and printing any training aids or instructional materials shall also be covered by the FI's monthly administrative fee. Such costs may **not** be included among the billable charges for the self-hired service itself. Any training or instruction provided directly by the person receiving services, or his/her family members or designees, shall be delivered free of any charge to the State or Medicaid.

Fiscal Intermediary Directed General Employee Orientation, Refresher, and Classroom/Seminar Training

This is training and instruction provided to all self-hired staff who are co-employed by the participant and the FI agency on professional, health, safety, and welfare skills, procedures, and standards. It includes all direct support professional training mandated by OPWDD or by the FI agency itself.

Billable Charges: Employee time spent receiving employer-mandated training typically constitutes "time worked" and should be paid as such. Although employee training time does not represent billable service time, the employment costs (wages + fringe assessment) associated with such training do represent a **reimbursable cost** of delivering the self-hired service. As such, training-related employment costs **may** be included in the billed service **charges** for the service date the employee training is attended. If there were no claimable service units for the person on that particular day (e.g., **all** of the person's self-hired community habilitation staff attended training that day, there was no substitute staff, and, therefore, the person did not receive any billable community habilitation service units that day), the training-related employment costs may be added to the regular charges on the next day claimable service units were delivered. Training should be scheduled and paced to minimize the potential of exceeding the effective reimbursement rate (ERR) caps (see Chapter 16 Preparing Claims to Medicaid for Self-Hired Services) in any billing cycle.

Billable Service Units: Since the staff receiving training renders no habilitation or respite services, this form of employee training will not yield billable service units.

Substitute Staff: During the planning process, the person and their Circle of Support should determine whether substitute staff will be required when regular self-hired staff attend training. When substitute staff is required, the cost should be included in the person's budget. This may be accomplished by either budgeting additional staff hours for self-hired workers who will cover the trainee's absence or adding Agency Supported or Direct Provider Purchased services to the budget.

Other Costs: The FI agency is responsible for all other costs of such training using funds derived from its monthly administrative fee. This includes the wages, fees, and/or reimbursed expenses of the trainer or instructor, costs of all instructional materials and their reproduction, facility costs, lodging, refreshments and meals. Such costs may **not** be included among the billable charges for self-hired service itself.

Person/Family-Directed Special Employee Training

This is a special required employee training **identified by the person (or his/her family or designee)** to address a specific need of the particular person served. It is not delivered by the person who is self-directing or his/her family members or designees. It is not general training required of all employees delivering self-directed community habilitation, supported employment or respite services.

Billable Charges: Employee time spent receiving employer-mandated training typically constitutes "time worked" and should be paid as such. Such paid time will be claimed as a billable charge on the Medicaid claim. Follow the same charging rules as described in the "FI-directed General Employee Training" section above.

Billable Service Units: Since the staff receiving training renders no habilitation or respite services, this form of employee training will not yield billable service units.

Substitute Staff: During the planning process, the person and their Circle of Support should determine whether substitute staff will be required when regular self-hired staff attend training. Follow the same budgeting rules as described in the "FI-directed General Employee Training" section above.

Other Costs: When appropriate, OTPS funding may be accessed, up to specified limits, to cover the costs of course/seminar admission fees, materials, mileage, meals and lodging for the self-hired employee being trained.

Training Reimbursement as an Employee Benefit

At its discretion, the FI may offer training reimbursement as an employee benefit. Most commonly, this involves full or partial reimbursement of college or technical school tuition and fees. It may also include reimbursement of job or career-related seminars, workshops, continuing education courses, professional conferences, etc. As an employee benefit, attendance must be at the employee's own volition and may not constitute a condition of continued employment. Neither should attendance be otherwise coerced by any co-employing party (i.e., not by the FI agency nor the person nor the person's family or designee). Time spent attending and preparing for such training is **not** considered hours worked by the employee.

Billable Charges: The employee attends training on his or her own personal time. Since no wages are paid, no billable charges against a self-hired service are incurred.

Billable Service Units: Since the staff receiving training renders no habilitation or respite services, this form of employee training will not yield billable service units.

Substitute Staff: Since the employee attends training voluntarily on his or her own personal time and not during duty hours, substitute staff should not be required to support this form of training.

Other Costs: As an employee benefit, the cost of reimbursed tuition, fees, and incidentals are charged to the FI agency's fringe rate (see Chapter 14).

CHAPTER 17 PREPARING CLAIMS TO MEDICAID FOR SELF-HIRED SERVICES

Self-hired services billed to Medicaid are processed using special logic. Ordinarily, eMedNY ignores the charge amount submitted by providers when paying HCBS waiver services. Instead, eMedNY calculates the amount due to the provider by multiplying the submitted units times the official rate on file for the provider for the rate code billed. Under Self-Direction, however, when they successfully arrange to reduce the total cost of Community Habilitation, Respite, or Supported Employment services using self-hired staff, participants free up PRA resources that can be used to fund additional or different services. Because of this, eMedNY must be able to pay claims for self-hired services at reimbursement rates that are at or below, **but not above**, the official rate for the equivalent Direct Provider Purchased or Agency Supported service. This has the following implications for claims submission and adjudication:

Service Unit Claiming

Just as with equivalent Direct Provider Purchased or Agency Supported services, FI agencies will submit the total billable service units provided on each date services were rendered. If multiple self-hired employees rendered services to the participant on a service date, the sum of billable service units delivered by all staff should be entered for that date. It is important to note that wage hours and billable time may differ. FI agencies must ensure only billable time, as described in OPWDD regulations and administrative memoranda, is entered on the claim form.

Amount Charged

The **total employment cost** paid out by the FI for self-hired services rendered to the participant on the service date should be entered into the **amount charged** field on the claim. Total employment cost includes **both** the wage payment to the employee plus indirect costs paid out (typically, the fringe assessment taken as percentage of wages and transferred to the FI's pooled account for that purpose). If multiple self-hired staff rendered services to the participant on the service date, the sum of total employment cost for all employees should be entered.

Multi-day versus Single-day Claiming

The eMedNY system permits providers to submit claims covering multiple dates of service in a single claim transaction. For a variety of reasons, OPWDD typically recommends against such bundling for most HCBS services. For self-hired services, however, this bundling technique may be advantageous. The effective

reimbursement rate, which is later compared to the fee for the equivalent Direct Provider Purchased or Agency Supported service (see below), is calculated at the claim document level. This means eMedNY will calculate the effective reimbursement rate as an **average** over multiple service dates. In situations where a participant's effective reimbursement rate is over the provider-purchased, or agency-supported fee, on some days but under on other days, FI agencies will want to submit multi-day claims. Claims for OPWDD service may not span calendar months, however. All such "averaging," therefore, must take place within the course of a single calendar month.

Reimbursement Rate Cap Logic

The State may not pay self-directed services at reimbursement rates that exceed the rate paid for equivalent Direct Provider Purchased or Agency Supported services.

Payment processing logic enforces the rate cap as follows:

1. Medicaid calculates the effective reimbursement rate claimed for the self-directed services submitted on the claim: total charges / total service units.
2. Medicaid retrieves the fee rate for the equivalent Direct Provider Purchased or Agency Supported service.
3. If the effective reimbursement rate on the claim for self-directed services is less than or equal to the equivalent Direct Provider Purchased or Agency Supported service fee, eMedNY pays the precise amount charged by the FI agency.
4. If the effective reimbursement rate on the claim for self-directed services is greater than the equivalent Direct Provider Purchased or Agency Supported service fee, eMedNY pays the submitted units times the equivalent Direct Provider Purchased or Agency Supported service fee.

CHAPTER 18 GUIDANCE ON OVERNIGHT SUPPORTS

People may need supports during the overnight hours when they spend some or most of the time sleeping. These supports could include monitoring for events that will require hands-on assistance or ongoing activities, such as developing the person's skills or tending to the person's safety. If nighttime supports are needed the following services should be considered when developing the Self-Direction Budget.

Paid Neighbor

Funded via IDGS. A Paid Neighbor can be available to the person so that, if the person has a need, the Paid Neighbor can respond and provide the appropriate support. A Paid Neighbor provides as-needed support. See the IDGS chart for Paid Neighbor specifics.

Personal Care

Funded via State Plan Medicaid. If the need for support relates to the provision of personal care, it may be appropriate to obtain supports from a personal care assistant through a community-based program where those supports are delivered. This does not count against the PRA.

Respite

If a participant lives in a setting with an unpaid support giver, respite may be an appropriate option for overnight supports.

Community Habilitation

The Community Habilitation (CH) service requires that a face-to-face service be delivered during the course of the continuous time period where the service is provided. A review of the hours that the CH staff person works should be part of service planning to determine and clarify the service expectations.

CH is a means of support for people attempting to live as independently as possible. A portion of the CH service includes implementing person-specific safeguards that are foundational to ensuring a person's health and safety. There is no one-size-fits-all approach in determining if CH is an appropriate service during overnight hours. Each situation needs to be considered during a person-centered planning process and the specific needs to the participant considered.

Many people need supports during the night to ensure their safety, but do not need direct observation during sleep hours. These people may need available support staff who can provide direct service if a specific need arises during the night. A Community Staff Action Plan can include the identification of indirect service time for a portion of the CH service that is integral to the overall plan, but is not delivered in a face-to-face manner.

Components of indirect service time for the CH service can include:

- Staff training time (hours worked to attend training)
- Planning time (hours worked as part of person-centered planning team/Circle of Support)
- Documentation time (time spent completing pertinent and required notes and service documentation)
- Staff coordination and scheduling
- On-call time (hours spent on site by staff who are “available as needed” to implement the Staff Action Plan)
- Asleep overnight staff

The following parameters must be met if asleep overnight staff time is built into the indirect cost:

- The total hourly cost cannot exceed the regional rate for CH;
- There are enough billable hours to ensure that indirect costs cover sleep time;
- The CH plan provides justification that asleep staff are able to provide adequate oversight to the participant;
- CH staff who are also Live-In Caregivers or Paid Neighbors for the person must not be paid for time spent asleep or in "on-call" status.

Under no circumstances does asleep staff support count as billable CH service time.

Indirect service time must be documented as indirect service time in support of the CH service, and must be tracked and paid as hours worked. However, indirect service time cannot be billed as CH service hours. The indirect service time is paid as part of the rate provided to agencies for the CH service, or as a component of the self-hired staff wage established by the participant or designee.

All revenue and payments for both direct and indirect service time for staff must be reported on the Consolidated Fiscal Report (CFR).



Self-Direction Guidance for Providers

Attachments

Attachment A: Self-Direction Budget Types

A person who chooses Self-Direction can choose from three different budget types, depending on what services they need. The budget types are Residential Only (RES), Other Than Residential (OTR) and Both. The chart below outlines the services available within each budget type. Note that some services may not be available depending on the setting where a person lives.

	Residential Only (RES)	Other Than Residential (OTR)	Both
Support Broker	X	X	X
Live in Caregiver	X		X
Individualized Goods and Services (IDGS)	X	X	X
Other Than Personal Services (OTPS)	X	X	X
Community Habilitation	X	X	X
Supported Employment (SEMP)		X	X
Respite	X		X
Group Day Habilitation		X	X
Family Supports and Services (FSS)	X	X	X
Prevocational Services		X	X
Pathway to Employment		X	X
Housing Subsidy	X		X
Family Reimbursed Respite (FRR)	X		X
Available to People Who Live In a Certified Setting		X	
Available to People Who Do Not Live In a Certified Setting	X	X	X

Attachment B: Personal Resource Account (PRA)

Applies to people who self-direct with Budget Authority (includes those with Self-Hired staff):

Services which must be included in Self –Direction Budget and budgeted for within a person’s Personal Resource Account	Services which may be delivered without being included in a person’s Self-Direction Budget and do not count against a person’s Personal Resource Account
Support Broker (SB)	Startup Brokerage
Live in Caregiver (LIC)	Fiscal Intermediary (FI)
Individualized Goods and Services (IDGS)	Community Transition Services (CTS)
Other Than Personal Services (OTPS)	State Plan Services (e.g. Personal Care, Nursing)
Community Habilitation (CH)	Article 16 Clinical Services
Supported Employment (SEMP)	Long Term Sheltered Employment (State-Funded Contracts)
Respite	Intensive Behavioral Services (IBS) and Systemic, Therapeutic Assessment, Resources and Treatment (START)*
Group Day Habilitation (GDH)	Environmental Modifications
Family Supports and Services (FSS) and Assistive Supports	Adaptive Technologies
Prevocational Services (Pre-Voc)	Care Management
Pathways to Employment	Residential Habilitation: Supervised, Supportive, Family Care**
Housing Subsidy/ISS	Family Education and Training (FET)
Family Reimbursed Respite (FRR)	Transition Stipend

* Not including Intensive Respite. Intensive Respite would need to be included in budget as a Direct Provider Purchased service.

**A person who receives Residential Habilitation is limited to receiving only an Other Than Residential (OTR) type budget. As such, these residential services are not included in a person’s budget.

Attachment C: Budget Review Procedure

Intent:

For people who choose to self-direct their supports and services with Budget Authority, Start-up, Initial and Amended Budgets need to be reviewed and approved by the Fiscal Intermediary (FI) before they are submitted to the OPWDD for review. The purpose of this procedure is to establish a consistent practice for reviewing Budgets to begin on **March 1, 2016**.

Process:

1. The person who is self-directing and the Support Broker fill out the Budget completely.
 2. The Support Broker sends the completed Budget to the Fiscal Intermediary for review.
 3. The FI reviews the Budget and advises the Support Broker on any necessary modifications. Once any needed changes have been made and returned to the FI, the FI informs the Support Broker by letter or email that the FI agrees to the Budget and will act as the FI for the person who is self-directing.
 4. The Support Broker or FI sends the Budget and a copy of the FI's affirmation to the DDRO Self-Direction Liaison.
 5. The DDRO Self-Direction Liaison reviews the Budget and advises the Support Broker and the FI on any necessary modifications. Once any needed changes have been made and returned to the DDRO Liaison, the DDRO Liaison sends the Budget* to OPWDD Central Office for review.
- *Cost Neutral Budget Amendments do not need to be approved by the OPWDD Central Office
6. OPWDD Central Office reviews the Budget and advises the DDRO Liaison on any necessary modifications. The DDRO Liaison notifies the Support Broker and the FI to incorporate any needed changes. Once any required alterations have been made and returned to OPWDD Central Office, OPWDD Central Office returns the final approved Budget to the DDRO Liaison with an effective date when self-directed services can begin.
 7. The DDRO Liaison sends the final approved budget to the person who is self-directing, the Support Broker, the FI and any other appropriate party.

Secure Communication:

Self-Direction Budgets contain Personal Health Information (PHI). Any transition should be by a method that is compliant with the Health Insurance Portability and Accountability Act (HIPPA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Attachment D: Continuity of Care

Prior to billing over-PRA Continuity of Care funding, an analysis needs to be done to determine if there are unused resources still available in a participant's budget that may be able to be accessed. The participant should work with their Support Broker to complete this analysis. If there are other Medicaid resources available in the budget that are not expected to be used during the budget cycle, the participant/Support Broker will need to complete a cost-neutral amendment form to move the dollars into Community Habilitation. If, after the analysis, it is determined that there are no unused dollars available in the budget to shift into Community Habilitation then the over-PRA Continuity of Care funding may be accessed. The amount billed would be reflective of the total cost, based on the current Community Habilitation fee in effect, in \$10 increments, up to the funding level authorized.

OTPS & Continuity of Care

For plans in existence prior to 10/1/2014, OTPS may be used for clinical consulting and additional living expenses not covered by a lease. This is on a time-limited basis and OTPS cannot be used for those purposes any plan implemented after October 1, 2014.

Continuity of care will not apply to experimental treatments or non-evidenced practices or for direct provision of clinical services. Continuity of Care Provisions are not applicable to Self-Direction Budgets developed on and after 10/1/2014. On and after 10/1/2014, OPWDD will not approve increases or cost neutral changes to Continuity of Care Provisions found in existing Self-Direction Budgets; OPWDD will only approve decreases to such Provisions.

General Continuity of Care Provisions - In order to ensure continuity, the following guidelines were followed:

- The state paid option for over-PRA is only available to the people who transitioned from the Consolidated Supports and Services model and is temporary. OPWDD will notify people when an end date has been established and work with affected parties to transition for state funding of costs over-PRA.
- Supports for Community Habilitation, SEMP and Respite must utilize the defined methodology and support must be provided within the defined costs of those services. State funds are not to be used to augment the rate paid for the self-hired staff costs of those services. See detailed guidance for Employment supports.

Clinician and Certain Therapy Services

Clinical Consultation – To ensure continuity of care, a Self-Direction participant may augment the hourly rate paid to a consulting clinician with 100% state funds. This is allowed when the participant's CSS budget (prior to 10/1/14) included the consulting clinician's services, and the hourly rate paid to the consulting clinician exceeds the hourly rate paid through IDGS. OPWDD will evaluate the timeframe that this continuity of care provision will be allowed.

Clinician - Direct Service provision - No use of state funds is allowed.

Therapies – To ensure continuity of care, a Self-Direction participant may augment with 100% state funds the hourly rate paid for Hippotherapy, Therapeutic Riding, Aquatic Therapy, Art Therapy, Massage Therapy, Music Therapy, and Play Therapy. This is allowed when the person's CSS budget (prior to 10/1/14) included the therapy, and the hourly rate paid to the consulting clinician exceeds the hourly rate paid through IDGS. OPWDD will evaluate the timeframe that this continuity of care provision will be allowed.

Attachment E: Support Broker Training Policy

Support Brokers assist people with developmental disabilities who choose to self-direct their Office for People with Developmental Disabilities services with Budget Authority to develop a Circle of Support and complete and manage a Self-Direction Budget. Self-Direction provides individuals more responsibility in the management of their supports and services. People who participate in Self-Direction may self-hire and manage their own staff supports (employer authority) and decide on the supports and services they need and how the funding allowed for these supports and services is allocated (budget authority). This policy reiterates the training requirements and expectations for all Brokers.

There are two phases of Support Broker services:

1. **Start-Up Support Brokerage** - Design and completion of an approvable Self-Direction Budget. Completion of a Self-Direction Budget is typically accomplished within six (6) months of the approval of a Broker Agreement for Start-Up Brokerage and issuance of a Start-up Broker approval letter. Start-up Support Broker services may be accessed once, with a lifetime funding limit of \$2400 for the Self-Direction participant's use in paying for Broker services needed to create an initial Budget.
2. **Ongoing Support Brokerage** - A variety of supports and services to ensure successful implementation and continuation of the approved Self-Direction Budget. The primary functions of the Support Broker are to maintain a Circle of Support and manage the Self-Direction Budget. If a participant has chosen self-hired Community Habilitation or Supported Employment services, Support Brokerage Services include completing and updating Staff Action Plans for these services.

Support Brokers are required to maintain copies of the training certificates for all trainings they have completed to fulfill the requirements included here-in, and provide (copies of) these certificates to the DDRO Self-Direction Liaison when requesting to work in a DDRO. Copies also need to be provided to each Fiscal Intermediary that bills for the Broker's Support Broker services. Each year, Brokers must prove fulfillment of the annual OPWDD and Professional Development training requirements.

Initial Broker Training Requirements

Completed PRIOR TO delivering any Support Broker services.

1. *Self-Advocacy/Self-Determination* - should be taken prior to BTI.
2. *Person-Centered Planning* – **must include both** *Introduction to Person-Centered Planning* and *Advanced Person-Centered Planning*. These courses may be taken together or separately.
3. *Broker Training Institute* (BTI) - provides the philosophy of Self-Direction, details regarding the responsibilities of Support Brokers, information regarding billing and documentation requirements, and Circle of Support training.
4. *Self-Direction Budget/Template* – required to access the Budget Template.

Other OPWDD Required Trainings

Available from the DDRO Self-Direction Liaison for Independent Brokers.

1. *Privacy and Security of Health Information* - annual
2. *Overview of Developmental Disabilities* - once
3. *Infection Control/ Blood Borne Pathogens/TB* - annual
4. *Medicaid Compliance* - annual
5. *PICA* (if working with an individual for whom this training would be relevant) - once
6. *PRAISE* (replaces Incident and Abuse Reporting) – annual
7. *Right to Know* – annual
8. *Rights and Responsibilities of Persons Receiving Services* - once

OPWDD Required Trainings must be completed by the end of the Broker's first calendar year. Trainings with an "annual" designation must be completed within every calendar year.

Professional Development Training Requirements

Annual requirements to continue to provide Broker services

Support Brokers must attend professional development training annually. The minimum number of training hours required is 12 hours annually. This professional development may include lectures, workshops, and other training sessions conducted by OPWDD, a Support Brokerage Learning Network, other agencies, or educational institutions. This may include online courses, webcasts or other electronic communication media, offered by OPWDD or other entities. The subject of the training must enhance the Support Broker's ability to serve individuals with developmental disabilities. The Support Broker is responsible for ensuring that the subject matter of all training applied to the 12-hour annual training requirement is appropriate. Attendance at the initial Broker Trainings

cannot be counted towards the required annual professional development training hours.

The twelve-month period in which the Support Broker must participate in the required 12 hours of annual training is called the “training year.” For brokers who were providing brokerage services prior to October 1, 2014, the training year remains the same. For brokers who began providing brokerage services on or after October 1, 2014, the training year is the twelve-month period following the month the Support Broker first began providing Support Brokerage services. The Support Broker is responsible for maintaining his/her training records that verify attendance.

Family members who reside in the same household as the person who self-directs their services or who are the parents of the person may NOT be paid for providing Broker services. If a family member of a person with ID/DD is interested in providing unpaid Broker service for that person, he/she must meet the initial Broker training requirements as described above.

Attachment F: Live-In Caregiver Maximum Reimbursement Levels

As of 10/01/2014, the maximum Live-in Caregiver reimbursement levels* are as follows:

Rate Setting Region 1 – New York City	Rate Setting Region 2 – Putnam, Rockland, Westchester, Suffolk and Nassau Counties	Rate Setting Region 3 - Rest of State
Rent - \$17,676 annually Food - \$5,000 annually Utilities - \$ 3,500 annually Annual Total - \$26,176 Monthly Max - \$2,181	Rent - \$19,200 annually Food - \$5,000 annually Utilities - \$ 3,500 annually Annual Total - \$27,700 Monthly Max - \$2,308	Rent - \$13,872 annually Food - \$5,000 annually Utilities - \$ 3,000 annually Annual Total - \$21,872 Monthly Max - \$1,823

*These are the maximum amounts by Region. Actual amount allowed in a person's budget will be limited by certain factors including county of residence, number of bedrooms and calculations determined by the ISS formula and the Self-Direction Budget.

Attachment G: List of Applicable Administrative Memoranda

The links to the ADMs referenced in this guidance are:

- OPWDD ADM #2019-07 Service Documentation for Fiscal Intermediary Services
<https://opwdd.ny.gov/adm-2019-07-service-documentation-fiscal-intermediary-services-0>
- OPWDD ADM #2019-06 Service Documentation for Support Brokerage Services
<https://opwdd.ny.gov/adm-2019-06-service-documentation-support-brokerage-services-0>
- OPWDD ADM 2019-05 Authorization Standards for Support Brokers
<https://opwdd.ny.gov/adm-2019-05-authorization-standards-support-brokers-0>
- OPWDD ADM #2015-05 Individual Directed Goods and Services
<https://opwdd.ny.gov/adm-2015-05-service-documentation-individual-directed-goods-and-services-idgs-0>
 - Individual Directed Goods and Services (IDGS) Definitions Chart
<https://opwdd.ny.gov/adm-2015-05-service-documentation-individual-directed-goods-and-services-idgs-0>
- OPWDD ADM #2015-02 Service Documentation for Community Transition Services
<https://opwdd.ny.gov/adm-2015-02-service-documentation-community-transition-services-0>
- OPWDD ADM #2015-01 (Supersedes OPWDD ADM #2010 – 05) Service Documentation for Community Habilitation Services Provided to Individuals Residing in Certified and Non-Certified Locations

<https://opwdd.ny.gov/adm-2015-01-service-documentation-community-habilitation-services-provided-individuals-residing-0>

- OPWDD ADM #2005-02 HCBS Respite/Non Waiver Enrolled (NWE) Respite Service Documentation Requirements

<https://opwdd.ny.gov/regulations-guidance/adm-2005-02-hcbs-respitenon-waiver-enrolled-respite-service-documentation>

- OPWDD ADM #2016-01 Supported Employment Service Delivery And Documentation Requirements

<https://opwdd.ny.gov/adm-2016-01-supported-employment-semp-0>

- OPWDD ADM #2016-03 Live-in Caregiver Service Documentation

<https://opwdd.ny.gov/adm-2016-03-live-caregiver-service-documentation-0>

- OPWDD ADM #2018-09R Staff Action Plan Program and Billing Requirements

<https://opwdd.ny.gov/adm-2018-09r-staff-action-plan-program-and-billing-requirements-0>