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 PCP Development and Authorization Guidance on March 29, 2022)**

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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 PCPs** for both the self-directed and traditional service delivery models.

This manual is intended to be used by PCP teams including people eligible and receiving DDA services, their families, 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 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 PCP process always begins with and is about the person. The PCP format, approval, and authorization are documented within the LTSS*Maryland*-DDA Module information system. The DDA's PCP processes include (1) pre-planning, (2) plan development and (3) plan approval/authorization. **PCP services are authorized for a one-year period and must be updated annually.**

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 PCP. Under the traditional services delivery model, DDA-licensed and DDA-certified providers will complete the Detail Service Authorization Tool (DSAT) and submit to the 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 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 PCP detailed service authorization section determines the self-directed budget allocation.

Once the PCP has been completed, the 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

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

- "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.

- "Coordinator of Community Services" or "CCS" means an individual who provides coordination of community services either as an employee or contractor of a provider organization.

- "DDA Medicaid Waiver program" means each Medicaid Home- & Community-Based Waiver program submitted by the Maryland Department of Health and approved by the Centers for Medicare & Medicaid Services pursuant to § 1915(c) of the federal Social Security Act, which is overseen and administered by DDA: Community Pathways, Community Supports and Family Supports.

- "Dedicated Hours" mean 1:1 and 2:1 staff-to-person support hours based on the person's assessed needs.

- "Designated representative" means an individual who acts on behalf of the person in managing the person's services under the self-directed services delivery model in accordance with applicable requirements.

- "Detailed Service Authorization" means the LTSS*Maryland* PCP section that lists the DDA-funded services including the specific service name, service provider, units per month, annual service cost and provider status.

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

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

- "Financial Management and Counseling Services agency" or "FMCS agency" means a DDA agency selected by and contracted with the DDA to provide fiscal

management services to support each person enrolled in the Self-Directed Services delivery model.

- "Flexibility" means the ability for a person and their team to adjust quickly and easily respond to an identified need. Specifically, 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.

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

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

- "Initial PCP" means the first person-centered plan developed for a person once they are approved to apply for waiver services or is the new 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.

- "LTSS*Maryland*" means an electronic information system, developed, and supported by the Maryland Department of Health, used by DDA, the CCS, and DDA providers to create, review, and maintain records regarding an individual's eligibility status for DDA-funded services, the individual's person-centered plan, and services and funding authorized by the DDA.

- "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.

- "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.

- "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.

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

- "Participant Agreement" means the form used by persons self-directing their services to document the person's choice to either (1) be the primary person responsible for managing employer and budget authority responsibilities; (2) to appoint a designated representative to be responsible for all tasks; or (3) to appoint team members to assist with specific tasks related to roles and responsibilities under self-direction.

- "Person-Centered Plan" means a written plan that is developed by a collaborative planning process driven by the individual with a developmental disability to:
  - Identify the goals and preferences of the individual with a developmental disability.
  - Identify services to support the individual in pursuing the individual's personally defined outcomes in the most integrated community setting.
  - Direct the delivery of services that reflect the individual's personal preferences and choice.
  - Identify the individual's specific needs that must be addressed to ensure the individual's health and welfare.

- "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.

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

- "Relative" means a natural or adoptive parent, stepparent or sibling.

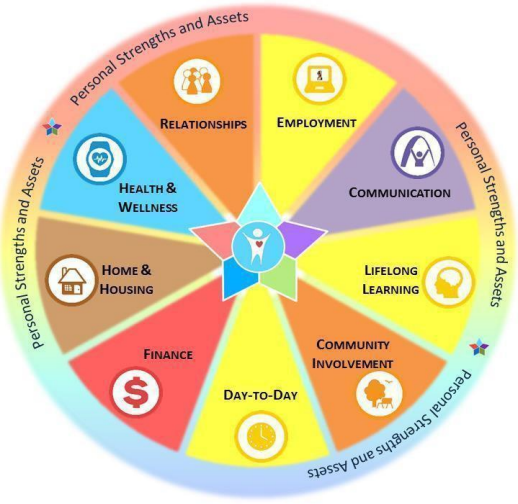
- "Revised PCP" means a plan developed when an active Initial or Annual PCP requires changes to services, outcomes, or other elements of the plan that reflect a change in the person's needs and wants. Reasons for a revision may include but are not limited to discontinuation, initiation or increase in a service, newly identified outcomes, etc.

- 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.

- "Team" means a collaborative effort to support a person receiving DDA services to develop

and implement their individual 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 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 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 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 PCP. Pre-planning occurs in collaboration with the person's 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 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 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 PCP as well as outcomes the person wants to accomplish initially and throughout the 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 **document all risks and mitigation efforts to support those risks in the Risks section of the PCP.**
    - 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 PCP expiration date. For HRST scores of 3 or higher, the nurse will need to complete a clinical review.
- An HRST is not required for authorization of an enhanced rate, 1:1 or 2:1 dedicated support or overnight support.
- The HRST should be completed early in the PCP pre-planning process to ensure timely submission with the 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 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 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. 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 CCS will also be alerted to the referral.

○ **Assess Needs**

- To support an integrated "community life" versus a "service life," the 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 PCP team should determine if any remaining unmet support needed can only be met with a 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.

Person-Centered Plan Development

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

- **The 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
        - Achieving a "good life."

- A request for **new or increased services** should be submitted via a **Revised PCP with all the necessary elements of the PCP completed**.
    - The CCS shall include information in the Revised PCP text box related to the purpose of the revision.
    - To help facilitate the review, 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 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 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 PCP along with their frequency, duration, and scope based on the effective date noted in the Revised 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 SDS PCPs:

- The person self-directing, with the support of their CCS and team, will utilize the established overall budget allocation that was produced in the Detailed Service Authorization (DSA) Section of the 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 PCP.
- After inputting all the needed services in the SDS Budget Sheet, the total annual budget amount in the SDS budget sheet should not exceed the total cost generated in the DSA section of the 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.
- **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 PCP.
    - Outcomes are specifically linked to the person's vision, values and fundamental rights.
    - Outcomes can be supported by or in a combination of generic, natural, community,

local and other resources 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 "Importance 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 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 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," PCP teams should identify and note:

  - How community resources and/or natural support are being used or developed.

  - How non-DDA funded and other contributing resources are being used to support the outcome.

- **PCP - Service Authorization Section**

  - Requested DDA-funded services are noted in the PCP's detailed 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.

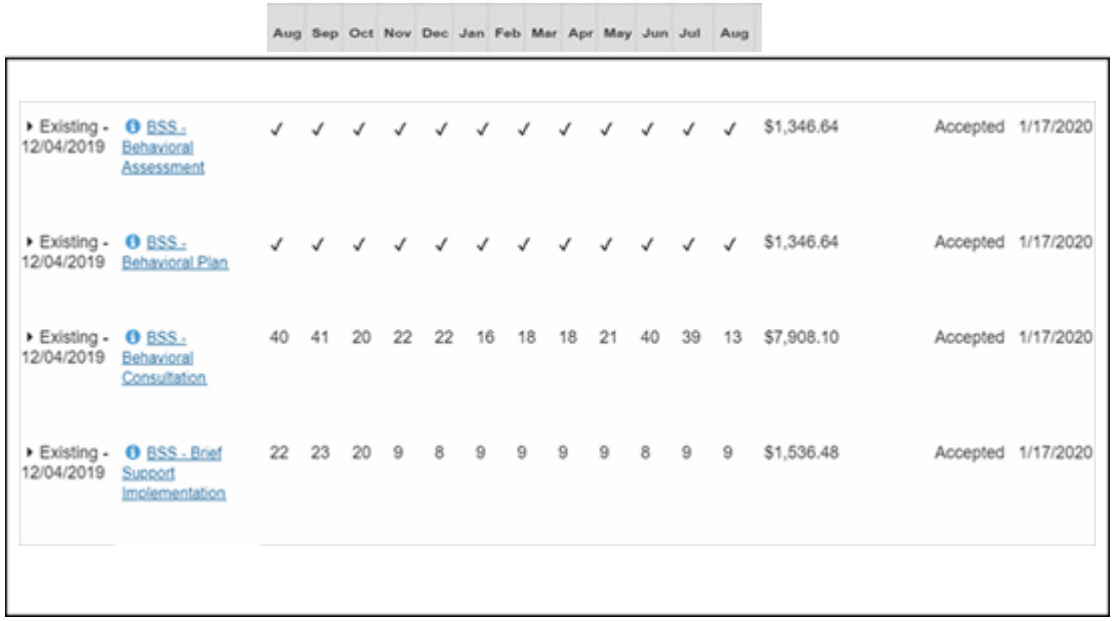
  - The person-centered planning process in LTSS*Maryland* requires month-by-month service planning. The CCS leads a conversation with the person and their PCP team to determine which services the person needs, the amount, and in which months services will be utilized.

  - **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. However, it can still be use 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, 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 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 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, 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.

<u>Detail Service Authorization Example:</u> Behavior Support Services (BSS) are being requested. The BSS-Behavioral Assessment and BSS-Behavior Support Plan milestone services are checked each

month to support the flexibility in service delivery and the provider's ability to bill in the actual month that the service was provided. Also, 15-minute unit BSS-Brief Support Implementation and BSS-Behavioral Consultation services have units of service across the entire plan year to support the person's needs and service flexibility.



		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
▸ Existing - 12/04/2019	BSS - Behavioral Assessment	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$1,346.64	Accepted	1/17/2020
▸ Existing - 12/04/2019	BSS - Behavioral Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$1,346.64	Accepted	1/17/2020
▸ Existing - 12/04/2019	BSS - Behavioral Consultation	40	41	20	22	22	16	18	18	21	40	39	13		$7,908.10	Accepted	1/17/2020
▸ Existing - 12/04/2019	BSS - Brief Support Implementation	22	23	20	9	8	9	9	9	9	8	9	9		$1,536.48	Accepted	1/17/2020

- **PCP - Service Referral (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 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 CCS will indicate the specific provider and site locations (if applicable) in the 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 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 CCS may contact the regional office provider services staff for further assistance.

    - If the provider is choosing not to accept the referral, the 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 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 PCP detailed service authorization.
        - The 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 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 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 by the person and their team.
  - The person, with the support of their CCS and team, creates the Self-Directed Budget Sheet based on their 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 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 CCS uploads the Self-Directed Budget Sheet into the Client Attachment section.
  - Upon receipt of PCP and Self-Directed Budget Sheet, the 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 agency.
  - The annual and actual columns of the 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 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 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 FMCS staff will confirm that the service included in the self-directed budget matches the assessed services needed in the approved PCP.
- Self-Directed services start date is based on:
    - The DDA program enrollment date.
    - PCP effective date.
    - Staff meeting required qualifications (e.g., background check, 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.

- **PCP - Documentation Section**
    - The PCP includes a section for PCP-related documents that can be uploaded into the system.
    - Providers can now upload relevant PCP documents, that they are responsible for, in the provider portal. CCS can then obtain these documents and ensure they are in the PCP documentation section.
    - Based on the service delivery model chosen by the person (i.e., self-directed, traditional services delivery model), 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, and the Rights and Responsibility Forms, and other documents as applicable.
    - For all persons using the 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 PCP documentation section should be relevant to the PCP. Documents associated with incident reports; provider house policies, pet policies, etc.; 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 PCP planning and development process, it is important for teams to discuss the following Life Domains related to potential PCP service authorization flexibilities:

Charting the LifeCourse Life Domain Symbol	Charting the LifeCourse Life Domain Title	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 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.
- To support week-to-week flexibility **under the traditional service delivery** 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 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 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 Behavioral Consultation services, it is important to consider potential monthly consultation units needed in addition to scheduled reviews, in the case of an emergency or off-cycle review.

- 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 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 shared support hours during other times. When making that determination for 1:1 dedicated support the team should consider 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 PCP such as in the Risks section, applicable FAE, or referenced in the BSP and NCP as applicable. The PCP should also reflect that the base and flexible hours within a residential setting are being utilized as it relates to other goals/outcomes in the PCP.

- 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 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 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 should be clearly described in the PCP documenting how these supports are being utilized to support relationship development and independence in the community. The Relevant areas in the 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 PCP team

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 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 PCP detail service authorization section.

- 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 SL address and configuration information.

- Displayed Rates for Community Living and Supported Living Residential Services

  - 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 CCS creates or revises PCPs in LTSS*Maryland* for a person who needs residential services, the LTSS*Maryland* 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.

Supervisory Level	Hours of Supervision
1	6.67
2	13.33
3	24
4	40
5	58

  - 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.

    - The person-centered planning process should include a discussion of the person's support needs, level of supports, 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.

- 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.

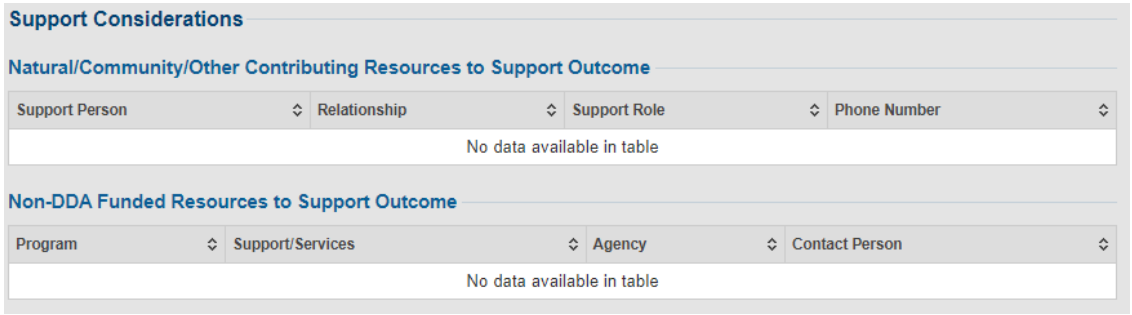
- Meaningful Day Services: Transportation Add On

- 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.

- Respite (Traditional Service Delivery Model only)
  - To support respite care services flexibility, hourly (15-minute units) and daily total hours combined can be requested and authorized by the DDA, above the 720 hours limit within each PCP.
    - This flexibility is provided under the 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.
  - However, similar to the meaningful day service flexibility, persons cannot receive, and providers will not be paid for more than the limit

for respite daily and hourly services combined.

- DDA Medical Day Care waiver services
  - DDA Waiver Medical Day Care services will be added to the PCP service authorization section in a future enhancement.
  - Until this functionality is implemented the following process should be used for authorized services:
    - Medical Day Care services shall be noted in the outcome under Support Consideration > Non-DDA Funded Resources to Support Outcome (see below).
    - 'Program' - should reflect Medical Day Care services.
    - 'Support/Service' - should specify the number of days per week the person is authorized to receive the service.
    - 'Agency' - should note the MDC provider authorized.



- 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 PCP and approved Nursing Care Plan and/or Behavior Support Plan unless otherwise approved by the DDA, services may be authorized.
- The following information must be documented in the person's PCP:
  - Overnight support must be documented in the PCP Risks section as one of the mitigation efforts in addressing applicable behavioral or medical risk.
  - The PCP detail service authorization section should reflect the units for Personal Supports (meaning overnight).
  - Support for overnight staffing and associated information must be documented within the person's

PCP 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 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.

    - 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.

PCP Approval/Authorization

The PCP Approval process includes (1) the service referral acceptance from the provider; (2) the persons or their legally authorized representatives' approval; (3) the CCS approval; and the final approval by the DDA.

- **Provider Approval - Service Referral Acceptance**
  - The Provider's acceptance of the PCP service referral is their approval.
  - When the provider accepts the service referral, the system will generate and save the "Provider Signature Page" in the PCP "Signature" Section.
- ***Persons or their Legally Authorized Representatives Approval***
- The CCS will review the draft PCP, providers' proposed service(s), scope, and frequency with the person and their legally authorized representatives (if applicable) to see if the PCP clearly outlines their vision, goals, and supports (including natural, community, and state-funded supports).
- If approved by the person, the CCS facilitates the person's agreement on the "Person Signature Page" and uploads in the PCP "Signature" Section.
- The Authorized Representative PCP signature page is requested when a person has a legal guardian of the person.

Note: The signature of the authorized representative for the 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 SDS Participant Agreement (see the Participant Agreement Option #2 that lists the person by name).

- If approved by the legally authorized representative, the CCS facilitates the agreement on the "Authorized Representative Signature Page" and uploads it in the PCP "Signature" Section.
- If not approved, the 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***

1. The CCS indicates their agreement to the PCP by completing the "Coordinators of Community Services (CCS) Signature Page" and uploading it in the PCP "Signature" Section.

2. Prior to approving the PCP, the CCS should complete a final review of the PCP to ensure it meets all DDA requirements. The PCP Review Checklist is a good tool that can be used for review of the 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 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 PCP will be sent back to 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 PCP is reflective of that need.

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.*

Resources

- LifeCourse Integrated Star link
- Maryland Long-Term Services and Supports Person-Centered Plan Overview
- PCP CCS Guide
- PCP Summary and Outcomes
- PCP Focus Area Exploration
- DDA PCP Planning web page
- DDA HRST web page
- DDA SIS web page
- Person-Centered Planning and Strategies Webinar
- Person-Centered Plan Authorization Webinar
- Supporting Families Community of Practice
- Charting the LifeCourse - PCP Foundational Tool
- Employment Conversations
- Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning
- Guidelines for Service Authorization and Provider Billing Documentation
- DDA Waivers web page
- DDA Waiver Programs Webinar
- DDA Person-Centered Plan Development and Authorization Guidelines
- DDA CCS PCP Checklist
- DDA Provider PCP Checklist
- Operating in PCIS2 and LTSS Guidance
- Guidelines for Detailed Service Authorizations and Provider Billing Documentation
- Link to Cost Detail Tool
- Link to the SDS Budget sheet

- Link to Support Broker Structured Interview Checklist
- Participant Agreement
- Family as Staff Form
- DDA Person Rights and Responsibilities
- MDHDDA_Flyer_KnowYourRights
- DDA Know Your Rights Final
- At a Glance - Detailed Service Authorization Tool (DSAT)
- University of Minnesota Manual for Person Centered Planning Facilitators