Maryland
DEPARTMENT OF HEALTH

Developmental Disabilities Administration
Person-Centered Planning (PCP)
Manual

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***All text in red indicates added/revised language since the prior release date of Person-Centered Plan ~~PCP~~ Development and Authorization Guidance on March 18, 2024**

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Introduction

This manual outlines the Developmental Disabilities Administration (DDA) Person-Centered Plan (PCP) development and funding authorization processes which apply to **all initial, revised, and annual Person-Centered Plans ~~PCPs~~** for both the self-directed and provider managed service delivery models. ~~traditional service delivery models.~~

This manual is intended to be used by **Person-Centered Planning ~~PCP~~** teams including people eligible and receiving DDA services, their families, Coordinators of Community Services, ~~coordinators of community services (CCS),~~ providers, support brokers, or other team members invited by the person. This manual has been adapted from and replaces the Person-Centered Planning Development and Authorization Guidance document. Please note it does not replace any other current policy or procedure related to **Person-Centered Plans ~~PCPs~~** or the planning process nor does it supersede what is documented in DDA's federally approved waiver.

A Person-Centered Plan ~~(PCP)~~ helps people create a vision for their future. The **Person-Centered Plans ~~PCP~~** process always begins with and is about the person. The **Person-Centered Plan ~~PCP~~** format, approval, and authorization are documented within the LTSS*Maryland*-DDA Module information system. The DDA's **Person-Centered Planning ~~PCP~~** processes include (1) pre-planning, (2) plan development and (3) plan approval/authorization. **Person-Centered Plan ~~PCP~~ services are authorized for a one-year period and must be updated annually and approved by the annual plan date.**

~~Until the DDA system has fully moved (transitioned) into the LTSS*Maryland* DDA Module, the DDA will be operating in two systems: LTSS*Maryland* DDA Module and the current Provider Consumer Information System (PCIS2). PCPs will be completed and approved in the LTSS*Maryland* DDA Module, and services will be authorized and billed through PCIS2 until the service provider transitions to the *LTSSMaryland DDA Module fee-for-service billing.*~~

~~As part of the DDA's final transition to LTSS*Maryland*, the DDA issued the "GUIDANCE FOR OPERATING IN PCIS2 AND LTSSMARYLAND," which includes information and process changes for transitioning from the legacy services authorized in PCIS2 to the LTSS*Maryland* DDA Module PCP detailed service authorization request. The DDA has also shared guidance on the different service names, units, scope and billing instructions to operate between the two systems.~~

All people will follow the same process for requesting services in their **Person-Centered Plan ~~PCP~~**. Under the ~~traditional services delivery model~~ provider managed service delivery model, DDA-licensed and DDA-certified providers will complete the Detail Service Authorization Tool (DSAT) and submit to the Coordinator of Community Services ~~CCS~~. ~~The Cost Detail Tool is also required under the traditional service delivery model for all providers listed in the PCP unless the services have transitioned to the LTSS*Maryland* fee-for-service billing.~~ The DSAT will help teams identify the appropriate services and units for the LTSS*Maryland*-DDA Module **Person-Centered Plan ~~PCP~~** detailed service authorization

section. ~~The Cost Detail Tool will be used to assist the regional offices with service authorization in PCIS2.~~ Under the self-directed services delivery model, the LTSS*Maryland*-DDA Module **Person-Centered Plan** ~~PCP~~ detailed service authorization section determines the self-directed budget allocation.

Once the **Person-Centered Plan** ~~PCP~~ has been completed, the Coordinator of Community Services ~~CCS~~ will submit it to the DDA via LTSS*Maryland* for review as per current guidance and policy. ~~Once approved, the DDA will ensure services are documented and authorized in PCIS2 as applicable. It is important to note that some LTSS*Maryland* services and units do not directly correlate to legacy services authorized in PCIS2. This is due in part to the different rate structures and historical practices of distributing authorized hours among several people residing in the same home. Therefore, teams and DDA staff will need to carefully assess the authorized PCP services to the authorized PCIS2 services to determine if new or additional services or hours are needed, or if edits are needed to the existing authorization in PCIS2.~~

Definitions

1. "Annual Plan" means the person-centered plan completed within 365 days of the agreed upon Annual **Person-Centered Plan** ~~PCP~~ date. This date is chosen by the person when they first enter services, and the initial **Person-Centered Plan** ~~PCP~~ is developed.

2. "Behavior Support Plan" or "BSP" is a written plan designed to modify behavior through the use of clinically accepted techniques that:
    - Is person-centered and trauma informed.
    - Is based upon:
        - Positive behavior supports.
        - The results of a Functional Behavioral Assessment (FBA).
        - Includes a description of the problem behavior, along with a specific reason as to why the problem behavior occurs.

3. "Budget Authority" means the participant makes choices about how they will spend the money in their budget within program limits. This includes choosing the goods and services the participant wants and who is paid to provide them.

4. "Coordination of Community Services" are case management services to help individuals receiving and/or requesting services from the waiver program. These services are known as targeted case management and are provided in accordance with COMAR 10.09.48.

5. "Coordinator of Community Services" or "CCS" is an individual who provides

Coordination of Community Services. They can be either an employee or a contractor of a DDA approved Provider of Coordination of Community Services.

6. "DDA-operated Medicaid Waiver Program" is the Medicaid home and community-based waiver program ~~one of three Medicaid home and community-based services waiver programs~~ operated by the Developmental Disabilities Administration that serves eligible children and adults with intellectual and developmental disabilities. The Community Pathways Waiver is the program that is approved by the Centers for Medicare & Medicaid Services.

    - ~~Community Pathways Waiver;~~
    - ~~Community Supports Waiver; and~~
    - ~~Family Supports Waiver. "Dedicated Hours" mean 1:1 and 2:1 staff-to-person support hours based on the person's assessed needs.~~

7. "Designated Representative" is an unpaid individual who acts on behalf of the participant to manage their services under the Self-Directed Services delivery model. They are noted in the Participant Agreement and must follow program requirements.

8. "Detailed Service Authorization" means the LTSS*Maryland* **Person-Centered Plan** ~~PCP~~ section that lists the DDA-funded services including the specific service name, service provider, units per month, annual service cost and provider status (where applicable, under the provider managed service delivery model).

9. "Direct Support Staff" or "Direct Support Professional" (DSP) means an individual who is paid to provide direct care services to a person.

10. "Employer Authority" means the participant is responsible for managing their employees. This includes hiring, training, scheduling, and firing employees, if needed, within waiver program limits.

11. "Family as Staff Form" means the form used by persons self-directing their services to indicate their choice to hire a relative as staff.

12. "Financial Management and Counseling Services" or "FMCS" are services provided to support a participant in the Self-Directed Services delivery model in using their budget authority and, if applicable, employer authority. Financial Management and Counseling Services include, but are not limited to:

    - Processing claims for payment for Medicaid waiver program services in

accordance with the participant's self-directed budget; and

- Verifying that the DDA provider, vendor, or employees meet all qualifications to provide the Medicaid waiver program service.

13. "Flexibility" means the ability for a person and their team to adjust quickly and easily respond to an identified need. Specifically, **Person-Centered Plan** ~~PCP~~ flexibilities take into account unanticipated or future needs that allow the person to readily access pre-authorized support to increase independence, build relationships, achieve career goals, and engage in their community within DDA service limitations and definitions with minimal administrative processes.

14. "Good Life" means a person's vision for what they want in their life, including what is important to and for them.

15. "Health Risk Screening Tool" or "HRST" is an assessment tool utilized by teams to determine health and safety risks for a person.

16. "Initial **Person-Centered Plan** ~~PCP~~" means the first person-centered plan developed for a person once they are approved to apply for waiver services or is the new **Person-Centered Plan** ~~PCP~~ for a different DDA program type. It is the first step in applying for another waiver program when the person is already currently enrolled in another.

17. "LTSS*Maryland*" is an electronic data management system, developed and supported by the Department. It is used to create, review, and maintain records about:

    - Eligibility status for services; and
    - The participant's Person-Centered Plan, services, and funding authorized by the DDA.

18. "Milestone" means a DDA service unit that is paid based on the completion of a particular deliverable such as an Assistive Technology Assessment, Behavior Support Plan or Employment-Discovery.

19. "Nursing Care Plan" or "NCP" is a plan developed by an RN, in accordance with Maryland Board of Nursing Standards, that identifies:
    - The person's diagnoses and needs.
    - The goals to be achieved.
    - The intervention required to meet the person's medical condition.

20. "Overnight Supervision" means
    - Residential overnight support services where staff may be awake or asleep, depending on the persons' needs and provider business model. Supports are available within Supported Living, Community Living-Group Home, and Community Living-Enhanced Services.
    - Personal Supports services provided overnight to meet an assessed need.

21. "Person" means an individual enrolled in, and receiving, DDA-funded services.

22. "Participant Agreement" is the form used by participants self-directing their services to document the participant's choice to either:

    - Be the primary person responsible for managing employer and budget authority responsibilities; or
    - Appoint a Designated Representative to be responsible for all tasks; or
    - To appoint team members to assist with specific tasks related to roles and responsibilities under self-direction.

23. "Person-Centered Plan" or "PCP" is a written plan made together with the person who has a developmental disability who participates in or will participate in a Medicaid waiver program. This plan helps, to the extent possible:

    - Identify any special needs they have to stay healthy and safe;
    - Figure out what the person wants to achieve; and
    - Find services and providers that can help them reach their goals while being part of the community.
    - "Person-centered thinking" means thinking focused on the language, values, and actions toward respecting the views of the person and their loved ones. It emphasizes quality of life, well-being and informed choice.

24. "Rights and Responsibilities Form" means the form used to notify persons of their rights and responsibilities as a person in a DDA program.

25. "Relative" is a natural or adoptive parent, step-parent, grandparent, step-grandparent, child, stepchild, sibling, step-sibling, aunt, uncle, niece, nephew. In-laws of these relative types are also considered relatives. ~~natural or adoptive parent, child, stepchild, stepparent, or sibling of a participant, who is not also a legal guardian or legally responsible person.~~

26. "Revised **Person-Centered Plan** ~~PCP~~" means a plan developed when an active Initial or

Annual **Person-Centered Plan** ~~PCP~~ requires changes to services, outcomes, or other elements of the plan that reflect a change in the person's needs and wants. Reasons for a revision may include but are not limited to discontinuation, initiation or increase in a service, newly identified outcomes, etc.

27. "Self-Directed Services" means that participants, or their representative(s), if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

28. "Support Intensity Scale" or "SIS" is an assessment tool. The SIS® measures the person's support needs in personal, work-related, and social activities to identify and describe the types and intensity of the supports an individual requires. SIS® was designed to be part of person-centered planning processes that help all individuals identify their unique preferences, skills, and life goals.

29. "Team" means a collaborative effort to support a person receiving DDA services to develop and implement their individual **Person-Centered Plan** ~~PCP~~ that outlines their needs, goals, and desired outcomes to achieve their personally defined good life. This collaboration is driven by the person, coordinated by their Coordinator of Community Services ~~CCS~~, and enhanced by important people chosen by the person such as family members, significant others, providers, support brokers, friends, colleagues and others.

Person-Centered Pre-Planning

Everyone has the right to live, love, work, play, and pursue their aspirations in their community. Since 2015, the Maryland Department of Health's Developmental Disabilities Administration (DDA) has been wholly transforming our programs, policies and funding

processes to put people with developmental disabilities at the center of our efforts.

People are the center of planning a vision for their personally defined good life. This is done through the Person-Centered Planning. Our guide for coordinators of community services provides more information on how individuals can choose in “My Life, My Plan, My Choice.”

Comprehensive and collaborative pre-planning is driven by the person and coordinated by the Coordinator of Community Services ~~CCS~~. Pre-planning is essential for Initial and Annual Person-Centered Plans ~~(PCPs)~~ to support the person’s life aspirations and address any unmet needs (i.e., immediate and for the upcoming year). It also reduces the need for a revised **Person-Centered Plan** ~~PCP~~. Pre-planning occurs in collaboration with the person’s **Person-Centered Planning** ~~PCP~~ team, which includes people chosen by the person and often includes their family members, friends and provider agencies.

Pre-planning should be initiated within 90 days of the **Person-Centered Plan** ~~PCP~~ Annual Plan date. Pre-planning can be formal or informal depending on the preference of the person. Some people may request an in-person pre-planning meeting or a virtual one. Others may choose to engage in pre-planning with their team via email or text. Regardless, the pre-planning process is an opportunity for the person to plan for their good life, identifying current and anticipated needs as well as goals and outcomes.

For Initial, Revised, and Annual Person-Centered Plans ~~PCPs~~

- **Personally Defined Good Life**
    - The first and most important part of planning is getting to know the person. Who are they? What do they want for their life and what don't they want? What is their vision for their "Good Life?"
    - Before discussing services and support, teams need to know and understand what aspirations and goals the person has in order to assist them with planning and helping them to achieve their self-defined good life.
    - Knowing the person and their strengths and assets, needs, goals and challenges allows the team to discuss, plan and identify different resources, supports and services, including DDA-funded services to positively support their trajectory toward their good life. Before discussing DDA-funded and other services, it is important to understand the person’s trajectory so that planning can then begin on the steps to lead a self-defined good life captured in the **Focus Area Exploration (FAE).**
- **Person-centered Planning Tools and Strategies**

- **Focus Area Exploration (FAE)**

  - Person-centered planning is a continual process of listening and learning (e.g., exploration and discovery) to create a meaningful and relevant plan that may be adjusted according to life circumstances.

  - Discuss focus areas as identified by the person and included in the **Person-Centered Plan** ~~PCP~~ as well as outcomes the person wants to accomplish initially and throughout the **Person-Centered Plan** ~~PCP~~ year.

  - **The Employment FAE must be completed annually.** All other FAEs are driven by the person and can be discussed at any time throughout the year, however, it is a best practice that the team review and complete all FAEs particularly when there are revisions being made to authorized services. The FAEs provide a good overview of need and documentation of need for authorized services.

- **Health Risk Screening Tool (HRST)**

  - The HRST is used to identify health care needs, risks and destabilization early. The HRST assigns scores to 22 health and behaviorally related rating items. The total points result in a Health Care Level with an associated degree of health risk. Health Care Levels (HCL) can range from 1 through 6, with Level 1 being the lowest risk for health concerns and Level 6 being the highest risk of health concerns. It is important to understand that the HRST measures health risk, not disability.

  - The HRST can help inform teams of health risks that should be considered during planning and provides recommended staff training.

    - Teams should review the HRST to ~~determine and~~ identify and document all risks, along with steps to address them, **document all risks and mitigation efforts to support those risks in the Risks section of the Person-Centered Plan ~~PCP~~.** The HRST will list risks identified, but the team determines how those identified risks impact the person, and should be individualized.

    - Mitigation efforts should be current, clearly outlined, and

reference applicable documents to support the identified risks such as the Behavior Support Plan (BSP) or Nursing Care Plan (NCP).

- The HRST must be reviewed, updated, and approved within 90 days of the **Person-Centered Plan** ~~PCP~~ expiration date. For HRST scores of 3 or higher, the nurse will need to complete a clinical review.
- An HRST is <u>not required</u> for authorization of an enhanced rate, 1:1 or 2:1 dedicated support or overnight support.
- The HRST should be completed early in the **Person-Centered Plan** ~~PCP~~ pre-planning process to ensure timely submission with the **Person-Centered Plan** ~~PCP~~ to the regional office.
- The HRST must also be updated when there are major health status changes.
- Conditions of Release or Probation
    - If an individual has Conditions of Release or Probation from a court, the court documents need to be uploaded into the LTSS*Maryland*-DDA Module under the DDA Eligibility tab > Court Order Form.
    - All Conditions of Release or Probation orders need to be documented in the Risks and Rights Restriction sections of the **Person-Centered Plan** ~~PCP~~ as well as the BSP to address those restrictions.

- **Support Intensity Scale (SIS®)**
    - The SIS® measures the person's support needs in personal, work-related, and social activities to identify and describe the types and intensity of the supports a person may require. It can help provide information and considerations during the person-centered planning processes by the person and their team.
    - The SIS® is to be completed for all new persons (16 or older) and should be used for the development of the Initial **Person-Centered Plan** ~~PCP~~ and annually during the pre-planning process.

- The DDA has been coordinating with the SIS® contractor to conduct a SIS® for all other DDA persons. The Coordinator of Community Services ~~CCS~~ should actively support people and families in coordinating the SIS® assessment with the SIS® assessor and help answer any questions about their role in the SIS® process.
- Once completed, the SIS® shall be reassessed every five years.
- The LTSS*Maryland* system will automatically send a referral to the contractor to complete the SIS® and the Coordinator of Community Services ~~CCS~~ will also be alerted to the referral.

○ **Assess Needs**

- To support an integrated "community life" versus a "service life," the **Person-Centered Planning** ~~PCP~~ team should continuously explore generic, natural, community, local and other resources to support the person in addressing any risks, and in meeting their needs and goals.
- The Charting the LifeCourse Integrated Star is a useful tool for people, families and teams to consider an array of integrated supports to achieve the envisioned good life, including those that are publicly or privately funded and based on eligibility, community supports that are available to anyone, relationship-based supports technology, and also take into account the assets and strengths of the individual and family. This tool is helpful to get a more comprehensive look at all the services and supports that may exist in a person's life, not just eligibility-specific supports. Reference: https://www.lifecoursetools.com/.
- After exploration of ~~generic,~~ natural, community, local and other resources, the **Person-Centered Planning** ~~PCP~~ team should determine if any remaining unmet support needed can only be met with a ~~W~~waiver or Medicaid service.
    - Natural Supports refer to the support and assistance that naturally flows from the associations and relationships typically developed in natural environments such as the family, school, work and community.

- ~~Generic service/support means support and services available to any member of the population and is not specific to meeting specialized needs of individuals with intellectual disabilities or developmental disabilities. Essentially, it's the same as a community resource, support or service.~~ Community and local resources, supports and services are those that are available to any member of the community and are not specifically designed to meet the specialized needs of individuals with intellectual or developmental disabilities.

Person-Centered Plan Development

Based on information and input gathered through the **Person-Centered Plan** ~~PCP~~ Pre-Planning process, the next step is the **Person-Centered Plan** ~~PCP~~ Development process. **The Person-Centered Plan ~~PCP~~ meeting can be formal or informal depending on the preference of the person. Some people may request an in-person Person-Centered Plan ~~PCP~~ meeting or a virtual one.**

- **The** Coordinator of Community Services ~~**CCS**~~ **will develop, in collaboration with the person and their PCP team, a PCP that reflects the:**
    - Person's vision.
    - A person's outcomes.
    - Identified risks, right restrictions, and needs.
    - Requested services necessary to ensure the person is:
        - Healthy;
        - Safe; and
        - Achieving a "good life."

- A request for **new or increased services** should be submitted via a **Revised Person-Centered Plan ~~PCP~~ with all the necessary elements of the Person-Centered Plan ~~PCP~~ completed**.
    - The Coordinator of Community Services shall include information in the Revised **Person-Centered Plan** ~~PCP~~ text box related to the purpose of the revision.
    - To help facilitate the review, the Coordinator of Community Services ~~CCS~~ shall include details to support newly assessed needs such as:
        - What is the need/risk?
        - How will the service being requested meet the need or mitigate the risk?
        - Additional documentation to support need shall be included in the **Person-Centered Plan** ~~PCP~~ such as a person schedule, risk, and mitigation strategies, HRST, Nursing Care Plan, Behavior Support Plan, and details in the Focus Areas such as What's working/What's not working, as applicable.
    - The effective date noted in the **Person-Centered Plan** ~~PCP~~ should allow the regional offices **20 business days for review and approval**.
    - All existing, new, decreased, or increased services should be captured in the Detailed Service Authorization section of the **Person-Centered Plan** ~~PCP~~ along with their frequency, duration, and scope based on the effective date noted in the Revised **Person-Centered Plan** ~~PCP~~. For example, if the effective date in the PCP is 03/01/2021, all services in the DSA should reflect service units starting from 03/01/2021 to the annual plan date.

For Self-Directed Services Person-Centered Plans ~~SDS PCPs:~~

- The person self-directing, with the support of their Coordinator of Community Services ~~CCS~~ and team, will utilize the established overall budget allocation that was produced in the Detailed Service Authorization (DSA) Section of the Person-Centered Plan ~~PCP~~ to develop a Self-Directed Services budget sheet that aligns with the services noted in the DSA and adheres to the DDA's reasonable and customary standards.

- The SDS Budget Sheet should contain the same effective date as noted in the Person-Centered Plan ~~PCP~~.

- After inputting all the needed services in the Self-Directed Services ~~SDS~~ Budget Sheet, the total annual budget amount in the Self-Directed Services ~~SDS~~

budget sheet should not exceed the total cost generated in the DSA section of the Person-Centered Plan ~~PCP~~. However, it can be less than what is noted in the DSA based on the chosen pay rates for employees and vendors.

- The annual and actual columns of the SDS budget sheet will have similar total budget amounts and do not require any further proration.

- Person-Centered Plan ~~**PCP**~~ **- Outcome Section**
    - Personal outcomes are goals people set for themselves and are defined from the person's perspective. They are items that each person identifies as "Important To" them and standards by which we measure progress and quality of service.
    - Teams should not only provide needed support but also help the person develop natural support in the community that will assist them in reaching goals.
    - Outcomes should be associated with each authorized service in the Person-Centered Plan ~~PCP~~.
        - Outcomes are specifically linked to the person's vision, values and fundamental rights.
        - Outcomes ~~can~~ should be supported by or in a combination of ~~generic,~~ natural, community, local and other resources whenever possible in addition to Waiver services.
        - The outcome description is a statement to further define what the person wants to happen because of the support, to include person-specific benefit or value. The outcome description(s) related to issues of "Important TO" the person should be based on their vision and preferences related to daily life, employment, relationships, spirituality, community engagement and membership, health, safety, self-advocacy, etc.
        - Those outcomes which addressed solely issues of "Importance FOR" the person addressed either functional/clinical needs or compliance with a service.
        - For outcomes related to dedicated 1:1 or 2:1 support it should be clearly documented how the person will utilize those supports to meet their needs, mitigate risk, access their community, build relationships, or increase their independence. This documentation can be found in the Risks section of the Person-Centered Plan ~~PCP~~, applicable FAE where the 1:1 or 2:1 is needed or referenced in the BSP or NCP.

- To support an integrated "community life" and prevent a "service life," Person-Centered Plan ~~PCP~~ teams should identify and note:
    - How community resources and/or natural supports are being used or developed.
    - How non-DDA funded and other contributing resources are being used to support the outcome. Examples include Maryland ABLE accounts and Special Needs Trusts.

- Person-Centered Plan ~~PCP~~ **- Service Authorization Section**
    - Requested DDA-funded services are noted in the Person-Centered Plan's ~~PCP's~~ service authorization section.
    - Requested services should be in accordance with the DDA's Waiver service descriptions taking into consideration:
        - Other available resources.
        - Assessed unmet need.
        - Potential duplication of services.
        - Service scope and limitations.
    - The person-centered planning process in LTSS*Maryland* requires month-by-month service planning. The Coordinator of Community Services ~~CCS~~ leads a conversation with the person and their Person-Centered Planning ~~PCP~~ team to determine which services the person needs, the amount, and in which months services will be utilized.
    - **Detail Service Authorization Tool (DSAT**)
        - The DSAT was created to improve and expedite the planning and development process for requested services in the monthly detailed service authorization section.
        - The DSAT is not required. ~~for providers who have transitioned billing to LTSS*Maryland*.~~ However, it can still be used as tool if helpful in communicating services the provider can provide to the person based on their goals.
        - ~~For those providers who are billing in LTSS*Maryland*, it~~ It is important to thoroughly review the service authorization that is sent to you for accuracy. It is also important to ensure good communication and collaboration with the team about the services a person is asking your agency to provide.
        - ~~The CCS will request the DSAT from providers, who have not transitioned to LTSS*Maryland* for billing, selected by the person as a guide to help identify the proposed services to meet the person's needs.~~

- ~~Providers, not billing in LTSS*Maryland* complete the DSAT, proposing the service, amount, and duration, and to support the person to achieve their goals and meet the assessed needs and preferences.~~

- ~~The provider agency, not billing in LTSS*Maryland*, submits the completed DSAT to the person's CCS, who will review the DSAT with the person and their support team.~~

  - ~~As always, the person may accept the proposed services or choose to seek different services that best fit their needs.~~

  - ~~The DSAT must be submitted to the CCS or uploaded to the provider portal for the CCS to obtain no less than one week (seven calendar days) prior to the planning meeting.~~

- ~~Once the DSAT is submitted to the CCS, the DSAT will be uploaded into LTSS*Maryland* as an attachment to the PCP.~~

  - ~~The form should be saved and uploaded in this standardized format:~~

    - ~~PROVIDERNAME.DSAT.Person's FIRSTLASTName.DATE (e.g., ABCAgency.DSAT.JonSmith.7-1-2020).~~

    - ~~The DSAT should be uploaded in the LTSS*Maryland* PCP documentation section.~~

- Person-Centered Plan ~~PCP~~ **- Service Referral (Provider Managed ~~Traditional~~ Service Delivery Model Only)**

  - After a DDA-funded service is identified to meet an unmet need and assist the person in meeting their goal(s), the Coordinator of Community Services ~~CCS~~ works with the person to select a provider for each service.

  - ~~Upon receipt of the DSAT and Cost Detail Tool as required from applicable providers,~~ The Coordinator of Community Services ~~CCS~~ will indicate the specific provider and site locations (if applicable) in the Person-Centered Plan ~~PCP~~ detailed service authorization section.

  - LTSS*Maryland* will send a service referral to the provider:

    - The provider reviews service referrals in the Provider Portal and decides to accept or reject the request.

    - The provider must take action to accept or reject the referral within **five**

business days. If no action is taken the referral expires and will need to be resent based on the person's choice.

- The Coordinator of Community Services ~~CCS~~ should also follow up with the provider to determine if there are technical issues preventing acceptance or if the provider is no longer interested in providing the service.
- If the provider is not responding, the Coordinator of Community Services ~~CCS~~ may contact the regional office provider services staff for further assistance.
- If the provider is choosing not to accept the referral, the Person-Centered Plan ~~PCP~~ team should work with the person, and as applicable, the designated representative to explore new providers or services to meet assessed needs.
- If either the provider or site that the person prefers is not available because the provider has not completed enrollment in ePrep or due to a system issue, the Coordinator of Community Services ~~CCS~~ shall email the appropriate regional office provider services director.

~~○ **Cost Detail Tool (CDT)**~~

~~○ The Cost Detail Tool is used to calculate the cost of services and map LTSS*Maryland* PCP requested services to DDA's historical services for authorization into PCIS2 for services that have not transitioned to the LTSS*Maryland* fee-for-service billing.~~

~~○ It is important to understand that the cost detail tool is needed for all PCPs (i.e., Initial, Revised, and Annual PCPs) that list a provider who has not transitioned to LTSS*Maryland* fee-for-services billing to ensure continued PCIS2 service authorization for applicable services. This tool is particularly important when there are changes made to authorized services billed in PCIS2.~~

~~○ For persons with selected providers, the provider completes the Cost Detail Tool and submits it to the CCS or uploads to the provider portal for the CCS to obtain.~~

~~▪ The DDA has developed several resources to assist with service mapping between the two systems including:~~

~~● At a Glance - Meaningful Day Services~~

~~● At a Glance - Support Services~~

- ~~At a Glance - Residential Services~~
- ~~At a Glance - Personal Supports Services~~

- ~~For persons that are (a) currently receiving employment-related services from a Meaningful Day provider; AND (b) seeking Employment Services, the Meaningful Day service noted on the approved Cost Detail Tool will be authorized in PCIS2 including Add-ons. Please refer to the DDA Meaningful Day Services Relationship Between LTSS*Maryland* and PCIS2 Services At a Glance for service mapping options.~~

- ~~After the CCS reviews and confirms with the person that the Cost Detail Tool meets their needs and preferences, they upload it in the PCP documentation section so that it is included with the PCP for submission to the regional office.~~
  - ~~The form should be saved and uploaded in this standardized format:~~
  - ~~PROVIDERNAME.CostTool.Person'sFIRST LASTNAME.DATE (e.g., ABCAgency.CostTool.JonSmith.7-1-2020).~~
  - ~~The Cost Detail Tool shall be uploaded in the LTSS*Maryland* PCP documentation section.~~

- **Self-Directed Service Delivery Model Budget Determination and Approval**
  - For Persons using the self-directed delivery model, annual budget allocations are based on the approved Person-Centered Plan ~~PCP~~ detailed service authorization.
    - The Person-Centered Plan ~~PCP~~ detailed service authorization includes the current DDA rate for services, including any cost-of-living increase which are built into each service rate.
    - The approved Person-Centered Plan ~~PCP~~ establishes the self-directed budget allocation which is based on the approved services and detailed services authorization total cost.
    - DDA regional offices self-direction lead staff or designee review and authorize all Person-Centered Plan ~~PCP~~ for persons using the self-directed service delivery model as per guidance.
  - **Self-Directed Budget Submission**
    - The Self-Directed Budget Sheet must be submitted to the Person's chosen ~~FMCS agency~~ Financial Management and Counseling Services provider by

the person and their team.

- The person, with the support of their Coordinator of Community Services ~~CCS~~ and team, creates the Self-Directed Budget Sheet based on their Person-Centered Plan ~~PCP~~ detail service authorization request and anticipated budget allocation from the service cost total.
- The Self-Directed Budget Sheet must mirror the services and units included in the Person-Centered Plan ~~PCP~~ detail service authorization request and the total cost shall not exceed the anticipated budget.
- Persons set wages in the Self-Directed Budget Sheet based on reasonable and customary standards.
- The Coordinator of Community Services ~~CCS~~ uploads the Self-Directed Budget Sheet into the Client Attachments section.
- Upon receipt of Person-Centered Plan ~~PCP~~ and Self-Directed Budget Sheet, the Financial Management and Counseling Services provider ~~FMCS~~ will review the Self-Directed Budget Sheet to ensure it meets program standards.
- Questions regarding the Self-Directed Budget Sheet shall be sent to the Person's ~~FMCS~~ Financial Management and Counseling Services provider. ~~agency.~~
- The annual and actual columns of the Self-Directed Services ~~SDS~~ budget sheet will have similar total budget amounts and does not require any further proration.
- **Self-Directed Service Delivery Model Budget Approval Criteria and Process:**
    - The self-directed budget sheet must include the DDA services authorized in the Person-Centered Plan ~~PCP~~ based on the assessed need.
    - Persons can determine staffing and pay rates based on reasonable and customary rate standards.
    - The self-directed budget sheet for all Person-Centered Plan ~~PCP~~ plan types (*i.e.,* Initial, Revised, and Annual) can contain allocation of funding for Individual and Family Directed

Goods and Services (based on cost savings) and for Staff Recruitment and Advertising.

- The Financial Management and Counseling Services provider ~~FMCS~~ staff will confirm that the service included in the self-directed budget matches the assessed services needed in the approved Person-Centered Plan ~~PCP~~.
- Self-Directed services start date is based on:
    - The DDA program enrollment date.
    - Person-Centered Plan ~~PCP~~ effective date.
    - Staff meeting required qualifications (e.g., background check, Cardiopulmonary Resuscitation ~~CPR~~, First Aid Training, etc.).
    - Completion of required Financial Management and Counseling Services paperwork/requirements such as establishing the person's Employer Identification Number and other tax paperwork.

- Person-Centered Plan ~~PCP~~ **- Documentation Section**
    - The Person-Centered Plan ~~PCP~~ includes a section for Person-Centered Plan ~~PCP~~-related documents that can be uploaded into the system.
    - Providers can now upload relevant Person-Centered Plan ~~PCP~~ documents, that they are responsible for, in the provider portal. Coordinator of Community Services ~~CCS~~ can then obtain these documents and ensure they are in the Person-Centered Plan ~~PCP~~ documentation section.
    - Based on the service delivery model chosen by the person (i.e., self-directed, provider managed ~~traditional~~ services delivery models), the documents uploaded may vary.
    - For persons using the self-directed service delivery model, documentation includes self-direction-related forms such as the Self-Directed Budget Sheet, Participant Agreement Form, Family as Staff Form, the Rights and Responsibility Forms, and other documents as applicable.
    - For all persons using the provider managed ~~traditional~~ service delivery model, the documentation section can include DSATs~~, Cost Detail Tools,~~ and the Rights and Responsibility Forms, and other documents as

applicable.

Note: Documents uploaded in the Person-Centered Plan ~~*PCP*~~ *documentation section should be relevant to the* Person-Centered Plan ~~*PCP*~~*. Documents associated with incident reports; provider house policies, pet policies, etc.;* Coordinator of Community Services ~~*CCS*~~ *notes, etc. may be uploaded in the Client Attachments.*

- **Service Considerations and Flexibility**
  - The DDA embraces the LifeCourse framework for service planning and believes that the integrated star model, mentioned above, is a critical tool available to people and their teams as they discuss needed services and flexibility within those services.
  - As teams are discussing a person's needs during the Person-Centered Planning ~~PCP planning~~ and development process, it is important for teams to discuss the following Life Domains related to potential Person-Centered Plan ~~PCP~~ service authorization flexibilities:

Charting the LifeCourse Life Domain Symbol	Charting the LifeCourse Life Domain Title	Person-Centered Plan ~~PCP~~ Flexibility Considerations
	**Daily Life and Employment**	• **Does the person have or want a job?** • **If the person is working, are there opportunities for them to pick up extra shifts or engage with colleagues during weekends at work events?** • **Is the person interested in college or community classes that may be time specific or season specific?** • **What resources exist through the school to support lifelong learning endeavors?** • **When thinking about the person's day-to-day activities and engagement opportunities is there a reasonable presumption of current and anticipated need that the team can plan for, month to month?**
	**Community Living**	• **What opportunities now and in the future exist for the person to develop resources in their community?** • **Does the person love to engage in a seasonal activity that requires additional support?** • **Does the person have independence goals in the community that may initially take additional support needs to ensure health/safety?**

		• **What are the person's housing goals?** • **What support can best help the person access their housing needs?**
	**Healthy Living**	• **Many of us must plan around seasonal allergies or a winter cold. Thinking about that, what additional supports may need to be built in that are seasonal in nature but ensure the person has what they need when cold and flu season hit?** • **Some of us also have annual well checkups that may require additional supports before and after the procedure.**
	**Safety and Security**	• **What are some opportunities over the next year for the person to access technology to further support communication needs at home, in the community or at work?** • **Are there any gaps in health and safety support needs? What could help fill those gaps and mitigate risk?**
	**Social and Spirituality**	• **What opportunities may exist in the next year for the person to meet new friends or strengthen already existing relationships?** • **Does the person have aging family caregivers who may need additional support?** • **What natural relationships exist in the person's life? Do they have a friend who may accompany them to church?**
	**Advocacy and Engagement**	• **What needs or opportunities exist around supporting a person to develop or increase their skills and independence regarding their finances? This may require additional support or increased community engagement, particularly around managing finances, making purchases, or monitoring bank accounts.**

- For persons seeking Employment Services including Discovery, Follow Along, Job Development, On-going Job Supports or Self-Employment Development Supports:

  - ~~The effective LTSS*Maryland* service billing date can be no earlier than July 1, 2021, unless the person's service transitions fully in LTSS*Maryland*.~~

  - As the team is considering employment support needs, it's important to remember that

Maryland is an Employment 1st State, meaning we presume that all people who want to work, can work.

- The DDA's goal is to ensure work can be a reality for everyone and that it's critical to ensure flexibility when stacking and braiding employment and meaningful day services for a person so they can maximize their opportunities. For example:
  - A person may want to work and while they are going through the assessment process may be receiving a variety of meaningful day services such as Discovery, Job Development, Community Development Services, etc.
  - For some people this may include additional projected On-going Job Supports to support potential increased work hours during holidays, expansion of work hours, etc. and when new job responsibilities arise.
  - It is important to remember that when planning for employment service needs the team should consider the person's individual path to employment and ensure services are authorized that allow the person to immediately access those services as needed.
  - Bottom line, the **DDA would expect to see potentially multiple meaningful day and employment services authorized in a** Person-Centered Plan ~~**PCP**~~ **to help a person meet their individual employment needs**.

- ~~For persons seeking Co-Worker Supports, the effective LTSSMaryland service billing date can be no earlier than July 1, 2021 unless the person's service transitions fully in LTSSMaryland.~~

- For the Provider Managed ~~Traditional~~ Services delivery model:
  - Participants who have newly added an employment goal, including participants new to service, the DDA may authorize Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports even if the participant is not currently employed.
  - Participants who have been authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports for one (1) previous plan year without securing employment during the previous plan year, the DDA may authorize these services for one (1) additional plan year even if the participant is not currently employed.
  - Participants who have been authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports for two (2) consecutive plan years without securing employment for (2) two consecutive plan years, the DDA may not authorize these services for any subsequent plan year unless the participant secures employment.

- For participants who are not currently authorized for Employment Services - Follow-Along Supports and/or Employment Services - Ongoing Job Supports, if a participant subsequently secures employment during the course of their plan year, and this employment is assessed to require these services, the DDA will approve a Revised Person-Centered Plan for these services within five (5) business days, in order to prevent disruption in the participant's employment prospects. The Revised Person-Centered Plan should note that employment was secured and marked as an "urgent" plan.

- To support week-to-week flexibility **under the provider managed ~~traditional~~ service delivery model** in the person's employment, schedule, and services needs for Meaningful Day Services, Meaningful Day services can be requested, and authorized by the DDA, up to the weekly limit set forth in the DDA Medicaid Waiver program application, subject to the following limitations:

  - Although the DDA may authorize up to the weekly limit for each Meaningful Day Service requested it is important to note:

    - Teams should review and discuss service needs including taking into consideration the hours a person is working (i.e., daytime, nighttime, and weekend hours). This does not necessarily mean the team will automatically request the maximum service units for each Meaningful Day service, rather the necessary units to ensure access and flexibility throughout the plan year. This will look different for each individual person.

    - The authorization of more than 40 hours in the Person-Centered Plan ~~PCP~~ is to support meaningful day flexibility for the person and their daily schedules. Persons cannot receive and the provider will not be paid for more than the limit for Meaningful Day services set forth in the DDA Medicaid Waiver program application.

  - Neither a service provider nor a person through a Financial Management and Counseling Services agency may submit a claim for payment to DDA for Meaningful Day Services provided in excess of the weekly limit. Such a claim for payment will be denied.

  - For example, a person may be authorized to receive Community Development Services, Employment Services, and other Meaningful Day Services. For maximum flexibility, the DDA can approve up to 40 hours per week of a combination of each of these services. However, in combination, the person may not use, and the provider may not bill for, more than a total of 40 hours of Meaningful Day services within a week.

    - Week One: The person may receive 10 hours of Community Development

Services and 30 hours of Employment Services.

- Week Two: The person may receive 20 hours of Community Development Services and 20 hours of Employment Services.

- The person may not receive 40 hours of Community Development Services and 40 hours of Employment Services in a single week.

This flexibility is provided under the provider managed ~~traditional~~ services delivery model only.

- Persons using the self-directed service delivery model have the flexibility to make adjustments within their budget. Over-authorization of services will inflate the budget.

- ~~For persons seeking Community Living - Enhanced Supports is available when the person's service transitions fully in LTSS*Maryland*. Until the transition, persons in need of residential services should request Community Living - Group Home services which will be authorized as Residential in PCIS2.~~

- Milestone units are indicated with a checkmark in the detail service authorization section. To support flexibility in the receipt of these services, each month can be checked as shown below:

Service Status & Effective Date	Service and Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

- Residential Shared Hours

  - The DDA's LTSS*Maryland* Rates for residential services (including Community Living-Group Home, Community Living - Enhanced Supports, and Supported Living) shared staffing hours include an allocation for base staffing hours per home size. The goal of these shared staffing hours is to promote full lives in the community and support individualized schedules. The DDA recognizes that people who live together may spend many hours together but also still have separate interests and activities.

  - ~~Beginning April 1, 2022,~~ Residential shared staffing hours include an allocation for base staffing hours plus an allocation of flexible hours per person to support and promote individualized support. These allocations together make up the total shared hours and build the residential rates to support the home through flexible staffing. It is expected that providers develop staffing patterns reflective of the needs, interests and schedules of their residents use natural

and community supports, and maximize the base and flexible hours available ahead of requesting dedicated support.

- For example, if three (3) participants reside in a single residential setting, 199.5 total shared hours are available, assuming 18 hours per day of support Monday through Friday, 24 hours per day coverage on the weekends, and 61.5 shared flexible hours to promote full lives in the community and support individualized schedules.

  - In addition to the use of shared hours, teams can request dedicated supports per person due to support:
    - Behavioral, medical, or community integration goals that require dedicated 1:1 or 2:1 staffing.
    - Residential Dedicated Supports During Meaningful Day Hours ~~up to 30 hours per week~~, Monday through Friday based on the person's assessed need as per current policy.

- A person may receive a combination of shared and dedicated hours based on their assessed needs. For example, a person may require 1:1 dedicated support during eating, and natural and community supports and/or shared support hours during other times. When making that determination for 1:1 dedicated support the team should consider natural and community supports, the base hours being utilized and the flexible hours available based on the person's needs and preferences. Flex hours may be utilized or accounted for each week due to a person's goals or outcomes. Dedicated support may be needed to ensure health and safety or further engage in their community, develop relationships, or increase independence.

- Dedicated 1:1 and 2:1 support needs to be clearly identified in the Person-Centered Plan ~~PCP~~ such as in the Risks section, applicable FAE, supporting documentation, and ~~or~~ referenced in the BSP and NCP as applicable. The Person-Centered Plan ~~PCP~~ should also reflect that natural and community supports and the base and flexible hours within a residential setting are being utilized as it relates to other goals/outcomes in the Person-Centered Plan ~~PCP~~.

  i. Support documentation demonstrating assessed needs may include formal health, developmental, communication, and behavioral assessments completed by qualified professionals such as physicians, mental health professionals,

behavioral specialists, special educators, and other licensed health professionals (e.g., Speech-Language Pathologists, Occupational Therapists, Physical Therapists), and the Health Risk Screening Tool, as appropriate.

1. Please note that a general statement or prescription indicating the need for overnight supports, "1:1" or "2:1" staffing is not sufficient to justify the requested level of support.

2. Supporting documentation must clearly describe the specific assessed needs of the individual, the functional tasks and supports to be provided, the circumstances under which additional staffing is required, and the level of training or expertise staff must possess to safely and effectively deliver the support.

- When looking at 1:1 or 2:1 supports in a residential setting, teams need to consider the following:

  - How many hours per day is each person receiving natural and community supports, and meaningful day support? If a person is engaged in meaningful day supports, then shared hours in the home are presumably not being utilized during that time allowing them to be utilized at another time.

  - Do other people in the home have 1:1 or 2:1 support for behavior or medical needs? If so, the shared hours can be redistributed among those in the home that do not have that level of support. These 1:1 and 2:1 dedicated support for medical and behavioral needs should be clearly identified in the person's Person-Centered Plan ~~PCP~~.

  - Do any people in the home engage in specific activities outside the home that their housemates do not also attend or that they prefer to do alone? For example, one person in the house could be a member of a sign language club that meets twice weekly for a total of six hours. If so, this may be a circumstance where the home's shared hours are accounted for among other people and the person needs 1:1 community integration dedicated support five hours per week to participate in a sign language club. Again, these 1:1 community integration dedicated support must ~~should~~ be clearly described in the Person-Centered Plan ~~PCP~~ including documentation and discussion of the person's support needs and ~~documenting~~ how these supports are being utilized to support relationship development and independence in the community. The Relevant areas in the Person-Centered Plan ~~PCP~~ to include this information would include the Focus Area Exploration (FAE) Sections: Community Involvement Focus Area, Day-to-Day Life Summary, Relationship Summary, it would also be included throughout the "Outcomes" section, as well as the "Important to" and "Important For" sections.

- Do some people in the home have alone time in the house or community? If so, have those shared hours that may have been utilized for that person been redistributed among other housemates who need support and do not have alone time?

- Residential providers should be able to identify and communicate with the Person-Centered Plan ~~PCP~~ team strategies for creating natural and community supports and connections. The team should also discuss how technology can meet this person's needs.
- In addition, residential providers must consider the number of hours available in the home, including overnight supports, and how shared hours in their homes are being utilized to support group and individual support needs on a day-to-day basis. If there is a need for exclusive support, shared hours need to be taken into consideration and accounted for as exclusive 1:1 or 2:1 supports are authorized in the Person-Centered Plan ~~PCP~~. Persons with an assessed need for additional supports can request Dedicated Hours in addition to the main residential service (i.e., Community Living-Group Home, Community Living - Enhanced Supports, and Supported Living). If approved, the person will have both the main service and the dedicated service listed in the Person-Centered Plan ~~PCP~~ detail service authorization section.

- The DDA Provider must assess the need for dedicated hours based on:
  - Person's assessed need (i.e., medical, behavioral, community);
  - Number of people in the home supported by shared hours;
  - Overnight supports;
  - A person's natural and community supports and connections; and
  - Previous service utilization of shared hours and dedicated hours.
- Dedicated hours for CL-GH and SL and residential add-on hours are different.

  - Dedicated hours are used in LTSS*Maryland* when a person needs more staffing support than what is included in the shared service hours and is based on the assessed need for habilitation and community integration.

    - Rates for Community Living-Group Home, Community Living - Enhanced Supports, and Supported Living services include shared hours based on the size of the home.

    - The option for shared overnight hours is captured in the residential configuration and included in the LTSS*Maryland* rates as shown in the chart below:

Service	Service
Supported Living: 1 w/ Overnight Supervision	**Community Living/Group Home: 1 w/ Overnight Supervision**

Supported Living: 2 w/ Overnight Supervision	**Community Living/Group Home: 2 w/ Overnight Supervision**
Supported Living: 3 w/ Overnight Supervision	**Community Living/Group Home: 3 w/ Overnight Supervision**
Supported Living: 4 w/ Overnight Supervision	**Community Living/Group Home: 4 w/ Overnight Supervision**
Supported Living: 1 w/o Overnight Supervision	**Community Living/Group Home: 1 w/o Overnight Supervision**
Supported Living: 2 w/o Overnight Supervision	**Community Living/Group Home: 2 w/o Overnight Supervision**
Supported Living: 3 w/o Overnight Supervision	**Community Living/Group Home: 3 w/o Overnight Supervision**
Supported Living: 4 w/o Overnight Supervision	**Community Living/Group Home: 4 w/o Overnight Supervision**

- The residential configuration for Supported Living (SL) is completed by the regional office provider services (PS) team based on information provided to PS by the provider (home address, capacity, overnight support on or off).

- To ensure that the correct Supported Living, Day, and Community Living - Group Home address is selected in the detailed service authorization by the ~~CCS~~, the "Notes" section of the DSAT should indicate the address and configuration information.

- A provider must also detail the use of natural and community supports, shared hours and use of dedicated supports in their Service Implementation Plan.

- A person may attend Meaningful Day services and other community programs for some days/hours per week, and receive Residential Dedicated Supports during other days/ hours. Meaningful Day Services and Residential Dedicated Supports cannot be provided at the same time.

▪ <u>Displayed Rates for Community Living and Supported Living Residential Services</u>

- On August 8th, 2022, DDA deployed an enhancement to the Residential Configuration billing process. The new functionality enables DDA providers to use the Provider Portal to indicate the number of persons residing in a provider home to drive the billing rate.

- As a Coordinator of Community Services ~~CCS~~ creates or revises PCPs in LTSS*Maryland* for a person who needs residential services, the LTSS*Maryland* Person-Centered Plan ~~PCP~~ detailed service acceptance section will calculate, and display rates based on the

number of people authorized for services in the home.

- Overnight Supports function as either “On” or “Off” for any given home in the system. Please contact your regional office if Overnight Supports need to be adjusted for the home based on your agency’s business model.

- ~~Residential add-ons can be authorized in PCIS2 when a person needs more staffing support than what is included in the rate for the person’s matrix score.~~

- ~~Rates for Residential services and Supported Living in PCIS2 include supervision levels based on the person’s matrix score.~~

  - ~~The number of supervision hours that are built into the matrix score must be taken into account when determining the number of residential add-on supports that are needed.~~

  - ~~The Cost Detail Tool is used to calculate the cost of services and map LTSS*Maryland* PCP requested services (with the exception of Personal Supports and Supported Living) to DDA’s legacy services for authorization into the legacy PCIS2.~~
  - ~~If PCIS2 rates apply, then any service authorization by the provider or the DDA in LTSS*Maryland* will not have any final legal effect, unless the provider and person are **participating in the fee-for-service payment methodology.**~~

- ~~For services that are being billed in PCIS2, the DDA will review dedicated hours in LTSS*Maryland* and ensure that the appropriate level is authorized in PCIS2.~~

- Meaningful Day Services: 1:1 and 2:1 Staffing

  - If the person’s needs cannot be met by the Day Habilitation Small or Large Group services or Community Development Services (1- 4 person groups) then a request can be made for Community Development Services 1:1 / 2:1 staffing ratio or Day Habilitation 1:1 / 2:1 staffing ratio.

    - ~~o~~ The person-centered planning process should include a discussion of the person’s support needs, level of supports, natural and community supports and connections, and hours needed. ~~Please note the need for 1:1 or 2:1 does not always need to be specifically medically or behaviorally based; it may be related to ensuring the person can achieve their goals.~~

- Based on these considerations, a request for 1:1 / 2:1 staffing ratio hours that the person will need can be made.
- The detail service authorization can reflect both (1) the group services (i.e., Day Habilitation Small, Large Group, or Community Development Services (1- 4 person groups); and (2) Community Development Services 1:1 / 2:1 or Day Habilitation 1:1/ 2:1 staffing ratios.
- LTSS*Maryland* functionality was enhanced to support billing of various Day Habilitation and Community Development Services support models (e.g., small group, 1:2, etc.) during the same day.
- Career Exploration 1:1 / 2:1 Staffing Ratio funding is not available.

- ~~Some Meaningful Day 1:1 and 2:1 staffing hours service authorization can be directly mapped between LTSS*Maryland* 1:1 and 2:1 staffing ratio to PCIS2 1:1 and 2:1 add-on hours. However, there are a few differences for some services and how the rates are constructed.~~
  - Services authorized in LTSS*Maryland* detail service authorization section include rates for:
    - Community Development Services 1:1 Staffing Ratio.
    - Community Development Services 2:1 Staffing Ratio.
    - Day Habilitation 1:1 Staffing Ratio.
    - Day Habilitation 2:1 Staffing Ratio.
- A provider must also detail the use of natural and community supports, shared hours and use of dedicated supports in their Service Implementation Plan

- Dedicated 1:1 and 2:1 support needs to be clearly identified in the Person-Centered Plan ~~PCP~~ such as in the Risks section, applicable FAE, supporting documentation, and ~~or~~ referenced in the BSP and NCP as applicable. The Person-Centered Plan ~~PCP~~ should also reflect that natural and community supports and the base and flexible hours within a residential setting are being utilized as it relates to other goals/outcomes in the Person-Centered Plan ~~PCP~~.
  - Support documentation demonstrating assessed needs may include formal health, developmental, communication, and behavioral assessments completed by qualified professionals such as physicians, mental health professionals, behavioral specialists, special educators, and other licensed health professionals (e.g., Speech-Language Pathologists, Occupational Therapists,

Physical Therapists), and the Health Risk Screening Tool, as appropriate.

- Please note that a general statement or prescription indicating the need for overnight supports, "1:1" or "2:1" staffing is not sufficient to justify the requested level of support.
- Supporting documentation must clearly describe the specific assessed needs of the individual, the functional tasks and supports to be provided, the circumstances under which additional staffing is required, and the level of training or expertise staff must possess to safely and effectively deliver the support.

~~- Services authorized in PCIS2 include:~~

~~- 1:1 and 2:1 add-on hours can be included in the Cost Detail Tool and authorized in PCIS2 for Meaningful Day Services when a person needs more staffing support than what is included in the rate for the person's matrix.~~

~~- Add-ons can be associated with Supported Employment, Employment Discovery & Customization, Career Exploration, Community Development Services, and Day Habilitation.~~

~~- Rates based upon the person's matrix scores.~~

~~- In PCIS2, 1:1 and 2:1 add-on hours are incorporated into Meaningful Day Service main service and billed as one rate.~~

~~- Meaningful Day Services: Transportation Add On~~

~~- Providers in need of the Meaningful Day Transportation Add On shall include it in their Cost Detail Tool. It does not need to be noted in the LTSS*Maryland* PCP detailed service authorization.~~

~~- Once the Cost Detail Tool is approved, the Transportation Add On will be authorized in PCIS2.~~

~~- Once the Meaningful Day Service is transitioned to LTSS*Maryland*, the Meaningful Day Transportation Add On will be ended as the rate includes a transportation cost component within it.~~

- DDA Medical Day Care waiver services
  - DDA Waiver Medical Day Care waiver service was added to the Person-Centered Plan ~~PCP~~ service authorization section on February 9, 2024.

- The Coordinator of Community Services ~~CCS~~ shall note Medical Day Care waiver services in the service authorization section of the Person-Centered Plan ~~PCP~~.
    - The Person-Centered Plan ~~PCP~~ must include the hours and days the participant will receive MDC waiver services per the primary care physician's orders.
    - The Coordinator of Community Services ~~CCS~~ will use the search functionality to select the applicable MDC provider.
    - The Coordinator of Community Services ~~CCS~~ will upload the MDC signature page.
- Once the person has an MDC service provider assigned, the MDC provider will now be seen in the current assignments section of the Client Summary.

○ Supported Living services under the self-directed services delivery model.

- Participants self-directing their services have budget authority for Supported Living services.
- Supported Living services rates are based on the number of participants in the home.
- To ensure the correct funding is allocated, the Supported Living provider must be identified and a LTSS*Maryland* service referral must be sent by the Coordinator of Community Services to the provider.
- The Supported Living provider must accept the service referral.
- The Supported Living provider will bill the participant directly for approval of the invoice for services. The participant's Financial Management and Counseling Services provider will pay the Supported Living provider.
- In situations where a Supported Living provider has not been identified, a Revised Person-Centered Plan may be submitted once the provider is identified and noted as an urgent request (as applicable).

○ Personal Supports - ~~Awake~~ Overnight Supports

- When awake overnight personal support is necessary to meet the person's assessed behavioral or medical risk, which is documented in the person's Person-Centered Plan ~~PCP~~, supporting documentation, and approved Nursing Care Plan and/or Behavior Support Plan ~~unless otherwise approved by the DDA~~, services may be authorized.
- Support documentation demonstrating assessed needs may include formal health, developmental, communication, and behavioral assessments completed by qualified

professionals such as physicians, mental health professionals, behavioral specialists, special educators, and other licensed health professionals (e.g., Speech-Language Pathologists, Occupational Therapists, Physical Therapists), and the Health Risk Screening Tool, as appropriate.

- Please note that a general statement or prescription indicating the need for overnight supports, "1:1" or "2:1" staffing is not sufficient to justify the requested level of support.
- Supporting documentation must clearly describe the specific assessed needs of the individual, the functional tasks and supports to be provided, the circumstances under which additional staffing is required, and the level of training or expertise staff must possess to safely and effectively deliver the support.

- The following information must be documented in the person's Person-Centered Plan ~~PCP~~:
  - Overnight support must be documented in the Person-Centered Plan ~~PCP~~ Risks section as one of the mitigation efforts in addressing applicable behavioral or medical risk.
  - The Person-Centered Plan ~~PCP~~ detail service authorization section should reflect the units for Personal Supports (meaning overnight) and a documented need for continuous overnight support is required.
  - Support for overnight staffing and associated information must be documented within the person's Person-Centered Plan ~~PCP~~, supporting documentation, and either the Nursing Care Plan or Behavior Support Plan, ~~unless otherwise approved by the DDA~~. Please refer to the updated Personal Supports Policy for additional requirements.
- Persons enrolled in a DDA-operated Waiver Program with DDA State Funded overnight personal supports Person-Centered Plans ~~PCPs~~ should be revised to move the services from Other (State Only Funded) to Personal Supports.

- DDA State-Funded Services
  - If a person was authorized DDA state-funded services, the specific services shall be noted in the DSA as follows:
    - Services that directly align with a waiver service should be indicated in the DSA with the Service Title that corresponds to the matching waiver service.
    - Service Title "Camp - Non-Respite (State-Only Funded)" shall be used when the camp is not on the approved list or an out-of-state camp due to unique

circumstances and authorized by the DDA.

- Service Title “Nursing - Skilled Nursing Services (State-Only Funded)” shall be used when “skilled” nursing services were authorized. Note: This service is only available to persons that were previously authorized by the DDA.
- Service Title “Rent - Individual Support (State-Only Funded)” shall be used when state-funded rent support was authorized by the DDA.
- Service Title “Other (State-Only Funded)” shall be used for all other items DDA authorized state-funded services. Note: This service is only available to persons that were previously authorized by the DDA.

▪ Additionally, the specific service must be noted in the Outcome Summary - Support For field and a short summary of the service should be noted in the Scope field.

▪ This process should be followed for all persons:

- That are Supports Only (i.e., not DD-eligible) state-funded.
- Who receive waiver services and authorized state-funded services.

▪ As per DDA’s policy on Use of State-Only Funds for DDA Services, the DDA shall continue to maximize funds for services by using state funds solely for Medicaid Waiver Services for which there is a federal fund match.

~~▪ LTSS*Maryland* system enhancements for April 2024 will include the option to note state-funded services for participants in the Family Supports and Community Supports Waiver. This new functionality is to support participants that are authorized funding under the Rent Subsidy program.~~

- **Assistive Technology**

  - Individuals and families are educated that assistive technology is available as a delivery option to receive their services.
  - Coordinator of Community Services ~~CCS~~ can share resources to provide education, (for example: AT Navigator, Maryland Technology Assistance Program (MTAP), Maryland Relay)
  - Assessment is needed for items that cost 2,500 or more, if less an assessment is not needed.
  - The plan should include the discussion of other resources sought and reason for the denial of funding.

- The request should include what need the device will meet and how it promotes independence, community inclusion, assisting with functionality, improving cognitive skills.
- Request includes cost of item training, and any maintenance needed for up keep
- If the request exceeds 2,500 the assessment and 3 quotes (if possible) should be submitted with the request. If item is only provided by a specific vendor that should be stated in the plan along with the resource link.
- Assistive Technology can be used in combination with other ~~a traditional~~ services.

~~○ DDA Bundled Services~~

- ~~In the past, some persons received state-funded services through programs such as Family and Individual Support Services (F/ISS), in which one or more services are "bundled" and provided to the person by a provider.~~
- ~~The bundled services may include services that align directly with waiver services as well as those that do not.~~
- ~~Services that align directly with waiver services shall be unbundled during the next Revised or Annual PCP process (whichever occurs first).~~
- ~~Services that directly align with a waiver service should be indicated in the DSA with the Service Title that corresponds to the matching waiver service.~~
- ~~Service Title "Camp - Non-Respite (State-Only Funded)" shall be used when the camp is not on the approved list or an out-of-state camp due to unique circumstances and authorized by the DDA.~~
- ~~Service Title "Nursing - Skilled Nursing Services (State-Only Funded)" shall be used when "skilled" nursing services were authorized.~~
- ~~Service Title "Rent - Individual Support (State-Only Funded)" shall be used when state-funded rent support was authorized.~~
- ~~Service Title "Other (State-Only Funded)" shall be used for all other items DDA authorized state-funded services.~~
- ~~Additionally, the specific service must be noted in the Outcome Summary - Support For field and a short summary of the service should be noted in the Scope field.~~
- ~~For Providers services that are unbundled, the provider shall coordinate with the DDA regional office to update their FISS contract.~~

Person-Centered Plan ~~PCP~~ Approval/Authorization

The Person-Centered Plan ~~**PCP**~~ **Approval process includes (1) the service referral acceptance from the provider; (2) the persons or their legally authorized representatives' approval; (3) the** Coordinator of Community Services ~~**CCS**~~ **approval; and the final approval by the DDA.**

- **Provider Approval - Service Referral Acceptance**
  - The Provider's acceptance of the Person-Centered Plan ~~PCP~~ service referral is their approval.
  - Under the provider managed model, DDA providers have 5 days to respond to a service referral.
  - When the provider accepts the service referral, the system will generate and save the "Provider Signature Page" in the Person-Centered Plan ~~PCP~~ "Signature" Section.
    - Medical Day Care Providers do not have the ability to accept services within the DSA at this time. If approved by the Medical Day Care Provider, the Coordinator of Community Services facilitates the provider's agreement on the "Provider Signature Page" and uploads in the Person-Centered Plan "Signature" Section.
- **Persons or their Legally Authorized Representatives Approval**
  - The Coordinator of Community Services ~~CCS~~ will review the draft Person-Centered Plan ~~PCP~~, providers' proposed service(s), scope, and frequency with the person and their legally authorized representatives (if applicable) to see if the Person-Centered Plan ~~PCP~~ clearly outlines their vision, goals, and supports (including natural, community, and state-funded supports).
  - The Coordinator of Community Services will review the attestation section with the person to ensure they understand their rights, including the right to choose team members and qualified providers (including their Coordinator of Community Services ~~CCS~~ provider agency ~~Agency~~). This review will also include information and guidance on available service delivery models (Self-Directed and Provider-Managed) and on how to identify and report potential abuse, neglect, and exploitation.
  - If approved by the person, the Coordinator of Community Services ~~CCS~~ facilitates the person's agreement on the "Person Signature Page" and uploads in the Person-Centered Plan ~~PCP~~

"Signature" Section.

- The Authorized Representative Person-Centered Plan ~~PCP~~ signature page is requested when a person has a legal guardian of the person.

  Note: The signature of the authorized representative for the Person-Centered Plan ~~*PCP*~~ *does not mean the person is also classified as a Designated Representative under the self-directed service delivery model. The Designated Representative is noted on the Self-Directed Services ~~SDS~~ Participant Agreement (see the Participant Agreement Option #2 that lists the person by name).*

- If approved by the legally authorized representative, the Coordinator of Community Services ~~CCS~~ facilitates the agreement on the "Authorized Representative Signature Page" and uploads it in the Person-Centered Plan ~~PCP~~ "Signature" Section.

- If not approved, the Coordinator of Community Services ~~CCS~~ facilitates further discussions with the team until agreement or changes to the plan are made, including selecting different services or providers.

- **Coordinators of Community Services Approval**

- The Coordinator of Community Services ~~CCS~~ indicates their agreement to the Person-Centered Plan ~~PCP~~ by completing the "Coordinators of Community Services ~~(CCS)~~ Signature Page" and uploading it in the Person-Centered Plan ~~PCP~~ "Signature" Section.

- Prior to approving the Person-Centered Plan ~~PCP~~, the Coordinator of Community Services ~~CCS~~ should complete a final review of the Person-Centered Plan ~~PCP~~ to ensure it meets all DDA requirements. The Person-Centered Plan ~~PCP~~ Review Checklist is a good tool that can be used for review of the Person-Centered Plan ~~PCP~~. Once finalized, they submit it via LTSS*Maryland* to the regional office.

  a. Annual plans must be submitted no later than 20 business days prior to the Person-Centered Plan ~~PCP~~ annual plan date.

  b. Initial and revised plans should be submitted within ten business days or less after the persons or their legally authorized representatives' approval.

  c. Clarification

    i. If clarification is needed, the Person-Centered Plan ~~PCP~~ will be sent back to the Coordinator of Community Services ~~CCS~~ via

LTSS*Maryland* clarification request functionality.

ii. **It is recommended that more than two requests for clarification during the plan review process would prompt a virtual conversation with applicable team members to determine the need and if applicable, support to ensure the** Person-Centered Plan ~~**PCP**~~ **is reflective of that need.**

iii. Clarification requests ~~Requests~~ may be made up to 3 times.

iv. The team must respond to the clarification within 5 business days.

- **DDA Plan Reviewer Authorization**
  - The DDA Plan Reviewer checks the Person-Centered Plan to ensure it meets the person's identified needs and follows requirements listed in Person-Centered Plan ~~PCP~~ Service Authorization Guide, policies, and the federally approved waiver.
  - Determinations will be made within 20 business days.
    - DDA will approve the plan if it meets requirements and notifies the person.
    - DDA will request more information if needed through clarification requests or phone calls to the Coordinator of Community Services ~~CCS~~.
      - The Regional Office will send up to 3 clarification requests during the 20-day review period.
    - DDA will deny the plan and notify the person if requirements are not met.
      - A new plan should be submitted - or the denied plan can be appealed.
    - The person may appeal the DDA's decision.

~~***Important Note:***~~

~~*For providers and persons who have not yet transitioned to* LTSS*Maryland fee-for-service billing, final authorization of services (and their approved scope, frequency, duration, and rates) by both the provider and the DDA will occur only in PCIS2. To crosswalk between* LTSS*Maryland and PCIS2, the provider (or CCS for persons enrolled in self-directed services) must review the requested services in the PCP in* LTSS*Maryland and then complete a Cost Detail Tool to apply the rates from PCIS2. If PCIS2 rates apply, then any services authorization by the provider or the DDA in* LTSS*Maryland will not have any final legal effect, unless the*

~~*provider and person are participating in the fee-for-service pilot program.*~~

Important Note: Monitoring and Follow-Up

- Monitoring and Follow-Up is a continuous process that begins before the initial Person-Centered Plan (PCP) is developed and continues throughout the delivery of services.
- This ongoing exploration and discovery create opportunities to access natural supports, community resources, and additional State and federal services. These resources must be incorporated into the individual's Person-Centered Plan ~~PCP~~ to support their goals and needs.

- Coordinators of Community Services are required to monitor and follow-up with a person at the service setting, including a person's home and in the community.
- These visits ensure that the person is safe and healthy, assess any changes in their needs, and confirm they are receiving services as outlined in their approved person-centered plan and that they are satisfied with them.

Resources

- LifeCourse Integrated Star
- LifeCourse Person Centered Planning Tools
- DDA Person-Centered Plan Overview
- DDA Self-Directed Services Overview
- Person-Centered Plan Coordinator of Community Services Guide
- Person-Centered Plan Summary and Outcomes
- Person-Centered Plan Focus Area Exploration
- DDA Person-Centered Plan Planning web page
    - DDA Person-Centered Plan Development and Authorization Guidelines
    - DDA Coordinator of Community Services Person-Centered Plan Checklist
    - DDA Provider Person-Centered Plan Checklist
    - Guidelines for Service Authorization and Provider Billing Documentation
    - DDA Person Rights and Responsibilities
    - MDHDDA_Flyer_KnowYourRights
- DDA Provider Role in the Person-Centered Planning Process

- DDA PCP Planning web page
- DDA Health Risk Screening Tool (HRST) web page
- DDA Supports Intensity Scale (SIS) web page
- Supporting Families Community of Practice
- Charting the LifeCourse - PCP Foundational Tool
- Employment Conversations
- Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning
- DDA Waivers web page
- Guidelines for Detailed Service Authorizations and Provider Billing Documentation
- ~~Link to the Self-Directed Services Budget sheet~~
- ~~Link to Support Broker Structured Interview Checklist~~
- Self-Directed Services Webpage
    - ~~Participant Agreement~~ Participant Agreement
    - ~~Family as Staff Form~~ Family as Staff Form
    - ~~Self-Directed Services Comprehensive Policy~~ Self-Directed Services Comprehensive Policy
    - ~~Self-Directed Services Manual, October 24, 2024~~
    - Self-Directed Services Manual, October 6, 2025
    - ~~Link to the Self-Directed Services SDS Budget sheet~~
    - Self-Directed Services Budget sheet
    - ~~Link to Support Broker Structured Interview Checklist~~
    - Support Broker Structured Interview Checklist
    - ~~Participant Agreement~~ Participant Agreement
- At a Glance - Detailed Service Authorization Tool (DSAT)
- University of Minnesota Manual for Person Centered Planning Facilitators
- Assistive Technology Navigator
- Maryland Assistive Technology Program
- Maryland Relay