Maryland
DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES ADMINISTRATION

Frequently Asked Questions (FAQs)

The Developmental Disabilities Administration (DDA) receives questions regarding programs, services, processes, and new initiatives directly and during topic specific webinars. These Frequently Asked Questions (FAQs) are organized into the topic specific categories to help you find those questions and responses most relevant to you. To go directly to a specific section, you can click on the link in the Table of Contents.

This is a live document which will be updated as categories and questions are added and updated. Questions received that are similar in nature were consolidated to best summarize the answers and resources. Questions that are no longer relevant have been moved to an archived document.

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I. Appendix K

1. ***How long will the flexibilities that have been authorized in the DDA waivers because of COVID be extended beyond the public health emergency?***

    - Appendix K was approved by CMS which authorized a number of flexibilities during the COVID-19 pandemic. Several of these flexibilities were also included in the approved waiver amendment #3 and therefore will not terminate and remain available after the Federal Public Health Emergency. CMS approved other flexibilities with very specific timelines tied to either the Maryland State of Emergency or to the Federal Public Health Emergency. To support the transition to full reopening of services, some flexibilities tied to the Federal Public Health emergency are planned to end no later than 6/30/2023. Please review the Appendix K and Executive Orders Flexibilities

2. ***Should Residential COVID hours be entered into LTSS?***

    - No. Residential COVID hours should only be entered into LTSS*Maryland* if the Residential provider is an early adopter or a pilot provider. Providers authorized for Appendix K related Residential Day Time Shared Service Hours shall discontinue billing in PCIS2 and *LTSSMaryland* as of 9/30/2022. .

3. ***Is DDA planning to continue all features of Appendix K, including the family feature, in light of re-opening of agencies and cancellation of the public emergency?***

    - The Maryland Department of Health (MDH) and Maryland Department of Disabilities (MDOD) have engaged with the Developmental Disabilities Coalition and other stakeholders to review Appendix K flexibilities in support of unwinding and reopening. For additional information, please review the Appendix K and Executive Orders Flexibilities
    - In addition, Waiver Amendment #3 retained some of the Appendix K flexibilities and so these will continue to be available.

4. ***Is the current ability to provide Day Hab Supports in licensed residential sites an example of "alternative service sites" as referenced in the memo's attachment?***

    - No. Alternative sites are specific to the need to relocate participants due to the need for separating, self-isolation or quarantine.
    - The flexibility to deliver services in licensed residential sites or other non-facility based sites ended on 9/30/22 per the following flexibility: Employment, Supported Employment, CDS, Day Hab, BSS, Family and Peer Mentoring, Personal Supports, and Respite. Services can take place in a variety of settings, instead of the community, including but not limited to the participant's home; family and friend's homes; residential settings; or other community settings.

5. ***The memo from MDH released lists "alternative sites" as a flexibility being stopped as of August 15th, 2021. Does this refer to the use of an alternative residence if an individual is expected to be discharged after an extended illness and is now unable to manage in the residence they were previously approved for in PCIS2/LTSS? If the provider is able to prepare a different residence for them in line with their discharge, does the PCP need to be approved before they can be discharged?***

    - Yes. If a different residence is needed to best support an individual's discharge, please work with your regional office as an emergency PCP would accommodate this planning/placement.

6. ***Can you please clarify what select services and/or circumstances allow relatives or legally responsible individuals to be hired by providers after the end of the Appendix K flexibilities?***

    - A participant enrolled in the Self-Directed Services Delivery Model or Traditional Services Delivery Model may use a **legal guardian** (who is not a spouse), who is appropriately qualified, to provide Community Development Services, Nursing Support Services, and Personal Supports.
    - A participant enrolled in the Self-Directed Services Delivery Model or Traditional Services Delivery Model may use a **relative** (who is not a spouse), who is appropriately qualified, to provide Community Development Services, Personal Supports, Supported Employment, Transportation, Nursing Support Services, and Respite Care Services.
    - The legal guardian or relative (who is not a spouse) may provide these services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):

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- The proposed individual is the choice of the participant, which is supported by the team;
- Lack of qualified providers to meet the participant's needs;
- When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
- The legal guardian or relative provides no more than 40- hours per week of the service that the DDA approves the legally responsible person to provide; and
- The legal guardian or relative has the unique ability to meet the needs of the participant (e.g. has special skills or training like nursing license).

7. ***As we begin to unwind Appendix K, when will the exception that permitted the Support Broker to provide a direct service and be paid end? Is that an exception that will be retained permanently?***

   - This flexibility will remain through 6/30/2023.

8. ***What happens to SD people who hired family as staff? Will this need to be documented in a revised PCP or in another form?***

   - For services that permit the hiring of relatives and/or legal guardians, a DDA SDS Family as Staff form must be submitted (for allowable services as permitted under the federally approved programs). Reference: Self-Directed Services - Family As Staff Form Guidance

9. ***How will DDA handle approved PCP's that include App K flexibilities when the annual plan date is beyond 6/30/2023?***

   - We recommend that CCS and providers work with the person and their team around the need to add or revise services (as permitted under the approved program) as soon as these interests or changes are known. This can be done in coordination with the CCS monitoring process or through an upcoming annual PCP. It is most important that all service additions are done before services are provided so this should be carefully timed with the Appendix K flexibilities end date. Appendix K and Executive Orders Flexibilities

10. ***What is needed for providers to continue to offer some services virtually after 6/30/2023? Does this need to be outlined in the program service plan (PSP)?***

    - Yes. As detailed in Memo #3 - DDA Amendment #3 - Virtual Supports -

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February 16, 2021 , allowable virtual services to be offered after the end of the Appendix K flexibility will need to be outlined in the providers program service plan (PSP) and submitted prior to the end of the App K for DDA review and approval. Instructions for completion of the PSP are included in the application process and can be found here: ww.dsd.state.md.us/comar/comarhtml/10/10.22.02.09.htm

11. ***Can Brief Support Implementation Services (BSIS) continue to be provided telephonically/remotely until 1/31/23 similar to the other behavior support services?***

    - No. Under waiver amendment #3, Behavioral Support Services (BSS) remain available under telephonic/remote services with the exception of brief support implementation services (BSIS) - this one behavior support service must be provided onsite/in person. Memo MDH 8.13.21

12. ***In the Appendix K authority and termination date chart, what is "Nursing training received from the DDA" referring to?***

    - Nursing Required Training refers to the Appendix K flexibility which allowed the temporary waiving of the requirement that a registered nurse receive training from DDA regarding delegating nursing until the state of emergency is terminated. These include, but not limited to DDA - RN/Case Management/Delegating Nurse Orientation

13. ***Is the flexibility for one hour of meaningful day service to bill for the full day continuing or when will this end?***

    - The emergency regulation and the approved Appendix K provides the authority for providers to provide fewer than the minimum hours required for billing for meaningful day services. The flexibility for one hour of meaningful day service billing ended on 3/31/22, and was replaced with a minimum of three hours of meaningful day service billing in accordance with the pending emergency regulation that will extend through 6/30/2023.

14. ***If we updated our PSP to include Remote Services, do we also need to update it to include Virtual Services?***

    - Yes. Remote supports is a specific waiver service whereas virtual supports is a modality that can be used to support delivery of various waiver services.

15. ***Can the App K additional hours available for Personal Supports be continued after 6/30/2023?***

    - Post Appendix K, requests for additional hours above 82 per week (due to day program closures or for other reasons), must be requested through an individual's team meeting and a PCP revision.

16. ***Is there a deadline for providers to submit revised Program Service Plans for virtual and dedicated support hours?***

    - As per Memo 3 - DDA Amendment 3 - Virtual Supports Final Feb 16, 2021, DDA Providers should update their Program Service Plan for the applicable services they proposed to include a virtual support service delivery model option:
        - As part of their annual re-licensure/recertification application; and
        - Prior to the end of the Appendix K authority.

17. ***Under the provisions of Appendix K continued flexibilities, are providers able to continue to bill for residential shared service hours? (New - March 10, 2023)***

    - Under the provisions of Appendix K, residential day time shared service hours will be authorized to provide funding for supports based upon the number of people in the home until June 30, 2023. Please see the most recent Appendix K flexibilities chart for updates related to flexibilities.

II. Billing

1. ***For Nursing Services associated with Personal Supports, is payment automatically paid through LTSS or should the Nursing Service be billed separately by invoices?***

    - Until the provider's services transition into *LTSSMaryland* billing, nursing services should continue to be billed through the DDA's established invoice process. For additional information, please review the Guidance for Operating in PCIS2 and LTSSMaryland – Revised March 15, 2021

2. ***Can you bill day services for 7 days a week in PCIS2 per Appendix K? Will PCIS2 actually let you enter on Saturday and Sunday?***

    - Yes.

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3. ***Under Appendix K, providers can bill a day of service for three hours of remote engagement. Once Appendix K ends, will the billing continue like this for legacy providers? Then once we move to LTSS will it need to be billed per quarter of engagement for Day Hab/Employment Services? Please clarify.***

    - No, providers will need to provide the regulatory number of hours per day to bill for a day of services in PCIS2.

4. ***For stand-alone support services, such as Assistive Technology, are providers able to bill for an administrative fee or just the actual cost of the items?***

    - The OHCDS may bill the DDA for the costs of the items and/or service, on behalf of the Qualified Service Provider that has rendered the service. The OHCDS may also bill the DDA separately for the costs it incurs in fulfilling its administrative and oversight responsibilities in the invoice process. For additional information, please review the DDA Organized Health Care Delivery System policy.

5. ***How are Dedicated hours in CLGH calculated? What is the formula?***

    - The person-centered planning process is used to identify the most integrated services and supports and minimize restrictive strategies to support the person's unique and individualized needs and goals. There is no formula. Resource: Person-Centered Plan Development and Authorization

6. ***Are the rates final or are they still a work in progress?***

    - The *LTSSMaryland*--DDA Module budgeted rates for FY22 and FY23 have been completed.

7. ***Is the 5.5% an annual increase or a one time only?***

    - The 5.5% ARPA retroactive increase in PCIS2 will provide an increase to the base of rates for eligible services which will carry forward in the rates. For targeted case management services in *LTSSMaryland*, this is also a 5.5% rate increase effective 11/1/2021 that will carry forward.

8. ***Under Supported Living, do providers mark attendance for each day of service AND dedicated hours?***

    - Yes

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9. ***Can a residential provider bill for 5 hours and the Day/CDS provider bill for 1 hour of virtual (as an example) for the same day as long as they don't overlap in time?***

- Yes. This example would be appropriate as the services (i.e., dedicated supports and meaningful day) are distinct and not occurring at the same time. It is important, however, to ensure that PCPs are updated to reflect these services and to consider that virtual supports cannot comprise the entirety of a service. Additional guidance will be developed specific to billing in PCIS2.

10. ***How would virtual day service providers be able to bill for one hour during the day when there is no possibility of doing that in current PCIS2?***

- Virtual supports is a modality that can be used to deliver day services. Virtual supports should be used in addition to in person supports and can comprise part of the service, where preferred, to meet the minimum requirements for billing after the termination of the Appendix K flexibility and the expiration of the emergency regulation.

11. ***Will the 10% rate increase for DSP's be accessible to all providers? Will the increase be a one-time-only increase or an increase to the overall base rate?***

- The one-time only emergency rate increase will be accessible to all DDA providers of HCBS for qualified claims. This is a one-time only increase, and will not be part of the overall base.

12. ***What is the status of Contribution to Care (CTC) for residents who will not be in a day program? Will it continue to be charged to an individual's account? How are service hours and costs handled? Are they transferred to Residential Services as a Support Service?***

- There have been no Policy changes regarding Contribution to Care. Please visit the DDA's webpage for Contribution to Care, located here, for additional information.

13. ***Is the intent for the ARPA money for providers to be able to use those funds in FY23?***

- For the 10% one-time emergency rate increase, there is no time limit for spending the money. This is a rate enhancement for the period of January 2022 - March 2022 for qualifying claims. Providers are

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encouraged to work with their accounting firms for questions related to booking the revenue.

14. ***When will the batch "Number of People Authorized" correction functionality (including infotip, report and batch process) be available to providers in the LTSSMaryland Provider Portal?***

- This functionality is expected to be released in the February 2023 monthly system update, around February 13th, 2023.

15. ***After the Residential Services Provider Portal Update, how often should we run the new DDA Residential Rate Discrepancy Report?***

- It is recommended that you run this report at least once a month. If you have a large volume of residential sites , it can be run more frequently such as once every two weeks.

16. ***Do we have to correct all the services that were billed with a mismatched residential rate?***

- You should correct all services that have a discrepancy if all participants were billed for at the residential site.
- If a participant recently moved into a residential location and is pending PCP approval, you may choose to exclude the impacted residential site in the file upload process.
- Once the PCP is approved, you will be able to bill for the residential services provided. This will address the rate discrepancy.
- To exclude the home in the export file, uncheck the impacted locations in the 'Provider Locations' field and run the report

17. ***What services will the Residential Rate Discrepancy report include?***

- It will only include the Community Living-Group Home, Community Living Enhanced Supports, Supported Living, and their respective retainer / trial experience days.
- Of those service types, it will only look at services that are in the following statuses: Pending, Ready, Closed, State Payment Eligible, State Payment Reported.
  - **Pending:** This status indicates that the service has failed one or more checks and exceptions are assigned to it. A service in this status will not be processed for claim creation and requires the Provider or MDH to take action to resolve or clear the Exception (based on the type of Exception) for further processing

    - **Ready:** This is an intermediary status when the Services have passed all validations checks prior to claim creation and will have a claim created and submitted to MMIS.
    - **Closed:** This status indicates that the Service has a Claim created, and can only be modified by Adjusting the Claim after the Submitted Claim has been Paid or Rejected.
    - **State Payment Eligible:** This is an intermediary status for state funded activities when the Services have passed all validations checks and will be submitted to the upcoming state payment report.
    - **State Payment Reported:**This indicates that the activity has been reported on the DDA State Payment Report invoice.

18. What services will the Residential Rate Discrepancy report not include?

- The discrepancy report will not pull services that have matching values in the 'Number of People Authorized' and the 'number of participants billed' fields.
- It will also not consider services that were Voided or Discarded as these are not considered as paid / eligible for payment.
    - **Void:** Claims that are reduced to 0 units in order to refund money back to MMIS / State Funds as they were billed in error.
    - **Discarded:** Activities that did not become a claim because the provider selected the discard button for the service as the service should not have been billed.

19. Do we have to use the Batch Process or can we continue to use the single service modification process?

- You still retain the ability to modify the service activities directly. However, if you have a large volume of residential sites, the batch process lets you correct all discrepancies at once.

20. What happens if I manually correct the activities and use the batch file on the same day?

- The system will maintain the manual correction on the individual service file and reject and/or skip the batch file correction for that service. When the overnight job runs the uploaded CSV file, the activity will be marked as 'Skipped' and will not be changed further.

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21. *What is the time limit to correct the Residential Rate Discrepancies?*

- Ideally, you should correct these discrepancies as soon as possible. However, in order for payment to be billed within *LTSSMaryland,* corrections must be made at least 364 days after the original date of service.

22. *What if we miss the 364 day limit in LTSSMaryland?*

- The discrepancy must be corrected manually through the LTSS Billing Claims Summary Forms - Exceptions process.

23. *Where are manual time entries entered for Nursing Support Services for people in SDS?*

- If a participant's nurse is an employee, they would input the time in the timekeeping system of the FMCS. If the nurse is a vendor, they would issue an invoice to the participant.

24. **Where can Providers find more information on the 2023 Competitive ARPA Grant? *(New - March 10, 2023)***

- Providers can access more information about the 2023 APRA grant by navigating to the dedicated DDA ARPA grant webpage.

III. COVID-19 Guidance

1. *If an individual is not fully vaccinated, should they get a COVID test if exposed to someone who is infected with COVID-19?*

- Yes, if a person is not fully vaccinated, they should seek testing for COVID-19 following exposure. We also encourage every Marylander who is eligible for a COVID-19 vaccine and is still unvaccinated to get vaccinated as soon as possible. Fully vaccinated means two weeks have passed since receiving all required doses (2 doses for Pfizer or Moderna; 1 dose for Johnson & Johnson) of a COVID-19 vaccine series.

2. *Given Governor Hogan's lifting of the outdoor mask mandates, does DDA have a requirement for providers?*

- No. We encourage all providers to follow the MDH face covering recommendations and any local requirements. Staff at congregate care

facilities should follow the CDC's current guidance on face masks, that all healthcare providers continue to wear face masks when in shared areas of the facility.

3. ***Is there specific guidance for what to ask on a daily health screen for participants, staff and essential visitors?***

    - Providers should consider asking participants, staff and essential visitors general questions about COVID-19 signs and symptoms. For additional information, please review the Checklist of Recommendations for Group Home Outbreak Revised May 10, 2021.

4. ***After July 1 is the DDA Suspected or Positive Staff/Person Supported form still required?***

    - Yes.

5. ***What if a participant refuses to be vaccinated?***

    - Participants may choose if they want to receive a COVID vaccine. The DDA highly recommends that participants get vaccinated to reduce the spread of COVID in the community. Additionally, if the participant chooses not to receive a vaccine, then they should follow all of MDH's and CDC's guidance on mask wearing, social distancing, and other preventative measures.

IV. DDA Communications

A. Communication Updates

1. ***There was much information shared that is of value especially during this time of COVID-19. Are there other ways to receive supporting documents/information such as a newsletter or blogs? How can folks connect with you?***

    - If you would like to stay informed about DDA webinars, guidance, and policies, please join our mailing list by completing the form.
    - The DDA Monthly Communication Highlights posted on the website provides a summary of information shared during each month.

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B. New DDA Stakeholder Input Process *(New - March 10, 2023)*

1. ***How will stakeholders be notified of the DDA Policy Stakeholder Input requests?***

   - Stakeholders will be notified when policies are posted to the dedicated DDA stakeholder feedback webpage via DDA's communication alerts. To sign up for alerts and communication updates from the DDA click the Join our Mailing List.

2. ***How can I be a part of the policy making process? (New - March 10, 2023)***

   - Visit the new DDA stakeholder input webpage when policies are posted to provide feedback. Steps to submit your feedback are listed on the webpage.

3. ***How will I know when policies will be posted to the webpage? (New - March 10, 2023)***
   - DDA will send out communication as policies are posted to the webpage.

4. ***How will I know when the Public Comment period is over? (New - March 10, 2023)***
   - Information will be included in the communication and on the webpage

5. ***What happens to my feedback? (New - March 10, 2023)***

   - DDA values your feedback - all feedback will be considered. Public comments will be summarized and posted when the final policy is published. Remember: The DDA cannot make changes to policy that do not align with the federally approved waiver application.

V. DDA Provider Applications

1. ***When will the DDA Provider Application and DDA Approval Letter be updated with the new changes?***

   - The DDA will be updating the DDA provider application and approval letter. Reference: DDA Provider webpage

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2. ***When will the new "Search for Provider" link be up on your DDA website?***

    - The Provider Directory is live within the DDA webpage. https://maryland.providersearch.com/

3. **Should an agency use the sole practitioner form for each of their staff?** ***(New - March 10, 2023)***

    - No. The Sole Practitioner agreement form should be completed for an individual licensed practitioner..

VI. Eligibility and Application

1. **Are the Community and Family Supports Waivers still limited to 400 slots each?**

    - Community and Family Supports Waivers no longer include participant enrollment limitations.

2. ***For FSW and TY – if FSW ends at the end of the school year (typically June) but the youth can't start TY waiver (such as CSW) until July 1 – will there be a gap in services?***

    - No. The participant's Family Supports Waiver eligibility will end on June 30th and their enrollment in DDA's Community Supports or Community Pathways, based on assessed need, will be effective July 1st so there is no gap in services.

3. ***For someone who is TY eligible, when and how do we notify the DDA Waiver staff of residential needs, so they can enter the folks in the Wave?***

    - Transitioning youth with an assessed need of residential services should share their needs with their CCS. The CCS should contact the Regional Office if the waiver referral notice program type does not include the Community Pathways Waiver.

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4. ***How will a provider know if a person's waiver status is up to date?***

    - Providers are able to view a participant's waiver status in the LTSS*Maryland* Provider Portal.

5. ***What should be done if an alert is received regarding waiver ineligibility during a State of Emergency?***

    - If a provider receives an alert of participant eligibility during the State of Emergency, then they should contact their Regional Office's CCS squad liaison. The liaison will work with EDD to further research and remediate any issues (as applicable).

6. ***When providers are fully billing in LTSS, will providers be able to bill for services, if a person loses waiver eligibility?***

    - No. If a Family Supports Waiver or Community Supports Waiver participant loses waiver eligibility, then the provider claims will not be processed. Under the current practice, Community Pathways Waiver participants are converted to State Funding and the claim will be processed. During the PHE, however, participants should not lose waiver eligibility. Please notify the Regional Office if this is occurring.

7. ***Is the upper threshold limit for Low Intensity Support Services (LISS) funding set to increase above the current limit? If so, is there a start date in place? (New - March 10, 2023)***

    - At this time, there have been no changes to Low Intensity Support Services funding limits. The current funding limit for LISS is $2000. You can find more information about LISS program services on the DDA web page here.

VII. Person-Centered Planning

A. Plan Development

1. ***What is a person-centered plan?***

    - DDA's Person-Centered Plan or "PCP" is a written plan that identifies the person's specific goals and preferences and specific services and supports (including natural, community, State, federal, and DDA funded) to assist the person in pursuing their personally defined goals. The planning process should include all members of the participant's

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team unless otherwise directed by the participant. It directs the delivery of services and supports based on the personal preferences and choice and identifies specific needs that must be addressed to ensure the person's health and safety. See DDA's Person- Centered Planning Web Page and DDA's Person-Centered Plan Policy

2. ***How is the PCP completed?***

- The PCP process always begins with and is about the person. The person's Coordinator of Community Services (CCS) facilitates the planning process and completes the PCP within the LTSS*Maryland* information system. The PCP format, approval, and authorization are documented within the LTSS*Maryland* information system. The DDA's PCP processes include: (1) pre-planning, (2) plan development, (3) plan approval, and (4) plan funding authorization. PCP services are authorized for a one-year period and must be updated and approved annually. See Person-Centered Plan Development and Authorization

3. ***Who is responsible for filling out the Charting the Lifecourse Tool and where do we find it?***

- This tool, which anyone can fill out, is recommended as part of the PCP planning process. The CCS can be helpful to you in using these tools to facilitate successful, robust, and timely PCP planning and implementation. You can access it at www.lifecoursetools.com

4. ***Will participants receive written communication when plans have been approved, including for revised PCPs? If so, who will the letter come from?***

- Yes. All plans are reviewed by the DDA regional offices for a determination of a plan authorization. The DDA will send a determination letter to the individual documenting the plan authorization.

5. ***If a request for a service is denied, can that decision be appealed?***

- Yes. All services requested that are not approved have appeal rights. The regional office will send appeal rights with denial letters to the participant. See the Person-Centered Plan Development and Authorization , page 31.

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6. ***How can families find guidance in planning future services of their loved one, in particular, if they are no longer able to assist in the management of the self-directed program?***

    - Future planning is an important consideration for your loved one. It is important to have these conversations during the PCP planning process and ongoing so that everyone feels informed and prepared. Your CCS and team can provide individualized support with consideration of your specific interests, needs and circumstances. Resources: Plan for life?; Exploring Life Stages; and By Their Side.

7. ***What is the timeline for DDA to review and approve plans and budgets?***

    - The DDA requires PCPs to be reviewed within 20 business days. Based on the review, the DDA may send a clarification request for additional information, authorize, or deny the plan. A comprehensive PCP, that meets DDA's requirements and standards, should be submitted by your CCS into LTSS*Maryland* more than 20 business days before the expiration of your current plan. Resource: Person-Centered Plan Development and Authorization

8. ***If there is needed clarification does the review period reset for another 20 days?***
    - No. The clarification should be addressed within 5 business days and the plan should be approved prior to the APD date so that there is no gap in services or funding. Resource: Person-Centered Plan Development and Authorization

9. ***Is the expectation to request all of the services a participant will need throughout their plan year during the PCP or request services as needed?***

    - The Initial and Annual PCP should include all services and supports a person will need throughout the plan year.

10. ***Where or how is it to be noted if someone has an assessed need for residential services? Is this simply the CCS noting it in the PCP?***

    - All assessed needs, including the need for residential services, should be reflected in the individual's Person-Centered Plan. These assessed needs will be determined through various assessments including, but not limited to, the Support Intensity Scale (SIS) as well as the Health Risk Screening Tool (HRST). The PCP team should use these tools and input from the PCP team to document needs in the PCP. If there is a

significant change in the participant's needs (e.g., health and safety), then a revised PCP with new assessed needs and service requests should be submitted.

11. ***Does the team discuss an outcome for a new service that will be requested during the PCP process, or do we wait until that service has been approved before discussing an outcome for the new service?***

- Outcomes need to be identified first. It is important to understand the participant's goals before seeking services. The PCP Outcome Section is part of the PCP development process and includes exploration of other resources including natural and community support in addition to local, State, and federal resources. All DDA funded services requests must be associated with an outcome to be authorized. For more information on completing the Outcome Section, see Person-Centered Plan Development and Authorization page 10.

12. ***Should DDA Providers accept service referrals in LTSS if the amounts in the authorizations are different from what the agency receives through PCIS?***

- Yes. Until the DDA system is fully transitioned into *LTSSMaryland*, the DDA will be operating in two systems: LTSS*Maryland* and the legacy Provider Consumer Information System (PCIS2). Therefore the services, units, and associated rates will differ. The service units in LTSS*Maryland* should line up with the Detailed Service Authorization Tool (DSAT) agreed to by the participant and the authorizations in PCIS2 should line up with the Cost Detail Tool.

- Resources:
    - Guidance for Operating in PCIS2 and *LTSSMaryland* - Revised March 15, 2021
    - Reference resources on service mapping between the two systems:
        - At a Glance - Meaningful Day Services - Revised March 15, 2021
        - At a Glance - Personal Supports Services - Revised March 15, 2021
        - At a Glance - Support Services - Revised March 15, 2021
        - At a Glance - Residential Services - Revised March 15, 2021

13. Has LTSSMaryland been updated to support the selection of Day Habilitation services for individuals in self-directed services?

- Yes. LTSS*Maryland* has been updated.

14. How can DDA Providers see the entire plan or all services?

- A PCP can only be seen by a provider if they have been referred for service and then accepted. DDA Providers view their referred and authorized services in the provider portal. The DDA is working to expand the information to include additional information and access... In the interim, the CCS can email a PDF of the entire plan to the participant and to their support team members or share their LTSS screen during the annual plan meeting.

15. As services begin to reopen, how will residential participants be supported around choices for returning to their day program or continuing to receive virtual services?

- It is critical for PCP teams to meet and have these conversations about what each individual person wants and needs as it pertains to their chosen services, providers, community access, and engaging with friends, loved ones, and coworkers. PCP teams should be discussing how the person can begin to safely engage in their communities again, while still following Maryland Department of Health (MDH) and Center for Disease Control (CDC) guidelines. These conversations can be difficult but they are important to have as more people become vaccinated. Each conversation is going to look different based on the individual needs of the person. If a PCP team has any questions or would like support in facilitating these conversations, please reach out to the Regional Office.

16. Who is responsible for entering the Service Referral into LTSS, so that the provider can view and accept the Service Authorization?

- The CCS is responsible for entering the service referral in LTSS. Once entered, the provider receives an alert and can view the request, accept, or decline the referral within 5 days.

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17. ***What happens to a provider's ability to bill, if a second provider is not submitting their documents to support PCP submission in a timely manner?***

    - A provider cannot provide services for a DDA Waiver participant without authorization of the PCP from the DDA. If an individual's PCP submission and review is delayed by a second provider's failure to submit documentation in a timely manner, then the individual and team have the right to select a new provider who is able to meet the individual's expectations and needs.

18. ***Do HRSTs have to be submitted as supporting documentation with PCPs?***

    - The HRST is included as part of the PCP in LTSS. Please note that the HRST can be referenced when addressing an individual's goals, assessed needs, and outcomes in the PCP and SIP.

19. ***Can the person use the same goals for two years in a row? Or should it be revised yearly?***

    - Yes, an individual can use the same goals for two years in a row. However, all goals should be reviewed minimally on a yearly basis or as often as needed, to ensure that the individual's current needs are being addressed. Each PCP outcome includes information related to the frequency for assessing satisfaction, implementations (e.g., SIP), and outcome.

20. ***Should a provider discontinue service with an individual if the PCP is not approved by the Annual Date?***

    - No, before discontinuing services with any participant, please work with their assigned CCS and/or Regional Office for assistance.

21. ***Who is responsible for reviewing the HRST?***

    - For participants who receive waiver services through the traditional services model and have an HRST score of 3 or above, the agency provider's nurse will review the HRST.
    - For participants that are new to Self-Direction and have a HRST score of 3 or above, the contractor, Optimal Health, will review the HRST. Participants who have been receiving waiver services through the self-direction services model for a while and have a HRST score of 3 or above, will need to hire a nurse for nurse consultation. That nurse will provide the clinical review.

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- For participants who receive waiver services through the traditional services model and have an HRST score of 3 or above, the agency provider's nurse will review the HRST.

22. ***Does a service need to be accepted by the provider as soon as notification is received by the CCS or by the "Due Date" in LTSS?***

    - Per the PCP development and authorization standard operating procedure, agencies have 5 days to accept the service.

23. ***What should be included in the risk section of the PCP?***

    - Any and all risks identified through the assessment process should be identified on the PCP and mitigated to ensure overall health and safety. This is a collaborative process among the PCP team to ensure the person's health and safety.

24. **Do pilot providers or early adopters providers need to do the cost detail for PCPs that will be active as of July 1?**

    - No.

25. ***Do we implement the new service on the date indicated on the SIP after the plan status has changed to "active" in LTSS, or do we wait for the approval letter?***

    - The PCP is the document that authorizes and documents the approval of services. The PCP documents the effective date of approved services. The services can be provided on or after the approved effective date.

26. ***Who initially receives the alert that a person's annual is coming? The CCS or the provider?***

    - The LTSSMaryland DDA Module alerts the assigned CCS that the participant's annual PCP is due at 90 days before Annual Plan Date (APD), 60 days before ADP, and 30 days before APD.
    - The provider receives alerts when a service is ending. This is according to when the end date is populated in the PCP. Providers do not receive alerts of upcoming annual PCP Dates.

27. ***Is there an updated Service Description guide with the new services and the waiver definitions?***

    - The Guidelines for Service Authorization and Provider Billing Documentation includes DDA Waiver service descriptions. Additionally,

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you can review the [Community Pathways Waiver - Amendment # 3]() to review service descriptions.

28. ***For Respite Hourly funding that does not have a set schedule, how should the funding be entered in the service authorization in LTSS?***

- For Respite Care Services (hourly) requests that do not have a set schedule, the estimated monthly service need should be entered. Using the calendar to document the proposed frequency and specific days of service delivery need does not prevent the participant from exercising flexibility to receive services on alternative days.

29. ***Is it correct that provider signatures sheets are no longer required?***

- Yes. Provider hard copy signature sheets were discontinued once the LTSS*Maryland* service referral process was implemented. The Providers 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. Therefore all services should be accepted via the DSA in LTSS*Maryland*. For more detail, please review the [Person-Centered Plan Development and Authorization]()

30. ***If the SDS participant selects a provider and the provider cannot be listed in LTSS, is that provider able to authorize the services in the LTSS system? Does the provider see the PCP on LTSS?***

- Under the self-directed service model, we do not list the specific service provider if one is selected, because payment is managed through the Financial Management and Counseling Services provider. Because of this, the provider will not be able to view the participant's person-centered plan through the LTSS Provider Portal.

31. ***If a provider has not submitted the SIP, should they be left off the PCP so that other providers' billing is not delayed or disrupted?***

- Communication and coordination is essential to ensure participants receive all needed services and supports. Regional Office can provide assistance with challenges with provider's submission of the SIP. After consulting with the participant and with their agreement, the provider can be left off the plan so that the services and other providers can be authorized.

32. Is the new Family as Staff form required for individuals who are retaining family members as paid staff for traditional services?

- No. This form is limited to individuals in self-directed services.

33. After 9/30/2022 , can CCS agencies provide supports virtually?

- Post Appendix K, and at the interest of the participant, PCP planning can be provided virtually. Quarterly monitoring visits, however, must be done in person.

34. How should the need for 1:1 during hospitalizations be documented in the PCP?

- This should be noted in the *LTSSMaryland* - DDA]Module PCP Risk section including details in the 'How Addressed' data field and also documented in the Service Implementation Plan.

35. Are there limits to how many hours can be requested for residential and day supports?

- To support week-to-week flexibility in participant'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 limitations noted in DDA guidance (Reference: DDA - PCP Development and Authorization. Teams should review and discuss service needs including taking into consideration the hours a participant is working (i.e., daytime, nighttime, and weekend hours) and not request the maximum service units for each Meaningful Day service. Participants 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 - a total of 40 hours per week for all authorized Meaningful Day services combined.

36. What information is entered into the scope section of the PCP?

- As per the DDA's guidance, the scope section should reflect: "Services and supports based on the approved waiver service scope and requirements as outlined in the service implementation plan, behavior plan, and nursing care plan (as applicable)" unless otherwise noted in policy or guidance.

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37. How can we verify the units match with the proposed schedule?

- Communication and coordination is important among team members. The Detailed Service Authorization Tool (DSAT) is used as part of the pre planning process.
    - PCP Web Page Reference:
    - DetailedServiceAuthorizationTool (DSAT) Form-Revised June 1, 2021 v2
    - Detailed Service Authorization Tool (DSAT) Memo
    - At a Glance - Detailed Service Authorization Tool (DSAT)

38. Does each person need an individualized schedule?

- As per DDA Meaningful Day Policy, an individualized schedule will be used to provide an estimate of what the participant will do and where the participant will spend their time when in this service. For each participant, what they do during the week should include opportunities to make choices about how they spend their time, to build community and relationships, and, if they are interested, to explore employment. Updates should be made as needed to meet the changing needs, desires and circumstances of the participant. The individualized schedule will be based on a PCP that clearly outlines how this time would be used.

39. What guidance is available around requesting additional service authorizations in the case of an unplanned event or emergency?

- In the event of an emergency, the CCS or RO should be contacted. An emergency situation form is completed and reviewed for approval of emergency services.
- As per DDA's Person Centered Plan policy, the Emergency Revised PCP is the plan used when a person already has an active person-centered plan (e.g., a current Initial PCP, Annual PCP, or Revised PCP) and at least one additional service needs to be authorized within forty-eight (48) hours.
- If approved by the DDA, the Emergency Revised PCP is authorized for no more than fifteen (15) days, but can be reauthorized for another fifteen (15) days, if needed. After authorization, if the service continues to be needed beyond this limited time-frame, the CCS will complete a Revised PCP and submit it to the Regional Office for review.

40. What is the expectation should the participant refuse in-person meetings past Appendix K flexibilities?

- The DDA understands that individuals and families may have specific preferences or needs regarding face to face monitoring. CCS are encouraged to engage people and families in those conversations while also ensuring health/safety and monitoring requirements. If there are unique circumstances that may require additional support or guidance, CCS are encouraged to reach out to their DDA regional office for assistance.

B. Plan Revisions

1. ***How has the PCP planning process changed since the modified service funding plan was phased out?***

   - Changes to your PCP will now involve submission of a revised PCP and supporting documents. Your CCS will provide assistance with plan revisions as needed. For more detail, please review the Person-Centered Plan Development and Authorization

2. ***How often can changes and requests be made within a year?***

   - If there is a *significant* change in the participant's needs (e.g., health and safety), then a revised PCP with new assessed needs and service requests should be submitted.
   - Comprehensive pre-planning is essential for Initial and Annual PCPs to support the participant's life aspirations and address any unmet needs (i.e., immediate and for the upcoming year) and also reduce the need for a Revised PCP. Pre-planning occurs in collaboration with the participant's PCP team which includes people chosen by the participant but often includes their family members, friends, and provider agencies.
   - This would include changes needed within 90 days of the annual plan.

3. ***If an individual is receiving services from two providers and makes a request to change just one service, do both providers need to attend the updated PCP meeting?***

   - While it is not required that they attend, it is important for the team to collaborate on PCP development and any revisions needed to ensure continuity of services across all providers.

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4. ***When the plan is revised, does the date change, or does the initial date stay the same?***

    - The person's annual PCP date remains the same, but the revised plan will have a new effective date indicating when the changes become effective.

5. ***If a person needs access to immediate services not listed on their current PCP, what processes should be followed?***

    - Notify the person's CCS and the Regional Office of the need for emergency services.
    - As per DDA's Person Centered Plan policy, the Emergency Revised PCP is the plan used when a person already has an active person-centered plan (e.g., a current Initial PCP, Annual PCP, or Revised PCP) and at least one additional service needs to be authorized within forty-eight (48) hours.
    - If approved by the DDA, the Emergency Revised PCP is authorized for no more than fifteen (15) days, but can be reauthorized for another fifteen (15) days, if needed. After authorization, if the service continues to be needed beyond this limited time-frame, the CCS will complete a Revised PCP and submit it to the Regional Office for review.

6. ***If a plan is held for clarification, can the provider see the clarification request? Currently we rely on the CCS to communicate this information.***

    - No, the provider does not have access to PCP clarifications within LTSS. The CCS will share any clarifications related to an individual's services with the participant and provider (as applicable) for input or clarification.

7. ***How can a CCS revise an initial PCP to add a provider?***

    - The initial PCP will remain inactive until a person is enrolled in a DDA program. Once a person is enrolled, the plan will become active and the CCS will be able to revise the PCP to add the selected provider(s).
    - If an initial PCP needs to be revised to include a provider prior to the DDA program enrollment date, the CCS can discard the approved initial plan and create a new initial PCP adding providers for regional office review. The CCS should indicate the specific changes to the initial plan (e.g., adding providers for authorized services).

8. ***Why do providers have to re-accept the Service Authorization portion of the PCP, if there is a change in hours/units but not a change in rate funded for the service?***

    - If any changes are made to the PCP after a clarification request or the effective date needs to be changed, the provider will need to accept the services again. This allows the provider to see what the changes in the effective date are or any other changes that need to be made.

9. ***When a participant changes services (revised PCP) before the annual PCP date, how do you determine the implementation date?***

    - The service implementation date should take into consideration the date the PCP is submitted to the DDA and the review process. The DDA has 20 days to review a revised PCP. If there is an emergent need for a new service, please work with the Regional Office to request emergency approval, if absolutely necessary.

10. ***Does a SD participant need to submit a revised PCP when there is a change in the Support Broker?***

    - No.

11. ***Does a SD participant need to submit a revised PCP when there is a change in the provider's rate of pay but it does not affect the total budget?***

    - A revised PCP is not needed when the provider's rate of pay changes, but the overall budget does not change. Therefore, a Budget Modification form should be submitted to the Regional Office and the FMS so they are aware of the new pay rate.

12. ***Do providers have until 9/30/22 to update each participant's SIP for the Virtual Supports service delivery model or can this just happen at their annual PCP? Is this guidance the same for the shared Dedicated Hours service delivery model?***

    - Participants who are requesting continued use of virtual support, the SIP needed to be updated by 9/30/22. This flexibility under the Appendix K has ended. In addition, if individuals are going to receive Dedicated Supports, this needs to be outlined in their PCP and DSAT prior to the delivery of services to ensure authorization for these supports.

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13. ***What guidance is available for teams around a change of service need during the 90-day annual plan renewal?***

    - *See PCP Guidance and most current webinars related to preplanning. It's critical that CCS and provider work closely together when developing and updating PCPs.*

C. Service Implementation Plan (SIP)

1. ***Where can I find the Service Implementation Plan (SIP) form?***

    - The Service Implementation Plan (SIP) can be found here. Please review the Service Implementation Plan (SIP) policy for additional information.

2. ***Can a provider create their own template as long as it captures everything in the DDA template?***

    - No, the provider must use the DDA's Service Implementation Plan (SIP) form. Participants and providers may include additional information as an attachment associated with the service implementation plan.
    - The DDA has been contacted by software vendors seeking to create the DDA SIP form template within their system. Software vendors can create the exact DDA SIP form within their system and have been advised that if the form is revised or updated, they will also need to make the update in their software system.
    - The SIP needs to be shared with CCS for inclusion in the LTSS PCP.
    - Please review the Service Implementation Plan (SIP) policy for additional information.

3. ***Who starts the work for the SIP -- the provider or CCS?***

    - The Provider is responsible for developing and sharing the SIP with the CCS, person, and their representative(s). Please review the Service Implementation Plan (SIP) policy for additional information.

4. ***Who is responsible for initiating the SIP for participants in self-direction?***

   - For people enrolled in the self-directed services delivery model, either the applicant/participant or their designated representative shall create service implementation plans for their direct support staff for whom the applicant/participant has employer authority for the Waiver program services authorized by the DDA. The participant's staff/vendor shall create the SIP implementation strategy for the requested services provided when the person does not have employer authority for that Waiver Program services authorized by the DDA. Please review the Service Implementation Plan (SIP) policy for additional information.

5. ***Are providers required to do the 30-day meeting for a new participant?***

   - No. However, teams can conduct a 30-day meeting for new participants to assess the initial SIP implementation.

6. ***What is the timeline for the SIP development and submission in relation to the PCP meeting timelines?***

   - For individuals new to services, the SIP should be submitted within five (5) business days of the LTSSMaryland service referral acceptance. For individuals with Annual PCPs, the SIP should be submitted at least five (5) business days before the annual person-centered planning meeting. For individuals with revised PCPs, the SIP should be submitted within five (5) business days or a team agreed date, so that a revision to strategy needs to occur. For Emergency Revised Plans, SIP forms should be submitted within five (5) business days of an Emergency Revised Plan. Please review the Service Implementation Plan (SIP) policy for additional information.

7. ***Will the provider have access to the client attachments such as the revised SIP when a strategy changes but there is no service modification?***

   - No. DDA providers do not have access to the client attachments section in *LTSSMaryland*. However, as part of the individual's team, it is important that the individual, CCS, provider and any other members of the team share information related to changes to the SIP, goals, outcomes, and services. The information and/or attachments in LTSSMaryland can be printed and shared with the team by the CCS.

8. ***How should SIPs be completed for individuals who have more than one outcome for a service?***

    - A SIP form should be created for each outcome the provider is supporting. Some outcomes have more than one service associated with it. In this case, the services can be noted and service specific implementation strategies can be noted for the different goals.

9. ***Can you confirm each provider submits a SIP and if one provider does two services, both could be in one SIP?***

    - Providers must complete a SIP form to address each outcome the person is seeking services as requested in the PCP. Providers can note multiple services associated with an outcome.

10. ***Should providers plan to include this form for TY PCPs going into the system now?***

    - Yes, providers are required to include the SIP form with all PCPs effective July 1, 2021. Providers can use the SIP form prior to the effective date, if they choose.

11. ***If the PCP includes a Behavior Plan (BP), will the SIP have to be completed for the goals in the BP, if it is outlined in the BP specifically?***

    - A SIP should be completed for Behavioral Support Services. A Behavior Plan can be implemented in various environments and with the delivery of various services such as meaningful day and residential services. The Behavior Plan can be referred to in the SIP.

12. ***If the PCP includes a Nursing Care Plan (NCP), will the SIP have to be completed to outline the details in the NCP specifically?***

    - A SIP should be completed for Nursing Support Services. A Nursing Care Plan can be implemented in various environments and with the delivery of various services such as meaningful day and residential services. The Nursing Care Plan can be referred to in the SIP.

13. ***Why are we encouraged to use person-first language in the implementation strategy?***

    - Person Centered Plans should be written in a way that is person-centered. Person-first language acknowledges the person, the way they prefer, before using language that describes their condition or disability.

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14. Can changes be made to the SIP after the PCP meeting? If so, will this require a revised PCP meeting?

- Yes, changes to the SIP can be made after the PCP meeting to incorporate the participant's interest, preferences, and assessed needs.
- A revised PCP meeting would not be needed at this time unless determined by the Participant and their team that the changes to the SIP will affect the participant's assessed need for service, outcomes and/or goals.
- A meeting should be conducted when requested by the participant and when significant changes are being made related to staffing levels, types of activities, and modification of the DDA service request.
- To revise the SIP: The Provider will need to send the updated SIP to the CCS. The CCS will review the updated SIP with the participant to ensure it meets their needs and upload into the LTSS*Maryland* Client Attachment.

15. We have been listing the methodologies for each goal on the SIP, is it preferred to write it as a narrative in a paragraph?

- The SIP should include enough information such that any direct support staff could step in to assist the person in completing the goal such as;
  - The participant's preferred learning style and communication method;
  - Specific strategies and learning steps (i.e., direct support staff individual actions that need to be completed for success);
  - Description of how integrated supports (e.g., natural or community supports) will be used to help the participant attain the goal;
  - Description of staffing levels, type of supports (e.g., verbal prompting, hand over hand, line of sight, etc.), types of activities, and how often an opportunity should be given to try or practice it, and for what duration of time;
  - Reference of Nursing Care Plan and/or Behavior Plan strategies to be utilized and circumstances (as applicable);
  - The method for evaluating success (e.g., how to determine what's working and what's not working); and
  - Location(s) of service delivery site(s), such as the community (if in the community environment); meaningful day provider site; residential (if at residential setting), or home (if provided at a non-licensed site).

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16. ***If we are preparing the SIP prior to the PCP meeting, how do we know the exact language that we will need to put on the SIP?***

- Comprehensive pre-planning is essential to support a participant's life aspirations, goals, outcomes, interest, preference, and assessed needs in collaboration with the participant and people chosen by the participant such as family members, friends, and other provider agencies.
- The SIP is the DDA provider's or direct support professionals' service delivery implementation strategy for the requested services to support the participant's chosen outcome.
- SIP should include SMART goals, which means goals that are specific, measureable, achievable, relevant to the participants plan outcomes, and have clear proposed timelines for achievement.

17. ***Where do I put information about the goal status and progress in the SIP form?***

- This information should be included in the description of the goal and also in the additional information section if more room is required.

18. ***What information should the SIP include and in what format?***

- The SIP should be read as a type of "instructions" on how to implement the outcomes and goals chosen for each service.
- The SIP must;
    - Be based on what is known about the participant and be revised based on discovery of what is important to and for the applicant/participant through the person-centered planning process and service delivery;
    - Contain "SMART Goals" which should be developed using information gained through person-centered planning and discovery tools, relevant assessments, the person-centered plan, and other information that would help inform how to support the applicant/participant to achieve their goals; and
    - Include enough information so that any direct support staff could step in to assist the person in completing the goal.

19. ***Should the SIP be sent to the person's planning team by the CCS with the final PCP? How must CCSs enter outcome information in the outcome section of the PCP?***

- It is best practice for the CCS to send the SIP with the final PCP based on the participant's preferences.
- The provider should also have copies and can also distribute them to the team as they are the ones who completed the document.

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- The "outcome description" is defined by the participant from their perspective. This is given to the provider to be entered into the SIP. The provider then documents the service delivery implementation strategy for the requested services, to support the participant's chosen outcome. The CCS enters the provider's service implementation plan, word for word into the PCP's outcome section accordingly.

20. ***What if the nursing or behavior plan falls under the Day Program? Would there need to be an outcome for the Behavior plan and an outcome for the Day Program?***

    - If a participant is receiving Nursing Support Services and/or Behavior Support Services, regardless of where they are receiving them, each service needs to have a SIP and, therefore, an outcome. However, if applicable, the outcome could be tied to more than one service.

21. ***Are we responsible for developing a SIP for respite services if our staff do not directly provide the service? For example, if the participant attends respite camp?***

    - The provider who is assisting the participant with signing up for and funding the camp, would complete a SIP where the goal could be something like "I will attend a camp of my choosing to provide opportunities to (insert) by *insert date.*" The steps necessary to find and apply for the camp would be the implementation strategies.

D. Budget Development - Self-Direction

1. ***What is the self-directed budget?***

    - Participants, using the self-directed service delivery model, are allocated an annual budget for which to manage and exercise their budget authority. The DDA self-direction budget allocation is based on the approved PCP total service cost noted in the service authorization section. Participants complete the Self Directed Services (SDS) Budget Sheet listing the authorized PCP services and determine pay rates based on the option of hiring their own staff or working with a vendor or provider as noted in the federal approved Waiver programs.

2. ***When should the self-directed budget be submitted to the DDA in the plan development process and which form is used?***

    - The Self-Directed Budget Sheet should be submitted to the particpant's chosen FMCS after the PCP is approved in *LTSSMaryland*. The SDS

Budget Sheet is the form used in the plan development process. This form must mirror the services and units included in the PCP detail service authorization request and the total cost shall not exceed the anticipated budget.

3. ***What is the process to make corrections or move funds from one service line to another in LTSSMaryland?***

    - Changes or corrections to your approved service plan will require a PCP revision. Changes to your currently approved budget for services already authorized can be made with a budget modification. Your CCS can assist you in making these modifications to your plan or budget. See Person-Centered Plan Development and Authorization

4. ***Where can I find the information on rates I can use to pay staff and providers and who can I contact if I have questions?***

    - Information related to setting wages and rates can be viewed on the DDA's Self-Directed Services Guidance, Forms, and Webinars Web Page. If you have additional questions, please reach out to your regional office self-direction lead staff with questions.

5. ***Is there a limit to broker fees and how are they reflected in the budget?***

    - Support Brokers services are limited to 4 hours per month unless authorized by the DDA. They are reflected as hours in the self-directed budget sheet. Information related to setting wages and rates can be viewed on the DDA's Self-Directed Services Guidance, Forms, and Webinars Web Page. If you have additional questions, please reach out to your regional office self-direction lead staff with questions.

6. ***Is there a limit to the amount of budget savings that can be used for the purchase of individual or family goods and services?***

    - Yes. Individual and Family Directed Goods and Services are limited to $5,500 per year from the total self-directed budget of which $500 is dedicated to support staff recruitment efforts such as developing and printing flyers and using staffing registries. For further guidance this can be found in the approved waivers. See pages 209 - 212 in our Community Pathways Waiver Amendment #3 2020. Appendix C: Participant Services and DDA Memo - Individual and Family Directed Goods and Services March 8, 2021.

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7. ***If the individual does not use all their approved budget in the budget sheet, do they have access to that funding later?***

    - Yes. Participants can access funding not allocated in their approved SDS Budget Sheet throughout the plan year.
    - Participants are not required to allocate their entire budget and can submit a budget modification if needed.

8. ***Do participants need to allocate funding from their budget to pay for the new Financial Management and Counseling Services FMCS)?***

    - Yes. Once a participant begins or transitions to the new FMCS services, they must include the FMCS agency's monthly fee in the participant's budget sheet.

9. ***How do CCSs complete the budget for a revised PCP for someone in SDS? Should the budget be for the full year or partial of the year from the effective date to the Annual Plan Date?***

    - A person's SDS budget, similar to their PCP, should reflect a full PCP year. When new services are added to the PCP or a person's budget, the plan and the budget should reflect the remaining days of service for those new services in the PCP/budget year. Reference: Instructions for DDA's SDS Budget Sheet.

10. ***If there is a difference between the DSA amount of an SDS plan and the utilized amount on the attached budget form, will the difference still be available to the person as "unallocated funds" to be used throughout the year, as needed through the budget modification process?***

    - Yes. The difference in funds between the DSA and the utilized amount in the budget form, will be available for self-directing participants as "unallocated funds."

11. ***If the max rate to pay staff in our budget is $24/hour but we have extra in the budget, can we pay up to the reasonable and customary $30/hour to more experienced staff?***

    - Yes, staff wages (which include a standard 14% tax fee) may be up to the maximum amount listed in the reasonable and customary rates table.

12. *Does the vendor select their rate for services in the DSA tool, or does the participant determine the rate in their PCP meeting?*

- The Detailed Service Authorization Tool is used to facilitate communication between the provider and the participant's Coordinator of Community Services. It is optional for participants in self-directed services. The participant will negotiate with the vendor and select the service rate based on the participant's choice, budget, and other considerations.

13. *Can unused funding be carried over into the next fiscal year?*

- No. The participant and their person-centered planning team should meet each year to identify the participant's current assessed needs, and services and supports needed over the next year. This information is used in the Detailed Service Authorization to create the participant's self-directed budget allocation for the year.

14. *Can you clarify how to calculate a budget line item when doing a revised plan?*

- Revisions to the participant's person-centered plan may increase or decrease costs related to each service. This will also change the overall service allocation budget, which is usually based on a full-year. In a few instances, the allocation budget will not be based on a full year, and the self-directed services budget sheet should reflect the months or weeks in the person-centered plan. The participant may reach out to their Coordinator of Community Services and Regional Office for assistance.

15. *If the person has an unpaid support broker, how does that get into the DSA to show they have the serve & don't want it paid for under the budget.*

- In the person-centered plan, there is an opportunity to show unpaid services and supports related to each outcome and goals. The unpaid support broker would not need to be reflected in the DSA, but would be listed in the outcome section.

E. Detailed Service Authorization Tool (DSAT)

1. *Regarding virtual services, how will they be entered into the Detail Service Authorization? Will 1:1 ratios be applicable?*

- As per Memo 3- DDA Amendment 3 – Virtual Supports, the virtual support service model should be included in the Service Implementation Plan (SIP) which must be uploaded to the LTSSMaryland Documentation section.

2. *Will the DSAT be updated to allow billing for 15 minute increments for those services affected?*

- No, the Detailed Service Authorization Tool (DSAT) will not be updated to reflect 15 minute increments. The DSAT currently reflects hours of service. If specific 15 minute increments are needed, the provider can indicate in the DSAT "Notes" section. The CCS can then reflect that information in the PCP detail service authorization section.

3. *Will Support Broker Services need to be calculated in 15 minute increments?*

- No. Support Broker Services can be calculated in hour increments.

4. *If Nursing was previously funded, will the cost detail say new service or no change because of the name change to Nursing Support Services?*

- The Detailed Service Authorization section of the PCP is LTSSMaryland will automatically reflect a new service line with Nursing Support Services unit calculations on March 1, 2021. For additional information, see page 10 in the Memo #2 - DDA Amendment #3 - Person Centered Plan Changes - February 16, 2021

5. *Will new DSATs be released to reflect the consolidation of Day Habilitation groups and Nursing Support Services?*

- The DSAT was updated on March 18, 2021 to reflect these service changes. Reference: Detailed Service Authorization Tool (DSAT) Form – Revised March 18, 2021

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6. ***Is the cost detail needed for Personal Support services? Previous guidance suggested that services currently billed in LTSS are not required to be included in the cost detail.***

   - A cost detail tool is not needed for Personal Support or other services that are billed in LTSS*Maryland*. Additionally, the DDA has recently updated the Detailed Service Authorization Tool (DSAT) to include the justification tab previously found on the Cost Detail Tool. Please see recent guidance regarding that update.

7. ***If a participant needs 30 hours of 1:1 at the day program, do we enter that as 30 hours of 1:1 or do we enter a "base rate" of day hab groups plus an entry for 1:1 hours?***

   - The DSA should reflect 30 hours of 1:1 support only.

8. ***If a client gets 30 units a month and uses only 20, do the 10 units carry over to the next month?***

   - No. Units are projected per month. If health and safety concerns for increased supports are needed, a plan revision should be requested.

F. Community Settings Questionnaire (CSQ)

1. ***How often will CSQ compliance letters be issued and how are the results of the CSQ shared with the provider?***

   - On a monthly basis, the DDA will send a report to the Office of Long Term Services and Supports (OLTSS) with a report of compliant/non-compliant sites. Letters will be sent to providers by OLTSS within 30 days of the data being received from the DDA. Non-compliant providers will have 30 days from the receipt of the letter to complete remediation.

2. ***How are CSQ's assigned to the CCS for a given site? Is the overall site compliance determined on an individual or collective base?***

   - CCS completes the CSQ for everyone they support. CSQs are not assigned by provider sites. Every participant in services must have a CSQ completed at a minimum of annually and/or within 30 days of a move to a new residence (*e.g.,* own home, family home, provider site) or day program site. Compliance is determined on an individual basis, and should be based on the individual's personal experience.

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3. ***What is the role of the provider, guardian and family in the development and completion of the CSQ? How are findings validated?***
    - CCS' are required to provide verification of determination through site visit(s), discussion with participants during the PCP process, review of relevant documents such as activity schedules, meeting minutes, provider policies, or other documents, photographs or direct observation, and discussion with family or other representatives in order for CSQ to be validated. The CCS should work collaboratively with the participant and provider to work through the CSQ development and planning process.
4. ***When will the CCS be required to complete the CSQ? Will the completion of the CSQ have any bearing on the PCP submission and/or the approval of the PCP?***
    - The CSQ is required to be completed with the participant annually and/or within 30 days of the participant moving to a new home or day program. The Day CSQ is required for both Day Habilitation and Career Exploration - Facility Based Services . The Residential CSQ is required for all participants. While the CSQ is completed during the planning and development of the PCP process, it does not affect the overall decision and approval of the PCP.
5. ***Does the HCBS final rule apply for employment service only providers?***
    - The HCBS final rule applies to all services. Employment Service only providers are community-based and must meet the HCBS final rule.
6. ***Will family members receive compliance letters for family members who receive Residential Services?***
    - Should a participant wish to have that information shared, family members will be informed if a site is found to be non-compliant. The CCS will coordinate a team meeting to ensure all team members are aware of their options.
7. ***How long will it take to receive a notice of compliance after a non-compliance letter was received?***
    - Providers will have 30 days to remediate a non-compliant site upon receipt of the non-compliance letter from the OLTSS. The OLTSS will issue a compliant letter within 30 days of successful remediation.

8. ***Can the PCP residential service authorization serve as a legally enforceable agreement? Can the CCS request a copy of the lease/residential agreement?***

    - The Residential Service Authorization is not a legally enforceable agreement and should not be used to validate CSR compliance. The CCS should instead request a copy of the lease or other agreement that anyone (with or without a disability) would use to verify occupancy.

9. ***Will conflicting CSR compliance reports affect the overall licensing status of the site?***

    - CSR compliance is largely based on the perspective of the participant in services. In settings where there are more than one person and the results of their CSQ may be conflicting, the validation process will be followed by the Regional Office to determine compliance or non-compliance.

VIII. Self-Direction

A. Forms and Processes

1. ***How does one go about selecting the suitable FMCS?***

    - Financial Management and Counseling Services (FMCS) are provided by qualified providers that help you with your responsibility for your employee payroll, and related tasks, as well as paying other bills for services outlined in your PCP and budget. Your CCS agency can share information about current providers and help you select one of the FMCS providers.

2. ***Is the CCS required to assist the person and the family with finding vendors for services?***

    - Self-direction is a service model that gives you decision making authority and responsibility for hiring and managing your services with your selected team. Your CCS is part of this team and will assist you with learning more about services and options. You can also work with a support broker who can provide you with information, coaching and mentoring on your responsibilities as an employer. Additional information on the roles and responsibilities in self-direction can be found here.

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3. ***If someone wants to switch from traditional services to self-directed services, what is the process?***

    - Your CCS agency can assist you with this planning and process. This will involve a revision to your person-centered plan to reflect self-directed services.

4. ***Can a participant in self-direction access 24 hour supports or do they have to transfer to the traditional service model?***

    - Yes. Participants self-directing can explore Supported Living services. Resource: Supported Living Policy. They may also be eligible for overnight personal supports based on assessed need.

5. ***Can participants in self direction access traditional providers for day services or respite?***

    - Yes. Participants can reach out to DDA Providers for day service and respite for the delivery of the services.

6. ***When someone switches from traditional to self-direction, whose responsibility is it to send the FMCS the SDS Budget Sheet?***

    - After the DDA reviews and approves the updated PCP, the team should send the PCP, SDS Budget Sheet, Family as Staff form, and any applicable wage exception forms to partipant's chosen FMCS agency. Submission of the PCP and Budget to the FMCS may be by the participant, CCS, or other team member; teams should follow the submission method of the FMCS (email, uploading into the FMCS portal, etc.).

7. ***Can you explain what the Financial Management and Counseling Services group does? Do FMCS services overlap with Support Broker services?***

    - Financial Management and Counseling Services (FMCS) helps the participant with their responsibilities for employee payroll, taxes, and related tasks, as well as paying other bills for services outlined in their person-centered plan and budget. The FMCS's responsibilities should not overlap with the Support Broker's responsibilities. For more information, please review the DDA Self-Directed Services Handbook.

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8. ***In regards to the Monthly Service Reports, please explain which date the reports are based on: the date of the PCP (which may be at any time) or the traditional fiscal year of July 1 to June 30? We have a lot of trouble figuring out how much sick leave is left, or how many hours are left in a category.***
    - The Financial Management and Counseling Service providers issue monthly reports and are able to provide more details on those reports, including the report start date.
9. ***Do participants in Calvert County etc. need to complete the exception form? Or is this allotted in the DSA Allocation?***
    - No, the exception form is not required to update the DSA budget allocation. LTSS*Maryland* automatically reflects the higher rates for those counties in the budget allocation.
10. ***Will the unallocated funds that are seen as "remaining funds" be listed as "unallocated funds" on the person's FMS statement?***
    - No.
11. ***In the budget monitoring process who creates the Monthly Statements?***
    - The Financial Management and Counseling Services provider creates the Monthly Statements for the participant.
12. ***Who notifies vendors when an individual's plan and budget is approved and the start date? Also how is a vendor kept abreast of what is left in the budget as the year goes by?***
    - The DDA sends notice of the approved plan to the participant and Financial Management and Counseling Services provider. The participant, as the employer of record, can work with their staff, vendors and providers to provide updates and coordinate the start of services. The participant is responsible for overseeing and monitoring their budget to have funding for their employees, vendors, and providers throughout the year.
13. ***If you have family as staff who were hired/working prior to Appendix K -- COVID-19, is the new Family as Staff form required?***
    - For family as staff already identified in the PCP, this form will be used during the PCP process (annual and revised).

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14. ***After the expiration of the Appendix K waiver allowing parents to work over 40 hours, how will parents as support staff be considered for approval by the DDA to work over 40 hours going to notify the FMS?***

- The Family As Staff form submitted directly to the FMCS for Appendix K unwinding that includes relative(s) noted as working more than 40 hours per week must be reviewed and approved by the DDA.

15. ***Does the family as staff option form need to be completed only for current family members as staff? Or will the form be required to be completed for current family as staff and all future family members as staff?***

- The DDA SDS Family As Staff form is required when hiring and using a relative. If a participant has previously completed the Family As Staff form process for a relative as noted in a DDA approved plan, then they do not need to take any action related to that relative until the next Annual or Revised PCP is completed. All new relatives and relatives hired during the public health emergency that were not noted in a Family As Staff form will need to be completed.

16. ***Will everyone have to fill out a new Participant Agreement Form with this update? Or will it need to be filled out at the next annual meeting or plan update?***

- If the participant chooses to appoint or designate different team members - acting as their agent - to complete specific tasks as noted under the Appointment of Specific Tasks then the form needs to be completed now to utilize these options. If the participant chooses to be the person responsible for managing all of their employer authority and budget authority under the SDS delivery model and they do not have a legally responsible person or legal guardian, then the form can be completed during the next Annual or Revised PCP.

17. ***Does the Participant Agreement replace the Waiver Agreement or is that form still required?***

- Yes. The Participant Agreement replaces the legacy self directed services waiver agreement.

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18. ***Which of the 4 options on the FAS form should the person choose if they are hiring a support broker who is NOT a family member?***

- Option #4 is checked when the participant chooses to appoint specific team members (including paid and unpaid team members) to assist them with specific tasks related to their roles and responsibilities under self-direction.

19. ***Can more than one team member be listed under each bullet on the form?***

- No. Only one person can be listed under each bullet.

20. ***Is a support broker required for those who need a Family As Staff (FAS) form completed prior to 6/30/2023 due to the unwinding of Appendix K?***

- No. The Coordinator of Community Services can assist the person in completing the form.

21. ***Is there a form that has to be completed for an individual to accept being the designated representative or to resign from being a designated representative?***

- The Participant Agreement can be used to appoint a designated representative by selecting the third option and listing them as Person #1 under the team member list. If the designated representative wishes to no longer be in this role, they should submit a statement in writing (such as a letter or email) to the participant and copy the Coordinator of Community Services.

22. ***If the participant goes the team approach and thus does not select a designated representative, is there a requirement as to the number of team members?***

- No. Participants choose their team members. There are no program requirements beyond the Coordinator of Community Services and Financial Management and Counseling Services team members to complete their respective tasks as outlined in the approved programs.

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23. Does the new FMCS provider need to be selected prior to the nursing having access to the HRST?

- No. Current participant's receiving nursing support services can access the HRST under the FMS services. New participants entering services will be provided access by the FMCS once selected.

24. Do vendors such as delegating nurses get login credentials to submit their own invoices?

- Any team member can obtain login credentials. Please contact your FMCS Agency for assistance. Please note, all vendors, including delegating nurses must issue invoices to the participant.

B. Benefits and Rates

1. Where is PTO (paid time off) entered in the self-directed budget sheet? Is this the same place to document sick and safe leave required for some counties?

- Paid Time Off (PTO) was recently added to the SDS Budget Sheet and is a separate stand alone item under benefits when hiring staff. Resources: DDA - Self Directed Services Budget Sheet and Instructions for DDA's SDS Budget Sheet

2. When does the PTO (paid time off) reset in a plan year?

- PTO is an optional benefit participants can offer to their staff. Participants indicate this option within their SDS Budget Sheet. Participants should create paid time off policies that are equitable and fair for all employees.

3. What benefits can be requested for staff and are these limited to staff working full-time (40 hours per week)?

- For services for which you have employer authority, you can allocate funds to cover staff benefits such as health benefits, staff training, and transportation/travel reimbursement.
- Depending on your business and reimbursement policies, you may choose to provide travel reimbursement for expenses your employees incur while directly supporting you. It does not include reimbursement for driving to and from work but may be offered for costs incurred during the course of direct service delivery, such as during direct

personal support services. Expenses that fall outside of the policies are generally not reimbursed or covered. Receipts are required by most employers except for those that pay a per diem, which means you reimburse your employees a fixed amount of money "each day" to cover incidental expenses such as transportation. You are not required to provide per diem to employees. You may choose to have a per diem payment cover part, or all of the expenses incurred.

- Some laws require employers to offer certain benefits to part-time employees. State and local laws vary and may require that benefits such as paid sick leave, short-term disability, or health insurance plans or premiums be offered to part-time employees.

4. ***Are SDS participants allowed to pay overtime as long as it is within their allocated budget?***

    - Yes, as permitted by the federally approved programs. Please note that the approved Waiver programs services have some restrictions such as legal guardians or relatives can provide no more than 40- hours per week of service.

5. ***Where can we find the reasonable and customary rates for employees, vendors, and providers?***

    - The DDA Reasonable and Customary Rates and Wages charts are posted on the DDA website.

6. ***How can SDS participants offer health benefits to their employees? How will this be billed or reimbursed?***

    - As a participant in self-direction, you are the Employer of Record and therefore have the authority to use your authorized budget to pay your employees the rate per hour of your choosing and offer benefits, as long as it is within Department of Labor (DOL) requirements and the DDA's policies including reasonable and customary rates located on the DDA's website. Health benefits are included as a line item in the SDS Budget sheet and paid by the FMCS.

7. ***Do staff wage increases within the reasonable and customary rate range set by DDA need to be approved by the DDA?***

    - No, as long as the total with the wage increases does not exceed the participant's budget allocation.

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8. ***Do the DDA maximum Personal Supports wages include the staff wage, taxes, and any benefits including mileage? Or is the maximum wage just the wages, and the left over for the rate goes towards the benefits, taxes, etc.?***

    - The DDA Reasonable and Customary Wages for direct support staff only includes the wages for the staff. The cost of any benefits and taxes are separate and should be calculated in the SDS Budget sheet from the participant's overall budget allocation.

9. ***How and when will an increase in a provider's rate be handled?***

    - Provider rate can change based on Cost of Living Adjustments approved by the General Assembly and Departmental decisions.

10. ***Can relatives and family members work overtime if authorized by the participant?***

    - The legal guardian or relative can provide no more than 40- hours per week of the service unless authorized by the DDA. Please note that all expenditure of funds must be in accordance with the authorized PCP and SDS Budget Sheet and program requirements. The participant cannot exceed the amount allocated in the Self-Directed Budget Sheet during the PCP year.
    - Participants may choose to exempt immediate family members from overtime and minimum wage laws. “Immediate family” for purposes of Maryland Wage and Hour Law means,
        - An employer’s parent, spouse, child, brother, sister, grandchild, or grandparent who:
            - Resides with the employer; and
            - Enjoys the same privileges as other members of the family.
        - “Immediate family” does not include anyone living outside the employer’s household, except the employer’s parent, spouse, or child.
        - “Child” means a natural child, adopted child, or stepchild but doesn’t not mean the spouse of that child.

C. Hiring and Training

1. ***Can family members get paid for their work in self-directed services?***

    - Yes, family members may be paid for providing some waiver services whenever they are qualified to provide these services. For more

information on which services can be provided by family members, please, see the service level detail in Appendix C-1/C-3.

2. ***Is it possible to hire staff for Supported Living under Self-Direction and is there training required?***
    - Participants using the self-directed model have budget authority over supported living services. Participants can work with supported living providers and identify staff they are interested in receiving services for which the provider can then consider hiring and training. Staff training requirements are noted in Appendix C-1/C-3 on page 266.
3. ***Are all employment services available to self-direction with employer authority?***
    - No. If enrolled in the self-directed services delivery model, the participant may exercise employer authority for Ongoing Job Supports and Follow Along Supports only. The participant may not exercise employer authority for the following types of Employment Services: Discovery, Job Development, Self-Employment Development Supports, or Co-Worker Employment Supports.
4. ***Are there training requirements that apply to SDS staff to be able to provide any of the employment services?***
    - Yes. Staff must have a GED or high school diploma; possess current first aid and CPR certification; and unlicensed direct support professional staff who administer medication or perform delegatable nursing tasks as part of this Waiver service must be certified by the Maryland Board of Nursing (MBON) as Medication Technicians, except if the participant and his or her medication administration or nursing tasks qualifies for exemption from nursing delegation pursuant to COMAR 10.27.11.
5. ***What services can participants hire a relative to provide?***
    - Relatives can be hired for the following services: Community Development Services; Employment Services (Ongoing job supports and follow along only); Nursing Support Services, Personal Supports; Respite Care Services; Support Broker; Supported Living; and Transportation. It is important to remember that the DDA Waiver services (for which a relative is hired to provide) must be included in the participant's authorized Person-Centered Plan (PCP) and follow all of the program's rules and requirements.

6. ***What are the program requirements for family members who wish to work as staff for participants? Are there any special considerations or requirements when the participants are minors (under 18 years of age)?***

- To ensure the use of a relative is in the best interest of the participant, the legal guardian or relative (who is not a spouse) may provide specific services in the following circumstances, as documented in the participant's Person-Centered Plan (PCP):
    - The proposed individual is the choice of the participant, which is supported by the team;
    - Lack of qualified provider to meet the participant's needs;
    - When another legally responsible person, legal guardian, or relative is not also serving as the participant's Support Broker or designated representative directing services on behalf of the participant;
    - The legal guardian or relative provides no more than 40- hours per week of the service unless authorized by the DDA; and
    - The legal guardian or relative has the unique ability of relative to meet the needs of the participant (e.g. has special skills or training like nursing license)
- When a legally responsible person, legal guardian, or relative is the Support Broker or designated representative who exercises decision making authority for the participant, then other legal guardians and relatives are not allowed to provide services.
- Legally responsible persons may provide services when the participant care exceeds the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age and which is necessary to ensure the health and welfare of the participant and avoid institutionalization. The care would be considered "extraordinary care."

7. ***With the Participant Agreement Form, if a family member is both paid staff and has management duties, is this allowed? And, if allowed are there any restrictions?***

- It is important that the participant is always at the center of planning a vision for their personally-defined good life.
- As each participant's circumstances and choices will differ, it is important for the participant and their team to discuss the option to use relatives as staff and use a team approach for their employer and

budget responsibilities. Some of the discussion should include potential conflicts of interest in using relatives or team members under the participant agreement. To address these conflicts, checks and balances can be put in place such as using a neutral third party Support Broker.

8. ***If a team is doing the tasks assigned by the participant, the team member is considered to be legally responsible or not? And is that creating a conflict of interest?***

    - If the participant chooses to appoint or designate a team member, the team member is considered to be acting as the participant's agent.
    - As each participant's circumstances and choices will differ it is also important for the participant and their team to discuss the option to use relatives and legally responsible persons as staff and use a team approach for their employer and budget responsibilities. Some of the discussion should include potential conflicts of interest in using relatives or team members under the participant agreement. To address these conflicts checks and balances can be put in place such as using a neutral third party Support Broker.

9. ***Any employee can also be on the team to help train, hire or submit timesheets?***

    - As each participant's circumstances and choices will differ it is important for the participant and their team to discuss the option to use a team approach for their employer and budget responsibilities. Some of the discussion should include potential conflicts of interest in using *employees* under the participant agreement. To address these conflicts checks and balances can be put in place such as using a neutral third party Support Broker.

10. ***Can family members not working as staff be assigned tasks by the team along with paid family members?***

    - As each participant's circumstances and choices will differ it is also important for the participant and their team to discuss the option to use a team approach for their employer and budget responsibilities. Some of the discussion should include potential conflicts of interest in using *family members (not working as staff)* under the participant agreement. To address these conflicts checks and balances can be put in place such as using a neutral third party Support Broker.

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- The Coordinator of Community Services (case manager) can not be assigned tasks.

11. ***Who is able to sign a family as staff timesheet if there is not a paid support broker?***

    - The participant can sign the timesheet as the employer of record. They can also consider other team members and use the Participant Agreement to appoint an agent working on their behalf. Support Brokers shall not make any decision for the participant, including signing off on service delivery or timesheets.

12. ***Can staff get paid for the time they are in training as well as for the cost of the training?***

    - Yes. A participant may choose to budget for both payment for a training and for the wages/taxes for an employee to attend a training.

13. ***Can PTO funds be used at the end of the participant plan year?***

    - Paid Time Off hours (PT0) can be accessed throughout the year by employees based on the participant's PTO policy. However, PTO cannot be paid out to employees in a lump payment in lieu of taking time off.

D. Individual and Family Directed Goods and Services (IFDGS)

1. ***Does staff recruitment costs come from the participant's budget?***

    - Yes. The DDA has allocated $500 per annual plan year for these costs which come out of the person's budget.

2. ***Where can I find a detailed list of services that are covered under IFDGS for each of the DDAs waivers?***

    - Individual and Family Directed Goods and Services (IFDGS) are services, equipment, or supplies that are not usually covered under a Medicaid program. IFDGS help participants to maintain or increase independence and promote opportunities to live in and be included in the community. The IFDGS must relate to a participant's need or goal identified in the participant's Person-Centered Plan. The federally approved waivers include some examples of IFDGS. The waivers also include a list of non allowable IFDGS. Reference: Family Supports Waiver pages 133 - 135.

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E. Support Broker

1. ***Can a support broker provide both personal support and support broker work?***

    - Support brokers can *temporarily* provide other waiver services to the participant at the rate applicable to that other waiver program service until 6/30/2023 as per the Appendix K.

2. ***Can a family member, legal guardian or representative payee serve as the support broker?***

    - A relative (who is not a spouse, legally responsible person, legal guardian, or Social Security Administration representative payee) of the participant may be paid to provide support broker services. A spouse or legally responsible person may provide Support Broker services, but may not be paid by the Waiver program.

3. ***Does Support Broker fees come from the participant's budget?***

    - Yes.

4. ***Is there a limit to the amount of hours an independent Support Broker is allotted in a participant's budget?***

    - Yes. As per the approved programs, "Information, coaching, and mentoring up to 4 hours per month unless otherwise authorized by the DDA".

5. ***Is the Support Broker max rate of $67.60 per hour allowable for non-agency Support Brokers, or is it still only allowable for agencies?***

    - The maximum rate of $67.60 per hour can be used for vendors and providers. It is a fully loaded rate meaning it already includes costs associated with taxes, benefits, and other costs components. When hiring staff the staff wage should be considered reasonable and customary compared to other staff wages. Since the wage was developed for vendors and providers it would not be considered to meet this standard.

6. ***Are Support Broker services required in order to participate in self direction?***

    - No. Support Broker services are not required in order to participate in the self directed service delivery model. Support Broker services

includes employer related information and advice for a participant in support of self-direction to make informed decisions related to day-to-day management of staff providing services within the available budget. It is an optional service that may be requested.

7. ***The Case Manager and the Support Broker can be assigned tasks by the participant as team members?***
   - The Coordinator of Community Services (case manager) can not be assigned an employer or budget authority task.
   - As each participant's circumstances and choices will differ it is also important for the participant and their team to discuss the option to use relatives and legally responsible persons as staff and use a team approach for their employer and budget responsibilities. Some of the discussion should include potential conflicts of interest in using *Support Brokers* under the participant agreement. To address these conflicts checks and balances can be put in place.

8. ***If team members are designated for specific tasks, then which specific tasks are required to be performed by the Support Broker in order to be compliant?***
   - Support Brokers services, as noted in the approved waivers as an optional service, includes coaching and mentoring the participant on their responsibilities as a common law employer related to employer and budget responsibilities as per federal, State, and local laws, regulations, and policies. As noted in the programs, the Support Broker must not:
     - Develop modifications;
     - Make any decisions for the participant as the Employer of Record including budgetary decisions;
     - Sign-off on timesheets for service delivery; or
     - Hire or fire workers.

F. Transportation

1. ***With the changes in the self-direct budget sheet, do staff still submit a mileage reimbursement sheet to the FMS?***
   - Staff should submit mileage reimbursement requests to the participant, who is their employer, prior to submitting to the FMCS.

2. ***With the changes in the self-direct budget sheet, does the staff rate now need to include the costs for transportation?***

   - For employer authority services for which a participant hires staff, they can include transportation related costs under the benefit section for the applicable services and allocate funding based on their business model. See [Instructions for DDA's SDS Budget Sheet](#) for additional information.

3. ***Would the stand alone transportation line in the self-directed budget sheet be used for services such as Uber or Mobility to get to places when staff cannot provide transportation to an individual?***

   - Yes. The stand alone transportation service is used when the person is independently going to places within their community and staff are not present.

4. ***If I am using and budgeting for Uber or Public transportation as part of my plan, can I also receive staff support when using these resources? If so, how do I document staff reimbursement for these costs when they are with me?***

   - No. The stand alone transportation service is used when the person is independently going to places within their community and staff are not present. When staff are present and providing transportation this would be included under the direct service the staff is providing such as community development services or personal supports.

G. FMCS Transition Guidance

1. ***Do all SDS participants need to do the new budget sheet during open enrollment, even if they are not changing their FMS?***

   - Yes. Everyone who currently self-directs their services will need to complete an updated SDS Budget Sheet to include the fees associated with their chosen FMCS.

2. ***Given that the FMCS fees are quite different, are there any other fees that aren't included in the totals such as reporting or higher fringe charges?***

   - Projected taxes percentage by FMCS agency are:
     - GT Independent - 14%;
     - Public Partnership LL - 12.11% for new participants and 14% for current participants self-directing ; and

- The Arc Central Chesapeake Region is 14%.
- If there is a savings due to a special tax exemption, your FMCS will advise you.

3. ***Is it required to add the FMCS in the Outcomes or Focus Areas?***
   - The PCP is a holistic plan that includes natural, community, and Medicaid funded services. All plans should reflect applicable supports for each Outcomes including FMCS.
4. ***Can the DDA COVID Form #5 still be used before the FMCS selection process starts?***
   - Yes. The DDA COVID Form 5 continues to be the form for budget modifications through 1/31/2023.
5. ***With the selection of a new FMCS, will there need to be a change of the support broker?***
   - No. A Support Broker can be hired by the participant and their team at any time. The Support Broker works directly for the participant and are not associated with any FMCS agency.
6. ***If someone is currently enrolled with an FMS, and has no intentions of changings agencies, do they just fill out the participant choice form and submit, or do they need to also complete the transfer process and documentation completion?***
   - The participant must complete the transition process even if they plan to stay with the same agency. In this situation, the process includes informing their CCS of their informed choice and creating the new DDA - SDS Budget Sheet- Revised July 21, 2022 - FMCS Addition. The CCS also need to indicate the choice of the chosen FMCS in *LTSSMaryland*, even if they are continuing with the same agency they have worked with previously.
7. ***What occurs if the Annual Plan date is within the FMCS choice period/ open enrollment?***
   - If the Annual Plan date occurs prior to the person's selected transition date (i.e. October 1, 2022 or January 1, 2022) then both the historic and new processes will need to be completed. The DDA Regional Office Self-Directed Lead is available for assistance.

8. ***Do all PCPs need to be revised for the new rates and the new FMCS choices by November 2022?***

    - No. PCPs should only be revised if participants need to take advantage of the July 2022 rates (to access unallocated funds). If a participant plans to pay for their FMCS fees from unallocated funds or cost savings, they will only need to complete an updated SDS Budget Sheet with the FMCS fees included.

9. ***Will the FMCS agency be added to the DSA in the PCP again? How will this be calculated as the fees are quite different?***

    - No. The FMCS fees will not be added as a service in the Detailed Service Authorization. The monthly fees for the FMCS will come from participants' approved budget allocation. The budget allocation is based on traditional provider rates. One of the components of the rates is referred to as general and administrative cost. Examples of costs within this category are costs associated with confirming staff qualifications, paying employees, tax reporting, and accounting. These are some of the functions of the FMCS. Therefore, the service rates used in LTSS*Maryland* to create the self directed budget allocation already includes a cost component for the FMCS services in each service.

10. ***If our submitted plan has not yet been approved or is in process, can we request a change now?***

    - Changes can be made to plans that are in process with the CCS. Plans can not be changed if they were submitted to the DDA unless the CCS advises the DDA.

11. ***Do the plan and budget need to be sent from DDA to the new FMCS?***

    - No. As part of the new FMCS processes:
        - The FMCS agencies will receive the PCP from the team; and
        - The participant, with the support of their team, will send their SDS Budget Sheet and Family As Staff Form directly to the FMCS.
    - The CCS must also upload these documents into *LTSSMaryland* Client Attachments. Reference: DDA -FMCS Transition, PCP, SDS BudgetSheet, and Timesheet/Invoice Process Updates and Guidance

12. ***What if the individual doesn't have enough unallocated funds to cover the FMCS charge?***

    - If the participant does not have enough unallocated funds, they must work with their team to:

- Move funding in their current budget to account for the FMCS fees; or
- Revise the PCP to include the July 2022 rates (if the PCP was approved before July 1, 2022)

- Please refer to the DDA -FMCS Transition, PCP, SDS BudgetSheet, and Timesheet/Invoice Process Updates and Guidance for additional information.

13. ***How will the FMCS handle if there is a delay in getting the plan and budget approved?***

- If a PCP has expired, the DDA will either authorize continued payment on the expired plan or advise the FMCS to stop payment services on a case-by-case basis.

14. ***Will the FMCS or DDA recreate a vendor payment template and approval process for services?***

- The Department is working with the FMCS to propose standard requirements across all FMCS.

15. ***If a person is enrolled with the Arc CCR as the FMS and chose them as their FMCS, will we need to resend all the documents again?***

- The participant must complete the transition process even if they plan to stay with the same agency. In this situation, the process includes informing their CCS of their informed choice and creating the new DDA - SDS Budget Sheet- Revised July 21, 2022 - FMCS Addition. The CCS also needs to indicate the choice of the chosen FMCS in *LTSSMaryland*, even if they are continuing with the same agency they have worked with previously.

- The participant will not need to share the following documents, unless requested, as the agency should already have them:

  - PCP
  - Participant Agreement
  - Family As Staff Form
  - Current SDS Budget Sheet
  - Employee information including wage rate
  - Any Wage Exception Forms
  - Vendor Forms
  - Service Implementation Plans
  - Employee/vendor schedules
  - New SDS Budget Sheet

- Please note the FMCS may request additional information based on program standards to ensure employees and vendors are qualified.

16. ***Where in LTSS will the SDS budget, Family as Staff Form and Wage Exception form be uploaded after PCPs are approved?***
    - As part of the FMCS transition, the CCS uploads these documents in the *LTSSMaryland* Client Attachments.

H. SDS Background Checks

1. ***With the update related to background checks, will I need to get another set of fingerprints done if I was recently fingerprinted?***

    - Individuals should check with the FMCS to ensure appropriate background checks are completed as per the program requirements.

2. ***How often would any vendor have to update their fingerprint report if not done under the State or the FMCS account number?***

    - The DDA requires vendors to update their fingerprints once during the clearance process under the FMCS. However, participants may require different standards. Vendors are responsible to conduct and pay for the background check as this is not a provision of the FMCS for vendors.

3. ***Are all employees of the Vendor entity required to meet background check requirements?***

    - All direct support professionals need to meet background check requirements. This includes participant's employees and staff from vendors and providers.

I. SDS - Electronic Visit Verification

1. ***Where can I find information on EVV?***
    - Electronic Visit Verification (EVV) is a federal requirement for all individuals receiving personal supports in their home or in the community. Information on EVV can be accessed on the DDA website Electronic Visit Verification (EVV) Page. If you have specific questions, please contact your CCS or DDA Regional Office for additional guidance.

2. ***When will individuals who are self-directing begin to use EVV?***

    - Individuals who are self-directing will transition to EVV on January 1, 2023. More information about EVV in self-direction can be found in Section VII, Sub-section I of this document - Self-direction Electronic Visit Verification .

3. ***Why is electronic visit verification for Personal Supports required?***

    - Electronic Visit Verification (EVV) refers to technology that electronically verifies that services are delivered at the right time, in the right place and to the right person. The Federal 21st Century CURES Act requires that Maryland uses EVV.

4. ***How will I get information on the EVV Application (App) that my FMCS will be using?***

    - Each FMCS has different tools and technology for EVV. Please contact your FMCS for information on the App they use and instructions on how to use it.

5. ***How many times can an employee miss a clock-in or clock-out before they are considered non-compliant?***

    - The MDH policy allows each direct support professional (DSP) up to six (6) unexcused service modifications a month. Please see Guidance for Electronic Visit Verification for Self-Directed Services for additional information about EVV compliance. DDA SDS EVV Guidance

6. ***Do Nursing, Support Broker Services, IFDGS, and other services have to meet EVV compliance?***

    - No. Only Personal Supports and Respite services must meet EVV requirements. Each FMCS has a different method for submitting time electronically for all services. Reach out to your FMCS to get information on how to record service records and time.

7. ***Can you edit employee time using the telephonic system? (Updated - March 10, 2023)***

    - Each FMCS has a different EVV system. You will need to contact your FMCS to learn more about their system.

8. ***If you provide two different kinds of support (like PS and Respite), is it an error if you forget to log-in and log-out of one before the other?***

    - Each DDA approved service is different. When an employee provides more than one service, they need to clock in and out separately for each service.

9. ***Does EVV involve GPS monitoring?***

    - No, EVV does not monitor where you go. It only captures your location when you are using it. It takes a "snapshot" of when and where you clock in and clock out of your shift.

10. ***Are DSP's required to sign in and out immediately before and after their shift?***

    - All employees providing Personal Support and Respite must clock in when they begin work and clock out when they end work.

11. ***Define corrective action and how issues in implementing corrective actions will impact the participant.***
    - Corrective actions are training on EVV and development of plans to prevent missing time requests. Implementing corrective actions support awareness, training, and other strategies to meet program requirements. Please see Guidance for Electronic Visit Verification for Self-Directed Services for information about EVV compliance and corrective action. DDA SDS EVV Guidance

12. ***How does one use EVV for virtual support? (Updated - March 10, 2023)***

    - Each FMCS has different tools and technology for EVV. Please contact your FMCS agency for information on the App they use and instructions on how to use it.

13. ***Who is responsible at the State level for oversight of the three FMSC providers. How will their performance be evaluated? What are the options for participants to file complaints and concerns?***

    - The DDA Operations Unit oversees contracts. If you have questions or concerns, please contact Monica Hariri, MDH FMCS Program Manager, monica.hariri1@maryland.gov

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14. Does EVV round the time to the quarter hour? (Updated - March 10, 2023)

- EVV clocks in by the minute and rounds up and down based on DDA's billing standards.
- Reference: Billing Service Procedure Codes with a 15 or 60 Minute Unit

15. Can other forms of technology such as an Ipad or tablet be used in replace of a phone for EVV clocking in and out?

- Each FMCS has different tools and technology for EVV. Please contact your FMCS for information on the App they use and instructions on how to use it.

16. How are overnight supports reported in the EVV system?

- EVV is required for Personal Supports and Respite when and clocks in or out of a shift. This includes overnight supports.

17. If the employer corrects an employee's time using a manual time entry (MTR) before the timesheet is approved, will the MTR be counted as non-compliant?

- MTR's for Personal Supports and Respite Services that do not meet the EVV requirements are considered non-compliant. Please see additional guidance about MTR compliance. DDA SDS EVV Guidance

18. Will new DSP's who start after January 1, 2023 receive the 6 month transition period?

- No. The transition period for EVV is for current SDS participant employees. Employees will not receive additional transition time.
- During the transition period, participants and their teams should consider writing policies and procedures that help new employees understand how to be compliant with EVV. Their FMCS is available to assist the participant, as well as Support Brokers, who can be very helpful with writing policies and procedures.

19. Does the support broker use EVV and if so, how does the participant review and submit that?

- No, EVV is not required for Support Broker Services. Support Broker vendors should send participants a timesheet or detailed invoice of their services each month (or more frequently).

20. Can DSP and respite staff complete timesheets at the end of the pay period?

- No. An employee's time can be approved by the participant at the end of the pay period; however, each visit must be entered at the time of service, when an employee clocks in or out.

21. Who is required to submit MTR's?

- Missing Time Requests are to be completed and submitted to the FMCS by the employer of record. MTRs should be completed within 30 days; late entries may result in delayed payment. Please see additional information about SDS Timesheet submission. DDA SDS EVV Guidance

22. How will participants approve time?

- Each FMCS has different tools and technology for approving time. Please contact your FMCS for information on the application they use and instructions on how to use it.

23. Are participants able to use a backup phone number for EVV use, in case of emergencies?

- Participants should use the EVV system of their chosen FMCS; please reach out to your FMCS for what to do in emergency situations.

24. How is employee training and info sessions compensated?

- For training, employees are paid using the training line item of the service in which they provide.

25. For families with both a family staff member and a family representative who asists with signing timesheets, who signs off on the family staff member timesheet if the family representative typically signs employee timesheets?

- Participants and their teams should consider conflicts of interest when creating the PCP and hiring staff.
- Paid employees should not sign off on timesheets.
- Support Brokers can always assist participants in reviewing and signing the timesheets for their employees.

26. What systems are in place for people who observe religious holidays that do not use electronic devices on specific holidays?

- MDH will support cultural and religious exceptions regarding the use of technology.
- An attestation indicating the specific timeline/time of day and need for a cultural or religious exemption should be submitted to the participant and their FMCS.
- The MTRs should note cultural or religious exemption and must be reviewed by the FMCS to confirm attestation prior to a payment.

27. What if the EVV technology fails or there is no internet service?

- You should contact your FMCS if you find any problems with the EVV technology so they can help resolve the issue.

28. What counts as an excused MTR?

- One example of an excused MTR may be if a person has a religious exemption from using electronic devices during a certain period of time. Another example might be if the FMCS's EVV application fails to work. These are examples, however; an excused MTR would be dependent on the specific circumstances of each event.

29. How does EVV billing occur during team meetings, and multiple employees are working at the same time?

- The employee providing direct support for the participant submits their time via EVV.
- The other employees are paid for using the training line item.
- DSP's cannot be paid for EVV submitted service times that overlap.
- This does not apply to Paid Time off or training hours.

30. What measures will be taken to secure the privacy of the employer?

- FMCS agencies must ensure private information is protected including sensitive data, such as Personally Identifiable Information (PII).
- You should contact your FMCS to discuss their policy on the participant's rights to privacy.

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31. ***Are FMCS agencies still required to provide a monthly budget statement to the participant and their team? (New- March 10, 2023)***

- FMCS agencies will no longer provide monthly budget statements. However, they are required to maintain budget statements online through their portal. Any member of a participant's team can request access to the FMCS portal with permission granted by the participant.

32. ***How do participants and teams access the Arc's Central Chesapeake Region electronic Evvie and Ivrie billing system? (New - , 2023)***

- FMCS agencies are responsible for properly training all participants and DSPs on how to use their electronic billing system. Teams should contact the Arc's CCR directly for assistance in accessing the Arc's EVV system.

IX. Services

A. Behavior Supports

1. ***The DDA Waiver states that BSS is only for a limited time. What if a person needs ongoing BSS?***

- Behavioral Supports Services (BSS) are an array of services to assist participants who without such supports are experiencing, or are likely to experience, difficulty at home or in the community as a result of behavioral, social, or emotional issues. These services seek to help understand a participant's challenging behavior and its function is to develop a Behavior Plan (BP) with the primary aim of enhancing the participant's independence and inclusion in their community. BSS includes Behavioral Assessment (BA), Behavioral Consultation (BC), and Brief Support Implementation Services (BSIS). The BA is conducted initially to determine if a formal BP is needed. BC is ongoing to support the monitoring and revisions of the BP. BSIS is a time limited service to provide assistance and modeling to families, staff, caregivers, and any other individuals supporting the participant so they can independently implement the BP.

2. ***If BSS is needed ongoing, is this something you can have added to the Budget Plan?***

    - Yes. Behavioral Consultation can be included throughout the year. Brief Support Implementation Services can be requested based on assessed needs.

3. ***What does it mean for a BP to be written in a trauma informed manner?***

    - Trauma-Informed Care means interventions that recognize the psychological, physical, and emotional effects of all types of trauma experiences. Trauma-Informed Care emphasizes the need for psychological safety, social connections and empowerment in the daily lives of people with intellectual disabilities, and the importance of a healing environment in which growth and development are supported is critical as well. When writing a behavior plan, it should take the individual's past traumas into account. For more information, please visit the Behavior Support Policy

4. ***If an individual is on the DDA waiting list and having lots of behaviors at home, can they still apply for DDA Behavior Support Services?***

    - Behavior Support is a DDA Waiver Service. If an individual is on the waiting list but has needs that may be addressed through a DDA Waiver Service, please reach out to the Regional Office and indicate that there is a change in the person's needs/circumstances. The Regional Office will update the Priority Category which may change their position on the DDA Waiting List. Additionally, an individual can reach out to Maryland Medicaid and the Behavioral Health Administration for assistance with behavioral needs.

5. ***If someone has a behavior support plan, is MANDT training mandatory for staff working with them?***

    - In accordance with DDA requirements, all Direct Support Professionals (DSP) must complete some or all of The MANDT System® requirements in order to work with individuals with developmental disabilities yearly. These requirements are detailed in the guidance available at DDA Mandt System Requirements

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6. ***Will Behavior Plans now coincide with PCP annual dates or will they stay on their own anniversary date?***

    - Behavior Plans are based on assessed need as outlined in the Behavioral Support Services policy. Behavioral Consultation includes monitoring and ongoing assessment of implementation of the behavior plan and needed updates. The Behavior Plan does not need to align with the PCP annual date but needs to be current.

B. Day Habilitation

1. **Since small and large day habilitation groups are combined into one Day Habilitation group, what is the expectation of staff ratios for this service?**

    - Day Habilitation staff ratios have not changed. Services may be provided in small groups (*i.e.*, 2 to 5 participants) or large groups (*i.e.*, 6 to 10 participants). The level of staffing and meaningful activities provided to the participant must be based on the participant's assessed level of service need. Based on the participant's assessed need, the DDA may authorize a 1:1 to 2:1 staff-to-participant ratio. Reference: Community Pathways Waiver Amendment # 3, Effective January 19, 2021

2. ***Does day hab have to be 1:1 or can it be the regular ratio that the provider has for what's adequate for the individual, such as 1:9?***

    - The person-centered planning team and the participant should discuss how this service should be provided for the participant. Some participants may best be served in small (2 to 5 participants) or large (6 to 10 participants) group Day Habilitation services, while others may have an assessed need for 1:1 or 1:2 services.

C. Dedicated Supports

1. ***Are dedicated support hours based on a person's matrix?***

    - No. Dedicated hours and residential PCIS2 add-on hours are different. Dedicated hours are based on the person's assessed need and in consideration of shared hours and overnight supervision for the home. For additional information, please review the Guidance for Operating in PCIS2 and LTSSMaryland – Revised March 15, 2021

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2. ***Can we be approved for dedicated hours for awake overnight staffing if needed for someone in CLGH services where overnight supervision is already provided?***

    - Yes, dedicated hours can be approved if the participant needs 1:1 or 2:1 dedicated support that is not covered with the overnight supervision supports. Proper documentation and justification must be provided.

3. ***Can 1:1 30 hours in lieu of day be shared with others?***

    - The DDA may authorize dedicated supports to be used to support more than one participant residing in the same residential setting if it meets each of their assessed needs and the following circumstances are met: a) The participants are retired, transitioning from one meaningful day service to another, recovering from a health condition, or received less than 40 hours of meaningful day services per week; b) The dedicated supports hours are documented in each participant's respective Person-Centered Plan; and c) The DDA provider may only bill the dedicated supports hours for one participant to avoid duplication. Please note 1:1 and 2:1 dedicated supports authorized for a participant due to medical or behavioral needs cannot be shared with other participants. Please review Memo 6 – DDA Amendment 3 – Dedicated Hours to Supports More than One Participant for more information.

4. ***Does this mean that shared service funding would be on both individual's service authorization? If two individuals are sharing 10 hours per week would the funding be for 5 hours each or both for 10 hours per week?***

    - In instances where individuals are sharing dedicated supports, the dedicated supports hours must be documented in each participant's respective Person-Centered Plan. Please note the DDA provider may only bill the dedicated supports hours for one participant to avoid duplication. Please review Memo 6 – DDA Amendment 3 – Dedicated Hours to Supports More than One Participant for more information.

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D. Employment Services

1. **Where can you find the Competitive Integrated Employment (CIE) Checklist?**

   - The Competitive Integrated Employment (CIE) Checklist can be found in the policy attachment section of the policy. For additional information, please visit the Competitive Integrated Employment (CIE) policy.

2. ***What documentation is required for approval for discovery milestones as well as to move forward with job development?***

   - The person must have a documented interest in employment or employment exploration in their PCP, or is currently employed and there is a documented interest in a different job in the PCP to be approved for Employment Services - Discovery. For additional information related to documentation needed for discovery milestones, please review the Guidelines for Service Authorization and Provider Billing Documentation.

3. ***For individuals that are seeking employment, should they request multiple employment services during their PCP to ensure that there is a continuity of supports when they obtain employment?***

   - The PCP should reflect current and anticipated needs within the plan year. The team should discuss with the person and take into consideration the applicable factors related to the person. For additional information to support flexibility within a person's service request, please review the service considerations and flexibility section starting on page 17 of the Person Centered Plan Development and Authorization

4. ***How will Employment Milestones be billed?***

   - Employment Milestones are billed via *LTSSMaryland* Provider Portal and can be viewed in the Guidelines for Service Authorization and Provider Billing Document.

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5. ***Should a person access employment supports through DORS prior to DDA?***

   - Division of Rehabilitation Services (DORS) service must be accessed first if the service the participant needs is provided and available by DORS and funding is authorized

E. Housing Supports

1. ***Is there a group of providers delivering Housing Support Services?***
   - Yes. Please follow up with your CCS or the Regional Office for additional information.

F. Nursing Support Services

1. ***Can you verify if Nurse Case Management can be used for Residential?***

   - Nursing Support Services including nurse case management is included as a component within the Community Living—Group Homes, Community Living—Enhanced Supports, Supported Living, and Shared Living Services. For additional information, please review the Approved Community Pathways Waiver—Amendment #3

2. ***Will Nurse Delegation be included in the basic rate for day programs or will it remain a non-SFP add-on?***

   - Nursing Support Services (i.e., nurse case management, nurse case management, and delegation services) are a component of Meaningful Day and Residential Services. The rates were built with the associated nursing supports.

3. ***How do you get a referral for nursing services for a client who needs assistance with medication management and what does that service look like?***

   - The participant and their team should discuss the new assessed need for Nursing Support Services. The CCS can then create a revised PCP, documenting the new assessed need, and send a service referral to the provider the participant selects for delivery of nursing services. The CCS then submits the PCP to the Regional Office for review and authorization.

4. ***With the change to nursing support, how does a provider or nurse determine what nurse service will be delivered?***

    - Based on the initial nursing assessment, the DDA Medicaid Waiver applications include the criteria associated with Nurse Consultation, Nurse Health Case Management, and Delegation services. For more information, please review the Community Pathways Waiver Amendment # 3 2021, Effective January 19, 2021

5. ***Do providers need to include Nursing Support Services for all clients who require their HRST to be reviewed annually? Or if they have a score of 3 or higher only?***

    - No. Nursing Support Services (i.e., nurse case management, nurse case management, and delegation services) are a component of Meaningful Day and Residential Services. The rates were built with the associated nursing supports and therefore should not be noted as a separate standalone service to complete the HRST Clinical Review.

6. ***Is the review of an HRST with a score of 3 or more included in the delegated nursing tasks if the individual is receiving PS only?***

    - Participants receiving Personal Supports that includes the provision of delegated nursing tasks will also need to request Nursing Support Services. Nursing Support Services includes the provision of the nurse delegation and the clinical review of the participant's Health Risk Screening Tool.

7. ***Is nursing a standalone service in Personal Supports?***

    - Participants receiving Personal Supports that include the provision of delegated nursing tasks will also need to request Nursing Support Services. Nursing Support Services includes the provision of the nurse delegation and the clinical review of the participant's Health Risk Screening Tool.

8. ***Can stand-alone nursing service funding be provided for a person in meaningful day services who need delegation of medication, tube feeding, catheter, etc?***

    - Nursing Support Services (*i.e.,* nurse consultation, nurse case management, and nurse delegation services) are included as part of the meaningful day services, therefore stand-alone services are not available.

    - In the event that additional nursing delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA's Regional Office and additional standalone Nursing Support Services delegation services hours can be authorized.

9. ***If someone has REM and receives Personal Supports through DDA, how can the HRST be reviewed?***

    - Meaningful day and Nursing Support Services nurses can conduct the second level review.

10. ***What guidance is available to complete the HRST for CCS's and nurses?***

    - The HRST initial online rater training is required for both the CCS (referred to as the rater) and nurse (referred to as the reviewer). For the CCS, there is also advanced rater training. For the nurse there is an advanced rater and clinical reviewer training.
    - Additionally, within the HRST resource tools there are Knowledge Base, Support Site and Tutorial assistance. The team at IntellectAbility will assist any agency or person with individual technical assistance as needed. Their contact information is mdsupport@replacingrisk.com

11. ***How many hours are allow for the nursing support services?***

    - The number of hours would depend on the risks and health care needs of the participant.

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12. ***For Nursing Supports, who determines which of the 3 services the person receives, or is it mandatory that the person receive all 3 if in Nursing Supports?***

    - The registered nurse will provide nursing consultation, health case management, and/or delegation services, based on the participant's assessed need. The nurse will perform an initial nursing assessment reviewing health needs, health records, physician orders, etc. which will then help to inform the level of nursing supports needed.

13. ***If someone is in res/meaningful day, does NSS services need to be outlined in the PCP since they are wrapped into the service?***

    - For the delivery of meaningful day and residential service, nursing supports services does not need to be noted in the service authorization section. It should be reflected in the provider's service implementation plan.

14. ***Are Nursing Support Services available to people participating in Day Habilitation services?***

    - The Day Habilitation services include nursing support services as a component of the service. In the event that additional delegation training supports are needed as indicated in the HRST because of a change in the participant's health status or after discharge from a hospital or skilled nursing facility, the request is reviewed by DDA's Regional Office and additional standalone Nursing Support Services hours can be authorized.

15. ***The HRST and SIS show an enhanced need for additional documentation to justify 1:1 supports, what else is required?***

    - Please refer to our guidance and policies that note approved Behavior Plans and Nursing Care Plans

G. Personal Supports

1. What are Personal Support Services?

- Personal Supports provides habilitative services to assist participants who live in their own or family homes with acquiring, building, or maintaining the skills necessary to maximize their personal independence. The service includes in-home skills development and community integration and engagement skills development supports.

2. What is the difference between enhanced Personal Supports and Personal Supports 2:1?

- Based on the participant's assessed needs, the participants can request 1:1 staff-to-participant supports or 2:1 staff-to-participant supports. In addition, an enhanced rate is available for 1:1 staff-to-participant supports when the person has significant needs as reflected in an approved Behavior Plan or Health Risk Screening Tool.

3. How does the participant access enhanced rate Personal Supports?

- The criteria for Personal Supports—Enhanced rate is: 1) The participant has an approved Behavioral Plan, or 2) The participant has a HRST score of 4 or higher. The enhanced rate will be reflected in the PCP as "Personal Supports—Enhanced." Please see Memo 5 – DDA Amendment 3 – Personal Supports

4. Does Personal Supports require a nursing assessment every 90 days?

- No. Only participants whose Personal Supports include delegated nursing tasks would need a nursing assessment every 90 days.

5. Is using public transportation approved for Personal Supports?

- Yes. Participants can use public transportation to support their Personal Support Services.

6. Does the change to include overnight PSS mean that the 82 hour max for PSS has changed?

- Personal Supports services are limited to 82 hours per week unless otherwise authorized by the DDA.

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H. Remote Support Services

1. Currently many of DDA supports for services like Supported Living and CDS (outside of Appendix K) don't support people having their supports remotely, will these services be funded under the same funding model as in person supports?

- Remote support services (RSS) can be used for Supported Living. RSS provide oversight and monitoring within the participant's home through an off-site electronic support system in order to reduce or replace the amount of staffing a participant needs, while ensuring the participant's health, safety, and welfare.
- Virtual supports are an electronic method of service delivery. Virtual supports are not a distinct, separate service under the DDA Waiver programs, but a means by which the following services may be delivered to a participant.
    - Employment Services;
    - Supported Employment Services;
    - Community Development Services;
    - Day Habilitation Services; and
    - Personal Support Services.
- As per Amendment #3, virtual supports was added to the waivers (outside of Appendix K) for CDS. Please review Memo # 3 - DDA Amendment # 3 - Virtual Supports - February 16, 2021

I. Residential Services

1. When you refer to Residential Services being the determining factor in whether a participant qualifies for the Community Pathways Waiver, what is the definition of Residential Services?

- Residential Services means provision of habilitation or other supports to a participant in a home environment, including the following services under the Community Pathways Waiver. Supported Living, Shared Living, Community Living—Group Homes, and Community Living—Enhanced Supports. For more information about DDA Waiver Residential Services, please review the DDA Residential Services Policy

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2. ***What is a retainer fee?***

    - A Residential Retainer Fee allows the provider to bill for services up to a certain amount of days when the participant is unable to receive services due to hospitalization, behavioral respite, or visits with family and friends. Residential Retainer Free is only available to providers of the Community Living—Group Home and Community Living—Enhanced Supports services. Reference: [DDA's Residential Policy]

3. ***Will the base/shared hours in CLGH rate in LTSSMaryland for a 1 person home be increased to 138 hours per week?***

    - Yes

4. ***Will the number of shared hours increase with each home size?***

    - Yes, the number of total shared hours will increase as the home size increases by one person. Shared hours are the combination of total base and flexible staffing hours.

5. ***If a person has fully dedicated 1:1 56 hours Awake Overnight, where is it recommended that we put the hours to seek authorization?***

    - The PCP service authorization can reflect Community Living - Group Home Dedicated 1:1 supports for 56 hours if the provider is not using the homes overnight supports to address this need.
    - For Personal Supports, the hours should be reflected in the services authorization section and proposed schedule.
    - For all services, overnight support must be documented in the PCP Risks section as one of the mitigation efforts in addressing applicable behavior or medical risk

6. ***If a provider is transitioning into the LTSSMaryland-DDA Module, do PCPs need to be revised related to residential dedicated supports?***

    - No. Dedicated hours already approved do not need to be revised. They should be used as needed above the base flexible hours available per home.

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7. ***What are the instructions for billing through our internal database systems that are connected through the API (Provider Upload) since the August 2022 system update?***

    - Please follow the instructions found in the updated API guide found here: https://content.govdelivery.com/attachments/MDDHMH/2022/07/20/file_attachments/2221955/Provider%20Upload%20API%20-%20User%20Guide%20Final%20V4.2.pdf
    - Please reach out to the LTSSMaryland helpdesk at LTSSHelpDesk@ltssmaryland.org to coordinate testing for your agency or to ask any other related questions.
    - Please note that the functionality is retroactive for all billing regardless of the billed date of service. This means that going forward you must indicate the number of persons in the home even for dates prior to August 2022.

8. ***If someone's address in their service authorization is incorrect, will we need to do a revised PCP?***

    - Yes. A revised PCP is still required in order to bill for this participant at the correct site and rate. However, this change will allow providers to bill for the remaining participants at the correct rate while the PCP is finalized.

9. ***How can the PCP be updated quickly so that clients are billed exactly where they lived if they change sites?***

    - In the event this occurs, the providers must work with their CCS to do the following:
        - Work to submit the revised PCP as soon as possible.
        - The person-centered plan Details section includes an option to indicate whether the person-centered plan needs to be reviewed within ten (10) business days of submission due to a significant issue or change in the applicant or participant's needs (e.g., move beginning a new job, supports needed after surgery).
        - CCS will select "Yes" next to Urgent to indicate that DDA's review of the person-centered plan needs to be expedited and additionally, the CCS should provide a note identifying that the revised plan was updated for the residential site address to ensure accurate billing.
        - Urgent must not be selected due to a late person-centered plan submission.

- If a move must be expedited before the PCP can be approved in the system, billing can still occur. You will bill for all the other participants at the given sites at the accurate rate.
  <u>*Example:*</u>
  Scenario: Participant One is moving from Site A to Site B with a pending PCP reflecting this change.
  Site A: Originally had 3 participants. Due to Participant One moving, now there are only 2 participants.
    - Bill this site for the 2 remaining participants at the 2-person rate effective the date of move.

  Site B: Originally had 2 participants. Due to Participant One moving, it now has 3 participants with 1 PCP pending approval.
    - Bill this site for the 2 participants with approved/active PCPs at the 3-person rate. Once Participant One's PCP is approved, you can then add their billing entry in at the 3-person rate.

  Note: If the PCP/service is ultimately not approved or the effective date is changed, the billing entries must be adjusted to reflect what was approved for the plan effective for the billed dates of service.

10. Are residential services billed daily, weekly or monthly?

- Residential services, specifically Supported Living, Community Living Group Home (with/without retainer) and Community Living Enhanced Supports (with/without retainer) are billed at a daily rate.
- Providers establish their own business model billing schedule and can bill daily, weekly, or monthly.

11. If a person residing in the same home fell out of the waiver, should agencies still count that person under the authorized number of participants?

- Yes. If the participant falls out of the CP waiver, billing automatically goes through the State Funded pathway. As such, you should continue to include this participant in your calculation. When their annual PCP date becomes due, they must either have a State Funded PCP or be re-enrolled in the CP waiver program for your agency to continue to be paid for providing this service to the participant.

12. ***When should providers start indicating the number of participants in the home in LTSSMaryland's Provider Portal?***

    - The billing process change where providers must indicate the number of participants in the home for providers authorized to bill for Residential Services in *LTSSMaryland* was effective August 8th, 2022.
    - Any corrections or all new billing entries for services, regardless of the date of service, must indicate the number of persons in the home.
    - Please note that *LTSSMaryland* allows for updates for up to one year from the current calendar date, for example if today is 8/31/22 you can only correct dates of services back to 9/1/21. Billing for services older than 365 days will need to be corrected using a manual billing process.

13. ***Will the new requirement where providers must indicate the number of participants in the home in LTSSMaryland affect billing in PCIS2?***

    - No. You will continue using the prior PCIS2 system and process until DDA directs you to bill in LTSS*Maryland*.

14. ***Why was the residential billing process in LTSSMaryland changed from automatic calculation of residential configuration to manual input?***

    - This update was developed to ensure appropriate rates are paid for billed services in cases where Person Centered Plans (PCPs) are not yet approved and participant eligibility is not yet updated within the system at the time of billing.

15. ***For services provided and billed through LTSSMaryland that were paid in prior months with the wrong number of participants, how do we need to correct those dates of service?***

    - Your agency should adjust the rates if you were mispaid. We highly recommend making the adjustments as soon as practical for your agency as services older than 364 days from the date of service cannot be processed by *LTSSMaryland* and would require manual adjustment.
    - Steps:
        - Locate the service to edit
        - Click edit
        - Change the number of people authorized
        - Select the edit reason
        - Click Save and Submit to adjust the service
        - Repeat for all the participants residing in the site and for all affected dates of service

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16. ***What does the "number of people authorized" refer to within the billing entry in LTSSMaryland? Is it the total number of people living in the home?***

- The "number of people authorized" refers to the total number of people living in the home that:
  - Have active CP or SF enrollment with PCPs reflecting the service for the date of service
  - Are present on the date of service or have retainer days available if they are out that day of service (max 18 days per calendar year).

17. ***Who should not be included in the LTSSMaryland billing entry when entering the number of people authorized?***

- Participants not to be included in the # of people authorized count include:
  - Participants who do not have the service listed on an active/pending PCP for the date of service
  - Participants are not under the right program (i.e. non-DDA participants, TBI Waiver, Autism Waiver, etc.)
  - Participants who are approved/active in the waiver/service but are absent and out of retainer days

18. ***Do participants living in the home without DDA funding count as Authorized?***

- No. Authorized persons do not include those who receive funding from outside programs. The numeric value entered for the Number of People Authorized should only consider those with a CP or SF PCP that authorizes the residential service billed.

19. ***What does the "number of people authorized" refer to?***

- The number of people authorized refers to the total number of people living in the home with a CP or SF PCP, that are present on the date of service, or has retainer days available.

20. ***If the site is authorized for 3, but only 2 people are living in the home on a long-term basis, what value should the provider enter?***

- Residential sites have capacities set by DDA. This capacity value should not be entered by your agency as it is only there for PCP planning purposes. The number of participants assigned to the site (with CP/SF

PCPs effective on the given date of service) are the ones that should be included in the calculation. In this scenario, the value entered should be

21. Are the rates in LTSSMaryland no longer uniform for a whole month?

- Correct. The amount paid in this system update is to reflect what was true on the given date of service.

22. If we have 3 people authorized to live in the home, but 1 person is in rehab, should it be 3 or 2 in the 'number of people authorized' field?

- If the 3rd participant has retainer days available, you will bill for 3 persons at the 3-person rate. If the participant has exhausted their retainer days, you will bill for 2 persons at the 2-person rate.

23. What if one participant is out of the home for 2 days, but is out of retainer days?

- If they are out of retainer days and are not in the home on a given date of service, you would not include them in the configuration.

24. We have a resident who is out for 30 days. Would we reduce the number of participants while he is out?

- If the participant has exhausted their retainer days, you would not include them in the calculation of the number of people authorized

25. Are Dedicated Hours included in this billing process update?

- Dedicated hours are a separate service in LTSS*Maryland* and will require their own billing entry in LTSS*Maryland*. In the service type dropdown for the single and multiple billing entry page, you will see an option that will present the Dedicated Hours services.

26. If a provider is transitioning into the LTSSMaryland-DDA Module, do PCPs need to be revised related to residential dedicated supports?

- No. Dedicated hours already approved do not need to be revised. They should be used as needed above the base flexible hours available per home.

27. How do you bill for a participant who does not have dedicated hours listed on their PCP?

- Participants can receive residential services without having dedicated hours assigned to them. You would enter them in the Multiple Billing Entry page or through the upload while also including the value of the number of people authorized on that date of service. Meanwhile, dedicated hours is a separate service when billed in LTSS*Maryland* and will not require indicating the number of people in the home.

28. Who can we contact for one on one training for use of LTSSMaryland's Provider Portal?

- Please email the ISAS team at mdh.isashelp@maryland.gov if you have questions or would like further instructions on billing in Provider Portal.

29. Is there a link for future or past trainings for LTSSMaryland billing processes?

- Please also see additional training guides and past MPS webinars on our training website here at the following sites:
  - Electronic Visit Verification (EVV) ISAS Services Training
  - Provider Portal Training

30. Who should we contact if we have questions about the update or the Residential Billing process?

- For billing in Provider Portal, the ISAS team can be contacted at mdh.isashelp@maryland.gov or by phone at 410-767-1719
- You can also reach out to this team if you have general questions or would like further instructions on billing in Provider Portal.
- For concerns about a participant's PCP, please contact their CCS for clarification and assistance.
- For concerns regarding registering a provider site, please contact your regional Provider Services staff.

J. Shared Living

1. Does Shared Living include Respite Care Services?

- Yes.

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2. ***Can someone accessing Shared Living be funded for overnight staffing?***

- No. Shared Living may be provided up to 24 hours a day based on the needs of the participant receiving services. Therefore, additional funding for overnight staffing is not included.

K. Transportation

1. ***Can stand-alone transportation be used when an agency staff member is in the vehicle if they are specifically taking a person to and from their job?***

- Stand alone transportation is to be used when a participant can travel independently to and from their job.
- Transportation support services are not provided at the same time as meaningful day services, personal supports, or residential services, with the only exception being participants supported with Follow-Along Job Supports.

2. ***Can someone who utilizes residential services access stand-alone transportation to get to their job?***

- Yes, a participant in residential services can access stand-alone transportation to get to work. However, transportation is included as part of residential services. The person and their team should discuss and consider all applicable resources, as it relates to their individual needs.

3. ***Are CDS providers allowed to reimburse mileage to the person supported or their families/legal guardians, when the person and their family uses their own wheelchair accessible vehicle during the service?***

- Providers are responsible for the coordination of transportation. If there is a more convenient, cost-effective way that may be used, it would be up to the provider to decide if they would reimburse for mileage. Please note the DDA will not supplement the rate to cover transportation costs.

L. Virtual Supports

1. ***Is it considered virtual supports if I have a DSP onsite with the individual but I have another staff virtually teaching them a class?***

- No, it is not considered virtual supports if an individual is participating in a class being virtually taught by one staff member, but another DSP

is onsite with the participant. For more information, please visit: [Memo 3—DDA Amendment 3 – Virtual Supports]

2. ***How would someone be able to use EVV through virtual supports services, if the individual requires an OTP device?***

   - If an individual has an OTP device and services are being rendered virtually, then the agency will have to manually bill for the services in LTSSMaryland. Reference: [DDA Service Modification Guide – September 25, 2020]

3. ***A requirement of virtual supports is to identify individuals to intervene and ensure they are present during the provision of virtual supports in case the participant experiences an emergency. We have participants that live alone. If someone we support lives in a home and has no one to be with them during virtual supports, does this mean they cannot receive virtual supports?***

   - No, participants living alone can be supported with virtual supports. Per [Memo 3—DDA Amendment 3 – Virtual Supports – February 16, 2021,] providers offering this service delivery model must establish policies to address processes for preventing and responding to medical emergencies during the use of virtual supports. Examples provided include identifying individuals who can intervene such as uncompensated caregivers, neighbors, etc. and contacting emergency medical services.

4. ***I was on the CMS Webinar yesterday and I thought they would not approve states doing virtual services after appendix K in a person's home? Perhaps I misunderstood?***

   - CMS approved DDA's Waiver Amendment #3, which included authorization for Virtual Supports, on January 19, 2021.

5. ***If a person does not want to return to in-person services, are they able to use virtual supports through the waiver as the sole method of service delivery?***

   - The DDAs waiver amendment #3 specifies that virtual support cannot comprise the entirety of the service to promote community engagement and the goals of the HCBS setting final rule. The PCP for each person should identify how they want to receive services including the amount of virtual supports they prefer to complement in person supports provision.

6. ***What is the highest amount of time an individual can receive virtual supports a day after 6/30/2023?***

    - The purpose of virtual supports is to maintain or improve a participant's functional abilities, enhance interactions, support meaningful relationships, and promote their ability to live independently, and meaningfully participate in their community.
    - Virtual supports are geared towards intentional learning (e.g., career planning, taking a bread making class, skill building) and can also be used towards helping a person do something more independently like remote job coaching.
    - To ensure community integration, however, virtual cannot comprise the entirety of the service. The frequency of in-person services should be established on an individual basis and documented in the person's plan consistent with their goals. As we continue to come fully out of the pandemic and learn from the community around how virtual support is a compliment to in-person supports, additional guidance will be provided. In the meantime, the frequency of in-person and virtual is flexible and should be established on an individual basis and documented in the individual's plan.

M. Respite

1. ***What is the minimum amount of hours that count toward the individual being present in respite care services?***

    - The daily rate is based on an assumption of 16 hours.

X. Quality Improvement Organization (QIO)

1. ***What is a Quality Improvement Organization (QIO)?***

    - QIOs are a group of healthcare professionals who evaluate if services help people to live fulfilled lives. QIOs provide technical assistance to states to improve person-centered service delivery.

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2. ***How does the QIO help states and people supported by their service delivery systems?***

    - The QIO supports states and people supported by their service delivery system by:
        - Interviewing people receiving services and their families to ensure their voice is heard;
        - Discovering ways to improve services and supports; and
        - Providing recommendations to improve service delivery.

3. ***What is Liberty's approach to leading a successful QIO in Maryland?***

    - Liberty has provided QIO services to three other states and the District of Columbia. Lessons learned to apply in Maryland are:
        - Ensuring people are at the center of their services
        - Utilizing QIO professionals who have Maryland-based experience
        - Building collaborative relationships with participants, families and providers
        - Building a culture of continuous quality improvement

4. ***What are the responsibilities and outcomes of the QIO?***

    - The QIO is responsible for the;
        - Data Collection for the Council on Quality and Leadership (CQL) Network Accreditation;
        - National Core Indicator (NCI) Surveying; and
        - Waiver Assurances Monitoring.

5. ***How will Liberty monitor the waiver assurances required by the Centers for Medicaid and Medicare (CMS)?***

    - The QIO will assist the DDA to collect and analyze performance measure data. This data is required by Centers for Medicaid and Medicare (CMS) to operate the three approved CMS waivers in Maryland.

6. ***What does National Core Indicator (NCI) surveying mean?***

    - Liberty is responsible for the collection of National Core Indicator Surveys including the face-to-face consumer interview and the family/guardian survey. Surveys ensure people receiving services and their families have the opportunity to provide feedback about the supports received through the DDA system.

7. *What is CQL Network Accreditation?*

- CQL Network Accreditation means the State of Maryland, the Developmental Disabilities Administration, will be recognized for reaching person-centered excellence as a system. This happens through quality monitoring and continuous enhancement to ensure improved supports and services to their participants.

8. *What are the three phases of CQL Network Accreditation?*

- The three phases are:
    - ***Network Foundation*** to build capacity across the network to learn about and utilize CQL tools, including the Personal Outcome Measures® and Basic Assurances®
    - ***Network Transformation*** to evaluate the current state of quality across the network. Data will be collected by using the Basic Assurances® and Personal Outcome Measures® tools
    - ***Network Accreditation*** through CQL facilitating the network's 'What Really Matters plan', which is an implementation plan that focuses on selecting goals for the state's journey toward person- centered excellence
    - For more information, please visit: https://www.c-q-l.org/accreditation/network-accreditation/

9. *What role will Liberty play in CQL Network Accreditation?*

- Liberty is responsible for the data collection activities of the CQL Network Accreditation. Liberty, DDA and CQL will partner together to reach the goal of achieving Network Accreditation by 2026. Future webinars specific to CQL-DDA Network Accreditation will be available in 2023.

10. *What is the QIO Collaborative Workgroup?*

- The QIO collaborative workgroup is a group of stakeholders representing people supported, families of those supported, providers and advocacy organizations along with QIO representatives and DDA representatives. The workgroup will support the design of data collection tools and processes necessary to accomplish the QIO scope of work.

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11. What can the DDA community expect from the QIO?

- Information and resources posted to the DDA QIO web page
- Collaborative Workgroup to assist with the review of evaluation tools, processes and communications developed by the QIO
- Participation in surveys, interviews, piloting QIO tools
- Collaboration on quality improvement

12. Are there new standards that will be required of providers?

- Review tools developed by the QIO are consistent with Medicaid waiver assurances and established guidance and policies issued by the DDA in PolicyStat. Data collected by the QIO will help to discover strengths and areas of improvement throughout the DDA system.

13. How will DDA and Liberty determine who is reviewed?

- A statistically valid, random sample of waiver participants, providers and/or Coordinators of Community Service (CCS) agencies are chosen for each type of review. If you or an organization serving you are chosen for a review, a member of Liberty will reach out to you to discuss your participation and the process.

14. Can a parent or legal guardian decline an interview?

- The person and their team will be communicated with when a person is randomly selected to complete a National Core Indicators survey or CQL Personal Outcome Interview. The person receiving services has the right to refuse participation in either the survey or interview. There are no negative impacts or consequences for not participating.

- To find out more about NCI or CQL, please visit their websites: https://nci-ad.org/ or https://www.c-q-l.org/.

15. How will participants who communicate through other modes be surveyed (i.e., use of sign language, gestures, Augmentative and Alternative Communication (AAC), etc.)?

- We will ask for the person's support professionals to support the person in their preferred communication mode so that they can engage with interviews. Additionally, we have interpreters available as needed.

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16. Is feedback to the QIO anonymous?

- Not all information will be anonymous for each QIO review. Before participating in any QIO review, informed consent will be obtained and information that will and will not be kept anonymous will be clearly explained.

17. How will the QIO interact with participants who are self-directing?

- Yes. Participants who self-direct their services will be asked to participate in NCI surveys and Personal Outcome Measure interviews. Additionally, self-directed participants may be asked to share information about the services and supports they are receiving if service documentation does not support that services were provided.

18. When will the Developmental Disabilities (DD) Community have access to the tools?

- The Collaborative Workgroup will be reviewing and providing feedback on each tool and process. The QIO will utilize the feedback and also pilot the tools prior to finalizing them. Information on these finalized tools/processes will then be shared with the DD community.

19. What documents will be required as part of the QIO planned reviews?

- Each review tool is a set of compliance standards and enhancements which will include review of:
  - Organizational program service plans;
  - Employee files;
  - Organizational policies and procedures;
  - Person-Centered Plans (PCP);
  - Staff notes and logs; and
  - Timesheets and payroll records.
- Observation and staff interviews will also be conducted.

20. What happens following a review?

- A Findings Report for each type of review includes the areas where standards are met, areas of improvement and areas where standards are not met. If corrective action is required, the Findings Report will list the areas that need to be corrected, how they need to be corrected and by when.
- Findings Reports will be provided to providers, DDA regional directors and the DDA QIO program manager. Summary reports of findings from each review will be provided and will be organized by Waiver and region. The reports will be made available on the QIO web page on a quarterly basis.

21. How will the QIO collaborate with the Office of Health Care Quality (OHCQ)?

- The QIO has an expanded viewpoint of the system. In contrast, the OHCQ's focus is to review individual cases. The QIO will provide summary and analysis of findings related to critical incident follow-up to OHCQ.

22. Will CCS's be included in the QIO's evaluation activities?

- Yes. Coordination of Community Services is an essential part of the services and support provided to individuals. The QIO will conduct Case File Reviews which will include a focus on Level of Care (LOC) determinations, quality of PCPs as well as required monitoring and follow-up activities. Paid claims for targeted case management services within standards of service definitions also will be reviewed.

23. When will each QIO Data Collection milestone be reached?

- November 2022 - National Core Indicator Adult Consumer Surveys and Family Surveys will be initiated.
- February 2023 – Waiver Assurance reviews including Utilization Reviews will begin. Utilization reviews are an extension of financial accountability to ensure waiver participants are receiving the scope, duration, and quality of services as outlined in their person-centered plan.
- Spring 2023 – The Council for Quality and Leadership (CQL) Network Accreditation data collection will initiate.

24. How can providers prepare for QIO reviews?

- Providers can review policies and guidance the DDA has already provided, as well as future communications on updates to policy and guidance. Providers can align organizational policies, procedures, and service delivery with Waiver requirements and the HCBS Final Rule. Additionally, providers can participate in regional DDA provider and CCS meetings where regular updates will be provided by the QIO.
- If you have questions or want more information, you can contact the QIO at 866-414-9525 or Nichole.Blalock@LibertyHealth.com.

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25. Will providers not in the pilot who go through their first round of Utilization Review be given the same opportunity to learn from their first review? (New - March 10, 2023)

- Yes. Providers who were not selected for the pilot will be given an opportunity to learn from the first review. There will be an initial finding for providers to review and allow an opportunity to supply additional documents, or addenda. Providers should know the first reviews are being assessed at the basic floor level of compliance to give providers an opportunity to learn

26. Does the QIO provide quality assurance reviews to participants who receive Self Directed Services? (New - March 10, 2023)

- Yes

XI. Resources

- DDA Website - To find information about DDA
- DDA Regional Office - To find information about regional offices, counties they support, and staff to contact for questions related to applications, eligibility, CCS, self-directed services, and more
- DDA Waiver Programs - To find information about DDA Medicaid Waiver Programs including:
  - Family Supports Waiver, Community Supports Waiver, and Community Pathways Waiver dedicated pages.
- Charting the Life Course Tool - To find information on this tool in support of person-centered planning
- Person-Centered Planning - To find information and resources on person-centered planning
- PolicyStat - To find information about the DDA policies
- Quality Improvement Organization (QIO) – To find information and resources of the DDA's QIO
- Self-Direction - To find information about DDA's self-directed services including:
  - Self-Directed Service Guidance, Forms, and Webinars

- Financial Management and Counseling Services
- EVV - Self Directed Services Model

- Training Opportunities - To find information about upcoming trainings, events, webinars, and initial certification and recertification Support Broker trainings which are listed on the DDA Training Calendar

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