MARYLAND DEPARTMENT OF HEALTH
Developmental Disabilities Administration

MACS General Membership Meeting

Bernard Simons, Deputy Secretary

May 10, 2018

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Topics

- Rate Setting
- LTSS
- Provider Application
- Waiver Renewal
- BSS and Mandt
- Electronic Visit Verification (EVV)
- Questions from MACS members

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Rate Setting-Geographic Differential

- Applied to counties in BLS Metropolitan Statistical Areas (MSAs) where the wage for DSP categories exceed the statewide average by 10%
- Two MSAs meet this criteria:
    - Silver Spring-Frederick-Rockville, MD Metropolitan Division (Frederick and Montgomery County)
    - Washington-Arlington-Alexandria, DC-VA-MD-WV Metropolitan Division (Calvert, Charles, and Prince George's County)
- JVGA analysis of DSP wages in Montgomery and Prince George's Counties showed that the weighted average salary was approximately 10% higher than the statewide average
- Differential will be applied to the following services: Community Living, Supported Living, Day, CDS, Behavioral Support Services, Nursing, Respite, and Employment Services
- Differential will be tied to the person receiving services via their current address

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General & Administrative Cost Component

- Originally proposed G&A cost component was based on the current operating environment
- DDA recognizes that changes to the payment process and billing units, and implementation of LTSS will require more administrative work
- JVGA indicated that common G&A percentages used in other states are 10% and 12%
- DDA proposes to increase the G&A from 11% to 12%
- This revised G&A will be applied to all services
- Will revisit in the future when data is available

Transportation

Meaningful Day Services

- Transportation time is not included in billable time
- Clock starts when the service activity begins and the clock stops when the service ends.
- Travel during the service activity is considered part of the service delivery
- If a person only needs transportation to and from work, then the provider should bill the stand alone transportation service

Services with enhanced transportation percentage of 49.1%

- Day
- Community Development Services
- Career Exploration
- Employment Services - Job Development, Discovery Milestone #2, and On-going Supports

Community Development Services

Ratios	Description	Wage	Program Support	Training	Transportation	Employee Related Expenses	G&A
2:1	2 staff supporting 1 individual	↑	-	↑	-	-	↑
1:1	1 staff supporting 1 individual	↑	-	↑	-	-	↑
1:4	1 staff supporting up to 4 individuals, *price ratio TBD*	↑	-	-	-	-	↑

Unit = hour

The wage will increase from the BLS statewide average for the selected category to the 75th percentile for all ratios to compensate for the higher competency needed to take an individual out into the community

The training component will increase for the 2:1 and 1:1 ratios to compensate for the higher level training and skill required to serve someone with more intensive behavioral or health need

Day Habilitation

Ratios	Description	Wage	Program Support	Training	Transportation	Employee Related Expenses	G&A
2:1	2 staff supporting 1 individual	-	-	↑	-	-	↑
1:1	1 staff supporting 1 individual	-	-	↑	-	-	↑
Small Group (2-5 people)	1 staff supporting up to 5 individuals, *price ratio TBD*	-	-	-	-	-	↑
Large Group (6-10 people)	1 staff supporting up to 10 individuals, *price ratio TBD*	-	-	-	-	-	↑

Unit = ½ day (3 hr. block)

Service provider can bill for 2 units/day (total 6 hrs.) and up to 2 units (2 hours) of CDS, Ongoing Job Supports, or Career Exploration per day for a total of 8 hours

The training component will increase for the 2:1 and 1:1 ratios to compensate for the higher level training and skill required to serve someone with more intensive behavioral or health needs

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Career Exploration

Service	Description	Wage	Program Support	Training	Transportation	Employee Related Expenses	G&A
Career Exploration - Small	Hourly service, time limited, contract basis, between 2-8 people, price ratio TBD	-	-	-	↑ 49.1%	-	↑
Career Exploration - Large	Hourly service, time limited, contract basis, between 9-16 people, price ratio TBD	-	-	-	↑ 49.1%	-	↑
Career Exploration - Facility Based - Large Group (6-10)	1/2 day unit, Facility based, price ratio TBD	-	-	-	↑ 49.1%	-	↑
Career Exploration - Facility Based (2:1)	1/2 day unit, Facility based	-	-	-	↑ 49.1%	-	↑
Career Exploration - Facility Based (1:1)	1/2 day unit, Facility based	-	-	-	↑ 49.1%	-	↑

Unit for Small and Large Groups = hourly

Unit for Facility based – ½ day (3 hour block)

The payment ratio is under review and will be determined.

The transportation component will increase for career exploration based on the nature of the service and the need for transportation

Community Living – Group Home (Licensed Congregate Living)

Home Size (based on occupancy)	Shared Staff per Home	Home Shared Hours w/ Overnight Supervision	Home Shared Hours w/ Remote Support Services or no Overnight Supervision
2	**1**	138	82
3		138	82
4	**2**	220	164
5		220	164
6	**3**	302	246
7		302	246
8		302	246

Creates base rate out of shared staff hours in the home

Unit = daily

Depending on the home size, all participants in the home will share a certain amount of staff which will create a base rate for the individual

An individual's daily base rate will be determined by the number of people authorized to live in the same licensed group home

In addition to the shared hours, each individual is able to add up to 48 hours of additional dedicated staffing per day to support health and safety needs and staffing ratios of 1:1 or 2:1

Community Living – Enhanced Supports

Service	Description	Wage	Program Support	Training	Transportation	Employee Related Expenses	G&A
Community Living - Enhanced Supports	1:1 Enhanced Supports residential services for individuals with high behavioral needs	↑	↑	↑	-	-	↑

Unit = daily

All hours in an enhanced supports community living setting will be provided on a 1:1 basis; hours will not be shared among residents

The wage and training component will be increased to compensate for the retention of more qualified and competent staff as well as the higher level training required to serve someone with more intensive behavioral needs

The program support component will be reassessed to ensure that there is an adequate level of professional staff available

Supported Living – Unlicensed Congregate Living

Home Size (based on occupancy)	Shared Staff per Home	Home Shared Hours w/ Overnight Supervision	Home Shared Hours w/ Remote Support Services or No Overnight Supervision
2	**1**	138	82
3		138	82
4	**2**	220	164

Creates base rate

Unit = daily

Depending on the home size, all participants in the home will share a certain amount of staff which will create a base rate for the individual

An individual's daily base rate will be determined by the number of people authorized to live in the same unlicensed home

In addition to the shared hours, each individual is able to add up to 48 hours of additional dedicated staffing per day to support health and safety needs and staffing ratios of 1:1 or 2:1

Rate Setting Next Steps

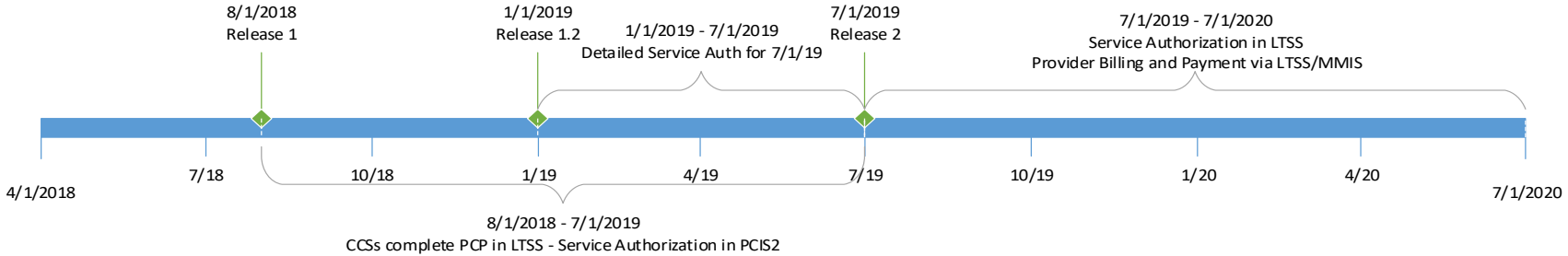
JVGA

- Update BLS wages based on 2017 data and will accelerate to 2019
- Adjust wages as requested by DDA
- Increase training cost component as requested by DDA
- Increase transportation cost component for Employment Services-Discovery M2, Job Development, and all levels of Career Exploration
- Recommend rates for group ratios for Community Development Services, Day Habilitation, Career Exploration, Community Living – Group Home, and Supported Living
- Recommend methodology for geographic differential

DDA

- Share revisions with Technical Work Group in late May

LTSS Release Update



- In FY19, service authorization will continue in PCIS2 along with the SFP/Modified SFP process
  - Prior to an individual's Annual PCP Date in FY19 - If there are changes to the service authorization, then a Modified SFP needs to be completed via the normal process
  - After an individual's Annual PCP Date in FY19 - If there are any changes to the FY19 service authorization, then a Modified SFP needs to be completed via the normal process AND a Revised PCP (update) needs to be completed in LTSS
- Starting in January 2019, when Release 1.2 occurs, CCSs will need to update all PCPs to include detailed service authorization for dates of service on or after 7/1/2019
- It is imperative that service authorization is correct in LTSS by 6/30/2019
- There will be a direct PDF print output of the PCP for CCSs to share with providers

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LTSS Payment Process

- Medicaid claims will be submitted to MMIS within a week of service data being entered (schedule is TBD)
- Claims will be processed and adjudicated by the MMIS system on a weekly basis
- Depending on when a service is entered into LTSS, payment should be expected within 10 to 16 days of the service data entry
- State-only activities (either non-waiver services or services to non-waiver individuals) will be paid through a monthly paper-based invoicing process currently being developed for CCS providers. Payment times will be similar to existing DDA invoicing

LTSS Provider Portal

- Depending on the user role, provider users will have access to LTSS to:
  - *Upload billing activities
  - *Resolve billing errors
  - *View the service plan of a participant they are serving
  - *Acknowledge service and unit changes
- DDA is exploring the ability to allow providers to accept changes in service authorizations electronically without having to use the current signature process. This will allow for more timely PCP/service authorization change and will give the provider more timely notification of a changing service authorization
- The acceptance would record the following elements:
  - *Person accepting based on who is logged in
  - *Date of acceptance
  - *Time of acceptance
- Anticipated user roles in the Provider Portal:
  - Provider Billing Staff – input service billing activities and resolve billing errors
  - Provider Program Staff – view and accept changes in an assigned participant's plan
  - Provider Admin – can manage provider staff and has both billing and program staff capabilities
  - Provider Staff – DSP staff who will use IVR/EVV call in system for personal supports

LTSS Service Data Upload

Only service providers will be able to upload data (this functionality will not be extended to CCS providers)

Concept:

- One-way interface between provider systems and LTSS
- Interface may either be a web service interface or a file based transfer of data
- MMIS will send remittance to LTSS
- The unique combination of a provider, individual, service and day can only be submitted once by a provider via the upload functionality
- All adjustments to previously submitted service data will need to be made in LTSS
- DDA will provide specifications for the upload that all providers must adhere to in order to use the functionality
- The upload of data is not required and all providers will have the option to use the entry screens discussed earlier

LTSS Service Entry

- DDA is exploring how to input service activities into LTSS most efficiently for providers who will not use the system-to-system provider upload function
- Per feedback from Provider Work Group, the preference is for a service-based entry screen where certain data elements would pre-populate reducing the amount of manual entry required
  - To create multiple entries, the provider would:
    - ✓Pick the service
    - ✓Pick the date of service
    - ✓Select all applicable participants simultaneously
    - ✓Save to table → create a unique line for each participant with pre-populated provider MA#, procedure code, date of service and participant MA#
    - ✓Input the units or cost of service render for each participant on a given day
  - To span multiple days, a provider can duplicate individual lines and change the dates
- Search capabilities will exist to aid providers in identifying service activities/claims with billing errors so that they can be resolved

Service Entry (cont.)

Billing Entry Creation										
Service Type	Day Habilitation				Proc Code	W8341				
Provider #	123456789		**Provider Name**	Super Day Habilitation Provider						**Create Billing Entries**
From Date	3/1/2018		**To Date**	3/20/2018	*(Leave blank if single day)*					
Participants	(Select Participants)									

Billing Entries to be Submitted									Submit	
Date	**Service Type**	**Proc Code**	**Client MA #**	**Client LTSS ID**	**Provider #**	**Units**	**Rate**	**Total Billed**		
3/1/2018	Day Habilitation	W8341	465451382		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	546541329		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	464654654		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	454654654		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	546546454		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	879745134		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341		987654321	123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	456798744		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	456654136		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	565123789		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	578979874		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341	465488712		123456789		$10		**Copy**	**Delete**
3/1/2018	Day Habilitation	W8341		987654325	123456789		$10		**Copy**	**Delete**

Provider Application

What has DDA done to assist with the provider application?

- Met with MACS members to streamline and clarify several sections of the application
- Posted all new changes with instructions on the DDA Website
- Conducted webinars on how to complete the application
- One to one provider application technical assistance
- Shared tips sheets, checklist and templates for providers

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Provider Application

What are the barriers to processing the applications?

- Applicants are not familiar with the waiver services so they are not properly checking the services or know when service are transitioning or their start date
- Applicants are not modifying the Program Service Plans to reflect new services or staff requirements
- CJIS information was not submitted for CEO or top management
- CPS information has not been completed if applying to support children
- Quality Assurance plans were not submitted with application
- Missing application information is taking two to three weeks to be submitted
- Emails or phone call are not being returned

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Provider Application

Moving forward DDA is doing the following:

- Each Region has hired additional staff to assist with this process
- Each Region will be having “provider application” time slots for a face to face interaction with the provider to go over the application and expedite the process
- Each Region is identifying if they have enough providers to meet the needs of people in the FSW and CSW
- Headquarters' Lead staff meets on-going with regional staff for consistency
- The DDA updates the website on approved providers per waiver services

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Provider Application

What does DDA need from you?

- Become familiar with the application instructions and waiver services
- Call the Regional Director to find out the status of your application
- Return emails or calls so needed missing information can be submitted to the Region immediately after the communication
- Complete the check list and be familiar with the tips sheet and templates
- Call Regional Office to schedule “provider application” face to face technical assistance

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Provider Application

Current status:

Region	Total Number of Providers in the Region	Providers that Submitted Application	Providers that have not submitted Applications	Total of Number of Providers Approved
Western	25	24	1	17
Southern	71	45	26	9
Eastern	29	28	1	27
Central	102*	75	26	24

**Undated Central Numbers from what was presented during the MACS meeting.*

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Provider Application

Current status:

Region	Number of Providers that Applied for FSW	Number of Providers that Applied for CSW	Number of Providers that Applied for CPW
Western	4	15	24
Southern	22	39	27
Eastern	10	19	20
Central	23	41	64

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BSS Providers

Current status:

Region	Number of Providers that Applied for BSS	Number of Providers that Have been Approved	Number of Providers that are Pending Approval
Western	4	2	2
Southern	10	2	8
Eastern	4	4	0
Central	12	6	6

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BSS Billing

- BSS approved providers for the FSW and/or CSW authorized to provide services for enrolled participants will submit an invoice based on the rates approved in the FSW and CSW waiver applications. DDA will be providing additional information about the invoice billing process in an upcoming webinar
- New BSS approved providers for participants in the CPW will be able to provide services once the renewal is approved. DDA will provide additional information related to the process by the end of June 2018

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Waiver Renewal

- The Community Pathways Waiver was submitted to CMS on April 2, 2018
- On April 10, 2018, DDA had a 15 day review call with CMS
- On May 1, 2018 DDA received the "informal" questions on the renewal which are due to CMS on May 15th
- The renewal application and stakeholder input summary can be found on DDA's website at https://dda.health.maryland.gov/Pages/Community_Pathways_Waiver_Renewal_2018.aspx

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Positive Behavior Supports and Mandt

- PBS Transition- The DDA is working with the State Behavior Support Committee (SBSC) to develop a transition plan, time frame and protocol under the leadership of DDA's Clinical Director, Dr. Meg DePasquale on transitioning from PBS to Mandt.

- It's DDA's goal to share the time frame, protocol and transition process with all of our stakeholders by the end of June 2018. We are anticipating that this transition will take approximately 24 months.

- Mandt- The DDA has engaged in a training contract with Mandt to provide training to all agencies so that they would have at least one trainer within their agency and/or two based on the size of the agency. The training will start this month and will continue until we have 350 trainers trained. The training schedule will be posted on DDA's website

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EVV

Electronic Visit Verification

- According to a recent news release, the National Association for States United for Aging and Disabilities (NASUAD) released a publication that provides information and an analysis on Electronic Visit Verification (EVV). "The publication describes key considerations and policy decisions that states should consider as they work to implement EVV systems in accordance with the mandate included in the 21st Century Cures Act. The paper also examines different approaches that states may wish to use to establish EVV within their HSBS programs, discusses some of the benefits and challenges associated with each approach, and includes case studies of four states with existing EVV systems."

- The full publication at http://www.nasuad.org/newsroom/nasuad-news/nasuad-releases-paper-electronic-visit-verification-hcbs.

EVV

DDA will:

- Be incorporated into the Department's current EVV system which is part of LTSS and will be used only for Personal Supports
- Be addressing the unique concerns of participants
- Be developing an implementation plan
- Be performing Readiness Reviews
- Use EVV to promote quality improvement

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Questions from MACS

Mandt

- The cost of training all of the agency staff is significant. What will DDA do about the additional cost to providers?

Answer: The Mandt training is being transitioned within the next 24 months. The current BSS training is required annually. Training percentage was added to the new rate structure for all direct support services.

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Questions from MACS

Provider Application

- What is happening to CJIS checks that are being submitted to DDA?

Answer: Information received is used by DDA solely for the purpose of evaluating the prospective provider's application, and it will not be disseminated outside the Department of Health except in accordance with applicable law.

- What are the criteria for approval or disapproval?

Answer: No criminal history which would indicate behaviors potentially harmful to individuals as per COMAR 10.22.02.11B.

- Can we do private criminal background checks?

Answer: Yes.

Questions from MACS

Provider Application

- Several providers have been approved with private criminal background checks, and some are being told they must have CJIS checks.

Answer: The DDA's regulations require that providers complete either: (1) a State criminal history records check via the Maryland Department of Public Safety's Criminal Justice Information System (CJIS); or (2) a National criminal background check via a private agency, with whom the provider contracts. ***If the provider chooses the second option, the criminal background check must pull court or other records "in each state in which [the provider] knows or has reason to know the eligible employee [or contractor] worked or resided during the past 7 years."***

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Questions from MACS

Provider Application

- How do providers start services now when they haven't been approved?

Answer: Providers can not start services until they have been approved if they are applying for new services, new waivers, or they are a new provider. They can continue to provide existing services that have been approved within the current approved Community Pathways Waiver.

- Many providers report not being notified of when their application has been received, and many are not getting in writing what is missing in order to be approved. Providers are also reporting new formatting requirements that were not in the initial application. How will DDA keep providers up to date on the status of their application, and any changes that are being made to the application process?

Answer: Contact your regional Director to find out your current application status.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Does existing people have to have new cost detail sheets as of their new PCP date?

Answer: Yes, when their planned services end (i.e. they reach their annual PCP date) they will have to update their PCP and complete the new cost detail sheet. This is the only way people will be able to access all the new waiver services. People in the CP Waiver will need to use this cost detail to access services in the Waiver renewal (starting July 1, 2018).

- Will cost detail sheets go away after June 30, 2019?

Answer: Yes. This tool was built for the new waivers in FY 2018 and the CP waiver starting in FY 2019. In FY 2020 (July 1, 2019), when LTSS is up and running we will no longer need the cost detail sheets.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Cost detail sheets have to change to new categories per the waiver?

Answer: The cost detail sheets are built for the new capped waivers effective in FY 2018 and the new CP waiver in FY 2019, and will reflect those categories as such.

- Currently some people have professional add-ons approved in their plans -- they will lose these?

Answer: Services will need to be reassessed during the annual PCP process. These types of services can be accessed through the Medicaid State plan, private insurance, standalone waiver services, or as a state only service in the Cost Detail Tool.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- People who currently receive Music Therapy or other therapies that DDA has approved in the past - do they just lose it?

Answer: Services will need to be reassessed during the annual PCP process. These types of services can be accessed through the Medicaid State plan, private insurance, standalone waiver services, or as a state only service in the Cost Detail Tool.

- How will regional offices be able to process the cost detail sheets for the volume that will now be required?

Answer: DDA is hiring 12 additional new staff to support this effort.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Nursing – not currently an approved waiver service. How do you lay out the cost under the new form?

Answer: For the Community Supports Waiver, nursing services are available today as stand-alone waiver service and should be included in the cost detail sheet.

For the Community Pathways Waiver, nursing services will no longer be part of the professional service add-on starting July 1, 2018 after the waiver renewal is approved. Stand-alone waiver nursing services can be included in the cost detail sheet. If skilled nursing was previously approved it can be requested as a state-only service for the regional office to review.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Participant's County -- this is used to identify the rate that is paid for supports. Funding will be based on where the person lives vs where the agency provides supports. Example: Montgomery County rates are higher than Anne Arundel's. If a Montgomery county agency provides support only in Montgomery, they will have to accept the lower rate for that person who's physical address is Anne Arundel County? Currently the rate is based on the county of the agency

Answer: The cost detail sheet has been revised since the webinar last week to include a county entry options for Meaningful Day Services, Personal Supports, and Residential Services.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Plan Effective Date vs Annual PCP Date: They explained that the Annual PCP Date is fixed and does not change. That would mean you must hold the meeting on or before each year. But then they said the Plan Effective date is the Date the plan starts. Questions about the meaning of the dates were asked over and over on the webinar, there needs to be more clarification.

Answer: The effective date is the date a person starts service. For people who are already in service their plan effective date is typically the same as the annual PCP date. It is possible that someone new coming in to service could have a plan effective date that is a few days after the PCP start date.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Personal Support hours: It was explained that if you are asking for 50 per month that would be 600 per year. They said you can carry over from month to month until you use your 600? Just confirming this is correct.

Answer: This is true for the current CP waiver but, monthly detail service authorization begins July 1, 2019.

Questions from MACS

Webinar on the New Cost Detail Sheet

Cost Detail Form needed during transition years as follows:

- Anyone new entering the waiver services

Answer: Yes.

Anyone making changes needing a MRFSC

Answer: Yes.

Anyone in current waiver seeking supports in new waiver

Answer: Yes, anyone in CP seeking new services available under the waiver renewal.

Questions from MACS

Webinar on the New Cost Detail Sheet

- Must always be completed annually with the PCP annually. If you have recurring add-on supports this must also be included each year with the new cost detail. Will these add-ons just be approved with the annual PCP since already recurring? Or will there be additional information requested for the add -on support? How will we know DDA has approved and how long will it take? Once the meeting is held when does it then have to be submitted by? This is something we do not currently do.

Answer: Services will need to be reassessed during the annual PCP process based on supporting documentation of the identified need. Cost detail sheets must be completed annually along with the annual PCP. Providers will receive approval letters as per the current process. Planning and discussions relate to services to be identified in the Annual PCP should occur 90 days prior to the actual meeting date so that the specific provider implementation strategies and cost detail sheets can be completed and submitted once services are confirmed during the annually meeting with the person.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Daniel said the new cost detail was not for people currently in services. I think he meant in the current waiver but if an agency applied for the new waiver you would have to submit?

Answer: Yes, the new cost detail sheet is for anyone entering the new FSW and CSW and anyone accessing services in the CP Waiver renewal after July 1, 2019.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- We were told to start using the new cost detail sheet asap when we get it this week from DDA. However, what do we do if we do not have our application approved yet? Also all the services in the drop down menus are not approved yet with the new waiver. This may confuse providers and they may submit for some of the services? Can we get a list of what we can ask for currently vs FY20? Or what date will the other services be approved? Confusing

Answer: Cost detail sheets should be used immediately for providers approved for the FSW and/or CSW for enrolled people. The cost detail sheets should be filled out for all persons receiving services under the CP Waiver renewal beginning July 1, 2018 (FY19). All services allowed under these Waivers are included as options in the Cost Detail Tool.

Questions from MACS

Webinar on the New Cost Detail Sheet

- On the cost detail sheet you only indicate what it is and add on but you do not indicate 1:1 etc. they said that would be written in the PCP. This may be a challenge to always have to go back in the PCP to see what it is for. Currently you put it on the part V.

Answer: We've added an input to track this in the Cost Detail Tool under the "Budget" tab.

Questions from MACS

Webinar on the New Cost Detail Sheet

- Where do you request services that are state only?

Answer: State Only services are available within the Cost Detail Tool under the "Support Services" section on the "Budget" tab noted as "Other (State Only Funded)" - if available in the selected Waiver and Plan Type. These will be reviewed on a case-by-case basis by the regional offices.

- What do you do when a current plan that is being funded, like personal supports, has items that are not waivered or do not show on drop down? We have been told to leave in the plan and/or they were not unbundled by regional office?

Answer: These need to be moved to a state-only service request if not covered in the waiver service definition.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- Where do you indicate start-up funds for residential and day program equipment that may be needed for a person? They said put it under "Transition" supports. How will you know what can be approved so time is not wasted?

Answer: The CP waiver supports specific items when someone is moving into a residential setting under "transition services". The DDA does not fund day program equipment. Covered items are noted in the CP waiver application.

- Who do we direct questions to when we start using the form and are having challenges?

Answer: Your regional fiscal staff or Ron Peele at ronald.peele@maryland.gov.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- What happens when Effective Plan Date starts and ends in 11 months and a new meeting has not been held due to reasons beyond the agency's control. How will we be paid for the gap in dates when you have still provided the service. The assumption would be in most cases the supports would continue and the meeting is just held late?

Answer: The process for annual review and update of the PCP typically begins 90 days before the annual plan date with quarterly monitoring activities. A new meeting needs to be planned in accordance with the effective end date of a person's plan. Appropriate planning and coordination with the person, CCS, and provider will minimize any risk of disruption. In situations where they may be a delay, PCIS2 currently has ability to authorize services from the previous year for a limited period of time. The functionality will also exist in LTSS.

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Questions from MACS

Webinar on the New Cost Detail Sheet

- DDA said on the webinar that DDA will have 20 days to approve the PCP annually. So the provider must have it to them 20 days before Effective Plan Date -- how will we know it is approved?

Answer: Notification will come from regional office once the plan is approved. The regional offices will follow the same protocol that they are currently using.

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- If your PCP meeting is held after July 1, 2018 you would not do another annual Cost Detail because this form is only to be used until June 30, 2019….only until the end of FY19

Answer: To clarify the new cost detail sheet will be used for all annual PCPs for the period of July 2018 through June 2019 for individuals in the CP waiver. As of July 2019, the cost detail will no longer be used because the functionality will be in LTSS.

- Stand alone services in Personal Supports – what do you do if they do not fit service definition?

Answer: Services will need to be reassessed during the annual PCP process. Some of the services can be accessed through the Medicaid State plan, private insurance, another standalone waiver services, personal resources, or as a state only service in the Cost Detail Tool.

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- How and when can you request transportation services? Not under day but under own drop down as stand-alone service? When is it approved?

Answer: Transportation is in the drop-down menu under "support services." Transportation cannot be requested for Supported Employment, ED&C, CDS, Career Exploration, Day, or Residential Services. Beginning July 2019, it can not be requested for Personal Supports.

- During the transition year of FY 19 how can agencies get the approvals like we do now in PCIS2? Will DDA still enter in PCIS2?

Answer: Yes, these will all be entered in to PCIS2 with service details.

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- "In lieu of day" - does that go under Residential as just an add on for Direct Support?

Answer: Yes this is the current process.

- We cannot see any of the rate calculations, they are locked and hidden. When will they be corrected and available?

Answer: The issues with the rate calculations related to the COLA have been fixed. The worksheet is locked to protect formula integrity.

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- Is the provider agency sending up the cost detail with the annual PCP? What happens when you don't get it from the CCS? Just send the cost detail alone? Is there just the one signature page with the PCP that covers the Cost Detail Page also or is there a separate signature?

Answer: The cost detail sheet goes along with the annual PCP or the Modified Service Funding Plan Request (MSFPR). The CCS is the point of contact for this process. There is only one signature required for the PCP. The cost detail sheet does not require a signature.

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Questions

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