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 Questions that are no longer relevant have been moved to an archived document.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? (Revised -- December 17, 2021)***

    - 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, flexibilities tied to the Federal Public Health emergency are planned to end no later than 3/31/22. Please review the Appendix K and Executive Orders Flexibilities - December 17, 2021

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.

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? (Revised -- December 17, 2021)***

    - 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 - December 17, 2021 .

    - 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? (Revised -- December 17, 2021)***

    - No. Alternative sites are specific to the need to relocate participants due to the need for seperating, self-isolation or quarantine.

    - The flexibility to deliver services in licensed residential sites or other non-facility based sites remains available through 3/31/22 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. 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): 1. The proposed individual is the choice of the participant, which is supported by the team; 2. Lack of qualified provider to meet the participant's needs; 3. 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; 4. 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 5. 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? (Revised -- December 17, 2021)***

    - This flexibility will remain through 3/31/22.

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? (Revised -- December 17, 2021)***

    - For services after 3/31/22 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 3/31/22? (Revised -- December 17, 2021)***

    - 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 - December 17, 2021

10. ***What is needed for providers to continue to offer some services virtually after 3/31/22? Does this need to be outlined in the program service plan (PSP)? (Revised -- December 17, 2021)***

    - Yes. As detailed in Memo #3 - DDA Amendment #3 - Virtual Supports - 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 3/31/22 similar to the other behavior support services? (Revised -- December 17, 2021)***

    - Yes. BSIS can be provided remotely until 3/31/22 under Appendix K. 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

13. ***Is the flexibility for one hour of meaningful day service to bill for the full day continuing or when will this end? (Revised -- December 17, 2021)***

    - 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 This flexibility will end on 3/31/22 in accordance with the pending emergency regulation that would also extend this through 3/31/22.

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 3/31/22? (Revised -- December 17, 2021)***

    - 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.

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.

3. ***Under Appendix K, providers can bill a day of service for one hour 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. (Revised -- December 17, 2021)***

    - The emergency regulation that has permitted providing 1 hour of supports and billing for the day will terminate on 12/31/21. There is however, a pending new emergency regulation that would extend this flexibility for day habilitation services through 3/31/22.

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. ***When was the notice sent to Providers about the recoupment of PS FY21 funds?***

    - The Memo Q4 FY 2021 Payment Notification was issued on March 30, 2021.

6. ***Please clarify: We saw no provider rate increases as of July 1, start of FY. Are there rate increases expected this FY?***

    - Yes - the rate increase was accelerated to January 2021; so providers have been realizing it for 6 months.

7. ***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 - Revised Jan 29, 2021

8. ***Are the rates final or are they still a work in progress? (Revised -- December 17, 2021)***

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

9. ***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.

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

    - Yes

11. ***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.

12. ***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.

13. ***Are BSS services included in the revenue that will receive the 5.5% increase?***

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- Yes. All HCBS services in PCIS2 were included in the retroactive 5.5% rate increase.

14. ***Will providers who are waiting for error updates that are being processed receive the 5.5% increase?***

    - Yes. Please see the recent communication sent via PCIS2 on 11/9/21 that details timeline and process for error updates.

15. ***When will the 5.5% rate increases in PCIS2 be reflected? (New - December 17, 2021)***

    - All of the rates in PCIS2 have been updated for all eligible waiver services.

III. COVID-19 Guidance

1. ***Now that the mask mandate and outdoor dining has been lifted, does a resident from a group home have to go into quarantine if they spend several days at a family home for a mini vacation?***

    - Residents who are not fully vaccinated must complete a two-week quarantine after leaving the home to visit friends or family. There is no requirement to quarantine for fully vaccinated residents. For additional information, please review the Checklist of Recommendations for Group Home Outbreak Revised May 10, 2021.

2. ***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.

3. ***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.

4. ***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.

5. ***Are CCSs allowed to do home visits, group home visits, and site visits?***

    - Yes, CCSs are permitted to do home visits, group home visits and site visits. Please note, that this is an agency decision, however the DDA is in full support of conducting visits with the proper safety protocols in place.

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

    - Yes.

7. ***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

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.

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 by the Fall 2021.

VI. Eligibility and Application

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

    - The Family Supports Waiver is limited to 400 participants. The Community Supports Waiver limitation includes: 1st Year - 1000 participants; 2nd Year - 1490 participants; 3rd Year - 1950 participants, 4th Year - 2440 participants; and 5th Year - 2880 participants.

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

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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.

4. ***If someone is currently under Community Pathways Waiver for Day Habilitation, will they now be moved to the Community Supports Waiver?***

    - No, if an individual is currently enrolled in the Community Supports Waiver, they will remain in that waiver program.

5. ***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.

6. ***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).

7. ***When providers are fully billing in LTSS, will providers be able to bill for services, if a person falls out of the waiver?***

    - 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.

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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 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 - Revised Jan 29, 2021

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 - Revised Jan 29, 2021, page 24.

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?***

    - Yes. The DDA may need to seek clarification or additional information from the CCS following the DDA's review. It is important for the PCP team and region to work collaboratively to ensure clarifications are resolved quickly. 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 8.

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 LTSS*Maryland*, 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)

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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 that will be available in May. The CCS can also email a PDF of the entire plan to the participant and to their support team members.

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.

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?

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- 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.

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.

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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, 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

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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 Fiscal Management 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?** ***(New - December 17, 2021)***

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

33. **After 3/31/22, can CCS agencies provide supports virtually?** ***(New - December 17, 2021)***

- 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.

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.

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.

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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 provider 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.

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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. ***When an agency has made the difficult decision to close some services as of 12/31/21 such as Day Hab and CDS, what would the next steps be for individuals who have not yet found another service provider? Would the team need to update the PCP to reflect those services ending even if the individual does not yet have another provider?***

    - For providers who are closing services, this must be supported with the required notification and a team meeting to discuss necessary transitions. PCP updates should be prioritized for situations where new services or providers are being added to ensure authorization for these changes. For individuals who have experienced a loss of a service, there service team should be supporting them to explore other options.

13. ***Do providers have until 3/31/22 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? (Revised -- December 17, 2021)***

    - Individuals who are requesting continued use of virtual supports, the SIP needs to be updated by 3/31/22. 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.

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.

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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.

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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.

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 with the PCP in LTSS*Maryland*. 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.

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 year.

    - Participants are not required to allocate their entire budget. The budget is based on DDA's traditional rates which includes cost components to address staff training, transportation, employer related cost, program service cost, and administrative cost. Presently, the DDA is paying for administrative costs associated with Coordinators of Community Services (CCS) and Fiscal Management Services (FMS) which will not come out of the participant's budget. In addition, participants self-directing do not have expenses related to program service cost, and administrative cost. Therefore, participants should consider their current assessed needs as authorized in their PCP and reasonable and customary rates when developing their SDS Budget Sheet and may decide to offer future pay increases or benefits.

8. ***Do participants need to allocate funding from their budget to pay for Fiscal Management Services?***

    - No, participants do not need to allocate funding from their self-directed budget to pay for FMS. The DDA is currently paying for these costs.

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 - Revised March 8, 2021

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.

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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

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.

VII. Self-Direction

A. Forms and Processes

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

    - Fiscal Management Services (FMS) 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 FMS 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.

3. ***Is the cost detail sheet being replaced by the Detailed Service Authorization in LTSSMaryland for self-directed services?***

    - Yes.

4. ***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.

5. ***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

6. ***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.

7. ***When someone switches from traditional to self-direction, whose responsibility is it to send the FMS the prorated budget?***

    - The DDA Regional Office will share the updated PCP and SDS Budget sheet with the selected FMS agency.

8. ***Can you explain what the Financial Management Services group does? Do FMS services overlap with Support Broker services?***

    - Fiscal Management Services (FMS) 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 FMS's responsibilities should not overlap with the Support Broker's responsibilities. For more information, please review the DDA Self-Directed Services Handbook.

9. ***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 Fiscal Management Service providers issue monthly reports and are able to provide more details on those reports, including the report start date.

10. ***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.

11. ***Is a contractual Day Hab listed as State Only funds as we were told in the last webinar on 1/26/21?***

    - No. There were initial technical challenges in listing Day Habilitation services for self-directed participants, so the DDA had directed teams to list the service under State Only funds as a temporary work-around. That issue has since been resolved, and Day Habilitation may now be selected in the person-centered plan detailed service authorization. The agency name should be coordinated with the Fiscal Management Services provider, and not listed in the person-centered plan.

12. ***Will the unallocated funds that are seen as "remaining funds" be listed as "unallocated funds" on the person's FMS statement?***

    - No.

13. ***In the budget monitoring process who creates the Monthly Statements?***

    - The Fiscal Management Services provider creates the Monthly Statements for the participant.

14. ***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 Fiscal Management 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.

15. ***Will a new Cost Detail be released soon? The 6/2/2021 version shows red for Plan end Dates 7/1/2022 and after.***

    - Yes. Revised Cost Detail Tools are available on the DDA Forms webpage, under Fiscal Forms. Please note the cost detail tool is not used for people self-directing their services.

16. ***If you have family as staff who were hired/working prior to Appendix K -- COVID-19, is the new Family as Staff form required? (New - December 17, 2021)***

    - For family as staff already identified in the PCP, this form will be used during the PCP process (annual and revised).

17. ***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? (New - December 17, 2021)***

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

18. ***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? (New - December 17, 2021)***

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- 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.

19. 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? (New - December 17, 2021)

- 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.

20. Does the Participant Agreement replace the Waiver Agreement or is that form still required? (New - December 17, 2021)

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

21. 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? (New - December 17, 2021)

- 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.

22. Can more than one team member be listed under each bullet on the form? (New - December 17, 2021)

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

23. ***Is a support broker required for those who need a FAS form completed prior to 12/31 due to the unwinding of Appendix K? (New - December 17, 2021)***

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

24. ***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? (New - December 17, 2021)***

    - 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.

25. ***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? (New - December 17, 2021)***

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

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 - Revised March 8, 2021 and Instructions for DDA's SDS Budget Sheet - Revised March 8, 2021

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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. It does not reset.

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.

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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 salary 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 FMS.

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.

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? (New - December 17, 2021)***

    - 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.

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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? (New - December 17, 2021)***

    - 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)? (New - December 17, 2021)***

    - 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):
        1. The proposed individual is the choice of the participant, which is supported by the team;
        2. Lack of qualified provider to meet the participant's needs;
        3. 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;
        4. The legal guardian or relative provides no more than 40-hours per week of the service unless authorized by the DDA; and
        5. 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? (New - December 17, 2021)***

    - 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? (New - December 17, 2021)***

    - If the participant chooses to appoint or designate a team member, the team member is considered to be acting as 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?*** ***(New - December 17, 2021)***

    - 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?*** ***(New - December 17, 2021)***

    - 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.

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

11. ***Who is able to sign a family member as staff's timesheet if there is not a paid support broker?*** ***(New - December 17, 2021)***

    - 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.

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.

E. Support Broker

1. ***Can a support broker provide both personal support and support broker work?*** ***(Revised -- December 17, 2021)***

    - Support brokers can temporarily provide other waiver services to the participant at the rate applicable to that other waiver program service until 3/31/22 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 $65 per hour allowable for non-agency Support Brokers, or is it still only allowable for agencies?***

    - The maximum rate of $65 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? (New - December 17, 2021)***

    - 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? (New - December 17, 2021)***

    - 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 FMS.

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 - Revised March 8, 2021 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.

VIII. 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

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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.

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 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

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. ***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.

4. ***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.

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

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.

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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.

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

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

J. Shared Living

1. ***Does Shared Living include Respite Care Services?***

- Yes.

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 after 12/31, 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 3/31/22? (New - December 17, 2021)***

    - 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 for 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.

IX. 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 this coming year to EVV with support and planning as this is developed by DDA. More information will follow as these details are confirmed.

X. 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
- Self-Direction - To find information about DDA's self-directed services including:

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    - Self-Directed Service Guidance, Forms, and Webinars

- 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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