



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX

Division of Medicaid & Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

JUN 22 2011

Patricia McManaman, Director
Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Ms. McManaman:

I am pleased to inform you that your request to renew the State of Hawaii's Section 1915(c) Home and Community-Based Services Waiver for Individuals with Developmental Disabilities or Mental Retardation (Control Number HI 0013.R05.00) has been approved. CMS approves the renewal with an effective date of July 1, 2011. With this renewal, the State requested phasing out Residential Habilitation services, modifying the scope of Chore services and adding Prevocational Services.

The following estimates of unduplicated participants and average per capita costs are approved:

	Unduplicated Recipients (Factor C)	Community Costs (Factor D+D')	Institutional Costs (Factor G+G')	Total Waiver Costs (Factor C x Factor D)
Year 1	2878	\$47,417.53	\$117,756.63	\$122,161,035.85
Year 2	3028	\$48,797.30	\$120,111.76	\$132,404,904.15
Year 3	3178	\$49,741.03	\$122,514.00	\$141,640,814.69
Year 4	3328	\$50,906.30	\$124,964.28	\$151,859,951.39
Year 5	3478	\$51,827.71	\$127,463.57	\$161,542,337.80

If the State wishes to modify the waiver program, an amendment request may be submitted to CMS via the HCBS web-based application portal. The waiver may be renewed at the end of the five-year approval period providing the State shows documentation of satisfactory performance and oversight.

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We appreciate the responsiveness of the Department of Human Services and the Department of Health during the renewal of this HCBS waiver program. If you have any questions regarding the waiver, please contact Cynthia Nanes at (415) 744-2977 or by email at Cynthia.Nanes@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Nagle for".

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Patti Bazin, Med-Quest Division, DHS
Ellen Blackwell, CMS, CMCS

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Revised name of program title to: Home and Community-Based Services for People with Developmental Disabilities (DD).

Appendix C:

- 1) Added service: Prevocational Services.
- 2) Removed service: Residential Habilitation.
- 3) Revised criteria: Chore.

Appendix H: Included a description of the Quality Improvement Strategy as it relates to the overall Quality Strategy for the Department of Human Services.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Hawaii** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Home and Community-Based Services for People with Developmental Disabilities (DD)
- C. **Type of Request: renewal**

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years 5 years

Migration Waiver - this is an existing approved waiver

Renewal of Waiver:

Provide the information about the original waiver being renewed

Base Waiver Number:

Amendment Number

(if applicable):

Effective Date: (mm/dd/yy) 07/01/11

Waiver Number: HI.0013.R05.00

Draft ID: HI.01.05.00

Renewal Number: 05

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

07/01/11

Approved Effective Date: 07/01/11

1. Request Information (2 of 3)

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

- §1915(b)(1) (mandated enrollment to managed care)
- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

To enable persons with developmental disabilities (DD) or intellectual disabilities (ID) who meet institutional level of care the choice to live in their homes and communities with appropriate quality supports designed to promote health and safety and independence.

Goals/Objectives:

- 1) To provide necessary supports to persons in the waiver to maximize participants' independence and participation in their communities.
- 2) To offer and provide necessary supports to individuals desiring and able to leave institutional settings to live in their communities.
- 3) To evaluate and continuously improve the quality of services to participants, including measuring the satisfaction of the benefits and services the participants receive, in order to improve them.

Organizational Structure:

Department of Human Services (DHS) is the Single State Agency/Medicaid agency and the Department of Health (DOH) operates the waiver. DHS and DOH have a Memorandum of Agreement (MOA) to administer, operate, and monitor the program. The MOA defines the roles and responsibilities required by each State department for waiver operation and administration.

Authority:

The waiver will be implemented by the DOH under the supervision of the DHS. DHS exercises oversight and ultimate operational approval over DOH's implementation/administration/operation of the waiver program. DHS makes rules and regulations that it follows in exercising oversight and ultimate operational approval authority that are binding upon DOH. DHS retains ultimate responsibility for the waiver. DHS serves as the communication liaison with CMS and includes DOH in matters pertinent to the waiver.

DOH is the State program responsible for administering programs for individuals with developmental disabilities. DOH issues policies, rules, and regulations regarding its implementation/administration/operation of the waiver program, under the supervision of DHS. DOH consults with and collaborates with DHS on all matters pertinent to waiver operations.

Waiver services are mostly delivered through agencies who enter into Medicaid Provider Service Agreements with DHS. For certain services, participants may select and direct their services through the consumer directed option. Service providers may provide one or more services as described in Appendix C.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities. Appendix E is required.**
 - No. This waiver does not provide participant direction opportunities. Appendix E is not required.**
- F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
 - Not Applicable**
 - No**
 - Yes**
- C. **Statewidness.** Indicate whether the State requests a waiver of the statewidness requirements in §1902(a)(1) of the Act (*select one*):
 - No**
 - Yes**

If yes, specify the waiver of statewidness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewidness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic

area:

- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
The Department of Health (DOH) secures input from stakeholders by holding public meetings (one per island and one for East and West Hawaii) prior to any waiver renewal or amendment is submitted. DOH also posts on the DOH website, the current approved waiver and provides a process for interested parties to submit comments.

In addition to periods prior to waiver renewals and amendments, DOH seeks regular comment and input through attendance at a variety of meetings:

- The Waiver Policy Advisory Committee (Waiver PAC), comprised of various stakeholders (individuals with DD, family members, providers, Developmental Disabilities Council (DD Council), DOH staff) meet minimally quarterly to discuss current and future services, gaps in services, rates, standards, staff qualifications, as well service delivery challenges and successes.

- Self-Advocacy Advisory Committee (SAC) operates under the DD Council and advocates for the rights of individuals with developmental disabilities and to have a voice in governmental and community affairs. The SAC meets monthly and provides the minutes to DOH and pertinent issues are discussed with DOH staff.

- The Developmental Disabilities Council consists of approximately 30 individuals appointed by the Governor of the State of Hawaii. The members plan, coordinate, evaluate, monitor and advocate on behalf of individuals with developmental disabilities. As with the SAC, the DD Council provides recommendations to DOH on pertinent DD waiver issues.

- The Hawaii Waiver Provider Association (HWPA) is comprised of DD waiver provider agencies statewide. This group meets at least quarterly and provides input to DOH on operations and programmatic issues.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:	<input type="text" value="Fink"/>
First Name:	<input type="text" value="Kenneth"/>
Title:	<input type="text" value="Med-QUEST Division Administrator"/>
Agency:	<input type="text" value="Department of Human Services"/>
Address:	<input type="text" value="601 Kamokila Boulevard, Suite 518"/>
Address 2:	<input type="text"/>
City:	<input type="text" value="Kapolei"/>

State: **Hawaii**
Zip:
Phone: **Ext:** **TTY**
Fax:
E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **Hawaii**
Zip:
Phone: **Ext:** **TTY**
Fax:
E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:
 State Medicaid Director or Designee
Submission Date:

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:

State:	Hawaii
Zip:	96813
Phone:	(808) 586-4997
Fax:	(808) 586-4890
E-mail:	pmcmanaman@dhs.hawaii.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Transition of Chore Services

Chore services will be limited to participants living independently and participants living with families without natural supports. Current chore services for participants not living independently, i.e., live with their family or who have natural supports, will be phased out over one (1) year beginning 6 months after the effective date of the approved waiver.

As the participant's annual ISP date nears (3 months from the due date), the DOH case manager will meet with the participant's circle of support to notify them of the change in the coverage of chore services under the waiver and discuss how the chores will be accomplished once the service is no longer available. The case manager and circle of support will explore whether the individual(s) performing the chore activities will continue to provide the tasks without compensation to assist in maintaining the individual in the community. If not, the next steps will involve identifying and securing alternate natural supports able to perform the chores.

All participants admitted into the waiver after the approval of the renewal application will only be offered chore services as part of the waiver benefits if they meet criteria (living independently or with family but without natural supports). This will prevent the need to remove the service a year later.

During the last waiver year, 156 participants of the 2,485 waiver participants received chore services on an average of 10 hours per week. Upon the elimination of chore services for participants who do not live independently, chore tasks will be incorporated into the Personal Assistance/Habilitation (PAB) services and/or performed by the participants' natural supports.

Transition of Residential Habilitation Services

Stakeholder groups recommended residential habilitation services be eliminated and replaced with the current personal assistance/habilitation (PAB) services. The services are similar with the primary difference in the two services being the location of the service delivery. Residential habilitation is provided in a licensed/certified home while PAB is provided in the community and private homes. Over the past waiver period, the DOH has come to understand that having the two services creates confusion and by returning to one service, the DOH can assure the service is evaluated and applied consistently in all settings.

Similar to chore services, for persons currently receiving residential habitation services, transition will begin 6 months after the effective date of the approved waiver. As the participant's annual ISP nears (3 months from the due date), the DOH case manager will meet with the participant's circle of support and notify them of the change in coverage under the waiver, assess the participant's needs, develop measurable goals, identify contributions from natural supports and explore the services that may be substituted for residential habilitation, e.g., PAB.

There were 686 out of a total of 2,485 waiver participants who received Residential Habilitation during the last waiver year. The DOH anticipates that most participants will receive PAB services equivalent to the number of hours for residential habilitation as the service was authorized based upon the participant's needs and goals. Since the needs and goals do not change significantly for this waiver population, the number of projected hours will not significantly increase or decrease with the elimination of this service.

As required, whenever the services are reduced or eliminated, the participant will be provided a Notice of Action identifying the action being taken. The process for requesting and filing for a Fair Hearing is explained in the Notice.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

Department of Health, Developmental Disabilities Division

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities: **As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative

functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

The Department of Human Services, as the Single State Agency/ Medicaid agency, administers all Medicaid waiver programs for Hawaii. In its capacity as the Single State Agency/Medicaid agency, DHS serves as the State's source for all matters pertinent to Medicaid. DHS provides technical consultation on all issues relevant to Medicaid and Medicaid waiver to DOH, which is the waiver operating agency.

The Department of Human Services (DHS) ensures the proper and efficient implementation of the waiver in the following manner:

1. Quality Assurance Reviews

These reviews are conducted by DOH and will examine the quality of services provided via the waiver as implemented by DOH. It is a process that is quality focused and assesses the DOH's role as the operational agency by conducting comprehensive participant reviews. Information to be reviewed will be gathered from participant and service provider records and interviews with participants, families and direct service workers. Indicators include but are not limited to: frequency and quality of worker/participant contacts; identification of measurable participant goals in service plans; documentation of services provided to achieve goals; responsiveness of the service planning process to participants' changing needs; adverse events regarding participants' health and safety; and quality of supervision and training provided to direct service workers by provider agencies to achieve participant goals.

Remediation and improvement activities may be participant and/or system focused. Anticipated outcomes include improvements to case management and participant service planning, recruitment and training of providers and increasing the ability of DOH to effect needed improvements and changes. Concerns specific to individual participants reviewed will be referred to the DOH case manager for remediation and follow up, with regular reports provided to the DHS.

2. DHS Management Compliance Review

DHS analyzes DOH's reports that review the entire process of waiver involvement from initial eligibility determination to payments rendered for services and claims filed. The DOH reports will include the following but are not limited to: the adequacy and efficiency of processes used to admit participants, how needs are assessed, how services are provided and how DOH monitors and tracks expenditures. It is a compliance focused activity. After analyzing the reports submitted by DOH, DHS will monitor remedial activities and outcomes and make recommendations for system improvement to DOH as needed.

3. Regular Management Meeting between DHS & DOH

This venue is used to facilitate more effective communication between the oversight and operational agencies. Discussion topics include areas of concern identified by either DHS or DOH during their quality assurance processes, strategies to improve services or mitigate problems, and strategies to improve existing services and processes. Issues are addressed as identified, leading to new processes or procedures, and follow-up discussions to monitor that implementation occurred.

The frequency of quality assurance reviews conducted by DOH and reports received by DHS varies depending on the specific type of information gathered. Refer to Quality Improvement sections located in each appendix for specific information and frequencies.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:* DHS has three contracts that perform operational or administrative functions on behalf of the Medicaid agency for the waiver.

1) DHS contracts its Fiscal Intermediary (FI) functions to Affiliated Computer Systems, Inc. (ACS) for the Medicaid Agency's fee-for-service (FFS) program. The waiver program providers bill ACS for payment.

2) DHS contracts with Ceridian to process payroll for consumer-directed providers.

3)DHS contracts with Cyrca to provide a medical consultant (licensed physician) to support the DHS Medical Director in reviewing the waiver level of care evaluations.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
Department of Human Services

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

ACS

ACS submits reports to DHS on a weekly basis. DHS monitors ACS' performance through review of these reports.

Ceridian

Ceridian submits reports to DHS on a monthly basis that are reviewed to assure contract compliance.

Cyrca

DHS' Medical Director or designee performs inter-rater-reliability on the work performed by the Cyrca medical consultant(s) on an on-going basis.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Utilization management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of new waiver applications completed by DOH within required time frame (90 days). N: # of new waiver applications completed by DOH within required time frame during the quarter; D: total # of new waiver applications completed by DOH during the quarter

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH applications tracking log

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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Performance Measure:

#/% of utilization reviews conducted by DOH in accordance with waiver approved policies/procedures. N: # of utilization reviews conducted by DOH in accordance with waiver approved policies/ procedures; D: total # of utilization reviews conducted by DOH

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH UR tracking log

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver policies/procedures in compliance with Memorandum of Agreement (MOA) and approved waiver. N: # of waiver policies/procedures in compliance with Memorandum of Agreement (MOA) and approved waiver; D: total # of waiver policies/procedures reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH policies/procedures

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Specify: <input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver policies/procedures revised during the waiver year by DOH and approved by DHS. N: # of waiver policies/procedures revised during the waiver year by DOH and approved by DHS; D: total # of waiver policies/procedures revised during the waiver year by DOH and reviewed by DHS

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH policies/procedures revised during the waiver year

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of reports submitted by DOH that are received by DHS in accordance with schedule. N: # of reports submitted by DOH that are received by DHS in accordance with schedule; D: total # of reports required to be submitted by DOH to DHS

Data Source (Select one):

Other

If 'Other' is selected, specify:

Scheduled reports from DOH

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: per schedule	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: per schedule

Performance Measure:

#/% of reports reviewed by DHS within 30 days of receipt. N: # of reports reviewed by DHS within 30 days of receipt; D: total # of reports reviewed by DHS

Data Source (Select one):

Other

If 'Other' is selected, specify:

Scheduled reports from DOH

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: per schedule	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: per schedule

Performance Measure:

#/% of scheduled validation activities completed by DHS (see specific assurance sections for scheduled validation activities). N: # of scheduled validation activities completed by DHS; D: total # of scheduled validation activities to be completed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Scheduled validation activities

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: per schedule	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
--	---

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Per schedule

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DHS is responsible for program monitoring and oversight. Identified problems are reviewed within appropriate quality committees to resolve issues timely and effectively. Corrective action plans and other remediation activities are logged and tracked and information is shared between DHS and DOH at regularly scheduled meetings.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: per schedule

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0 <input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	0 <input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

HRS § 333F-1 defines intellectual disability as follows: “ ‘Intellectual disability’ means significantly sub-average general intellectual functioning resulting in or associated with concurrent with moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period.” Significantly sub-average intellectual functioning is determined by a standardized measurement of intelligence testing, the outcome of which yields an intelligence quotient (IQ) of 2 or more standard deviations below the mean, or an IQ of 70 or below.

HRS § 333F-1 defines developmental disabilities as follows: “ ‘Developmental disabilities’ means a severe, chronic disability of a person which:

- 1) Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- 2) Is manifested before the person attains age twenty-two;
- 3) Is likely to continue indefinitely;
- 4) Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
- 5) Reflects the person’s need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.”

The severe chronic disability constitutes substantial impairment for the affected individual, and is attributable to intellectual disability or related neurological conditions that result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability. Substantial functional limitations are identified by a score of 3 or more standard deviations (SD) below the mean on a standardized assessment of adaptive behavior, which may be adjusted by utilizing a 95 per cent confidence interval.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:
- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
 - Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

- The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

- Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
- The following percentage that is less than 100% of the institutional average:

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- b. **Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (check each that applies):

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2878
Year 2	3028
Year 3	3178
Year 4	3328
Year 5	3478

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:
 - The State does not limit the number of participants that it serves at any point in time during a waiver year.
 - The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.**
 - The State reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals are admitted on a first-in, first-out basis. Exceptions to this order of admission as defined in the Hawaii Disability Rights Center Settlement Agreement (2005) will be made only for: an individual who requires crisis-level services in order to avoid institutionalization (persons who require crisis-level services are those for whom there are no supports available so that their health, safety and/or welfare are at risk); or an individual or his/her legal guardian who chooses to receive HCBS from a specific individual or provider and that individual or provider is not able to immediately provide services.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a.
1. **State Classification.** The State is a (*select one*):
 - §1634 State**
 - SSI Criteria State**

209(b) State

2. Miller Trust State.

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Blind or disabled individuals under §1634(c) of the Act.

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
 Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217

- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
 A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
 Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
 Medically needy without spend down in 209(b) States (42 CFR §435.330)
 Aged and disabled individuals who have income at:

Select one:

- 100% of FPL**
 % of FPL, which is lower than 100%.

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Optional State Supplement participants.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a**

community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (2 of 4)****b. Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility**B-5: Post-Eligibility Treatment of Income (3 of 4)****c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- The following standard included under the State plan**

(*select one*):

- The following standard under 42 CFR §435.121**

Specify:

- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(*select one*):

- 300% of the SSI Federal Benefit Rate (FBR)**

- A percentage of the FBR, which is less than 300%

Specify percentage:

- A dollar amount which is less than 300%.

Specify dollar amount:

- A percentage of the Federal poverty level

Specify percentage:

- Other standard included under the State Plan

Specify:

- The following dollar amount

Specify dollar amount: If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:

Specify:

- Other

Specify:

ii. Allowance for the spouse only (select one):

- Not Applicable
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

- The following standard under 42 CFR §435.121

Specify:

- Optional State supplement standard

- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

Specify:

- Other**
- Specify:*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional State supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

- The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- The following formula is used to determine the needs allowance:

Specify formula:

- Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. **Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

For individuals who do not require services on a monthly basis, face-to-face monitoring by the case manager will be at least quarterly with monthly telephone contacts with participant and/or collaterals, i.e., caregivers, parents, guardians, providers, teachers, employers.

- b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

Specify the entity:

- Other**

Specify:

DHS determines initial ICF/MR level of care (LOC) evaluations. Initial level of care determinations may be extended by DOH for up to 60 days, only in cases when unforeseen circumstances have delayed initial acceptance into the waiver program, provided that there is no change in the individual's functioning/needs.

Reevaluations are conducted by DOH.

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The initial LOC evaluation is performed by a DHS physician or physician designee. The DHS physician is a licensed physician in the State of Hawaii. The physician designee is a consultant, also licensed in the State of Hawaii, contracted by DHS.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

(a) Initial evaluation

The initial level of care evaluation is done by DHS. The following information is reviewed:

- DHS 1150C documenting DOH recommendation and request for level of care authorization
- Physician's evaluation completed and signed by the applicant's physician
- Results of an adaptive functional assessment
- Psychological evaluation, if performed
- Intake reports documenting personal/medical/family/social history, if no psychological evaluation is attached
- Cognitive scores
- Adaptive scores

Based on the above information, the criteria to determine level of care is as defined in HRS Chapter 333F-1 under the definitions for intellectual disability and developmental disabilities. The applicant's adaptive functioning should be assessed with at least moderate deficiency or below; and be able to benefit from waiver services.

(b) Annual Reevaluation

The annual reevaluation is done by DOH. The following information is reviewed:

- Quarterly health monitoring assessments
- Provider reports
- In-person interviews by DOH case manager
- Services planning assessment(s), e.g., Inventory for Client and Agency Planning (ICAP), Supports Intensity Scale (SIS)
- Adaptive functional assessment, e.g., Adaptive Behavioral Assessment System (ABAS)
- Individualized Service Plan (ISP)
- Annual physician's evaluation completed and signed by the participant's physician
- Updated psychological assessment for children, for participants with mild-moderate intellectual disability, and for participants with major health changes whose cognitive and/or adaptive functioning may have changed

Based on the above information, the criteria to determine level of care are as defined in HRS Chapter 333F-1 under the definitions for intellectual disability and developmental disabilities. An adaptive functional assessment is updated when the service planning assessment does not meet criteria, e.g., ICAP score >70; a psychological evaluation is updated when the adaptive functional assessment does not meet criteria, e.g., ABAS is in the mild range. An updated psychological evaluation or updated testing is also required for children at certain age groups as well as for any adults whose service planning assessment and adaptive functional assessment do not meet criteria, e.g., ICAP scores above 70 and ABAS scores in the mild range, whose current assessment is unclear, whose cognitive and/or adaptive functioning has changed significantly, or whose health has undergone major changes. Adaptive functioning is at least in the moderate range or below and the participant is able to continue to benefit from waiver services.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):
- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
 - A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The DHS 1150 (facility) is different from the DHS 1150C (waiver) in that the DHS 1150 evaluates an individual's need for active treatment 24 hours/day, 7 days a week. The DHS 1150C takes into consideration the natural supports available to the participant to enable the participant to live in the community.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Details of the processes for Initial Evaluations and Annual Reevaluations are outlined below:

(a) **Initial evaluation:** All applications for waiver services are reviewed and processed by the DOH. Following the receipt of all required documents, the DOH reviews the available information that will include at a minimum: 1) application requesting services; 2) physician's evaluation; and 3) adaptive behavior assessments identifying functional levels. A psychological evaluation of cognitive and adaptive functioning by a licensed psychologist will be required if the physician's evaluation indicates a diagnosis of intellectual disability. Additional information such as Department of Education assessment reports may be available to the DOH. The DOH collects and reviews applicant information and determines whether the applicant meets criteria as defined by HRS Chapter 333F-1 under the definition for intellectual disability and developmental disabilities as having qualified for services with intellectual disability or a developmental disability. If the applicant meets the criteria and is Medicaid eligible, DOH recommends to DHS that the applicant be evaluated as meeting the ICF/MR LOC. The recommendation is documented on the DHS 1150C form.

DHS receives the DHS 1150C form with attachments supporting the recommendation. The attachments include the physician's evaluation completed and signed by the applicant's physician, results of an adaptive functional assessment, a psychological evaluation if performed, and intake reports documenting personal/medical/family/social history, if no psychological evaluation is attached. The cognitive and adaptive scores and classifications (MR or DD) are included in the DHS 1150C.

DHS reviews the DHS 1150C form with attachments and determines the ICF/MR LOC. If the applicant meets LOC, he/she is admitted into the waiver. If denied and not admitted into the waiver, DHS submits to the applicant, a Notice of Action stating the denial and the right to appeal to DHS.

DOH maintains in its files, all forms and reports received that provide information to evaluate the applicant, e.g., application, Department of Education or other evaluation(s) including psychological, physical therapy, occupational therapy, speech evaluation, and adaptive functioning assessments, a participant profile form that summarizes the applicant's intellectual functioning, levels of support needed in self-care, communication, mobility, individual living environment, employment or supported employment, self-direction, and cognitive retention (adaptive behavior), physical health/etiological consideration. This information is available to DHS and CMS should it be requested.

(b) **Reevaluation:** Annually, the DOH reevaluates the participant using available information such as quarterly health monitoring assessments, provider reports, in-person interviews, the services planning assessment(s), e.g., Inventory for Client and Agency Planning (ICAP), the adaptive functional assessment, e.g., Adaptive Behavioral Assessment System (ABAS), the Individualized Service Plan (ISP), as well as the annual physician's evaluation. A psychological assessment will also be updated for children, for participants with mild-moderate intellectual disability, and for participants with major health changes whose cognitive or adaptive functioning may have changed. The DOH Qualified Mental Retardation Professional (QMRP) determines whether the participant meets LOC. The LOC of participants whose cognitive or adaptive functioning may have changed, (children, participants with mild MR and/or mild deficiencies in adaptive functioning, or participants with major health changes) are reviewed and determined by the DOH Clinical Interdisciplinary Team (CIT). The LOC reevaluation is maintained in the participant's file. If the participant does not meet LOC, DOH provides the participant with a Notice of Action stating the denial and the right to appeal to DOH. Any participant who does not meet LOC is additionally reviewed by DOH clinical team and by DHS prior to being discharged from the waiver.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

Specify the other schedule:

	 
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h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

Specify the qualifications:

The DOH staff who perform reevaluations are Qualified Mental Retardation Professionals (QMRP). A QMRP is defined as an individual who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who has graduated from an accredited university or is licensed/certified in a field related to developmental disabilities.

Participants whose cognitive or adaptive functioning may have changed (children, participants with mild intellectual disability and/or mild deficiencies in adaptive functioning, or participants with major health changes) are evaluated by the DOH Clinical Interdisciplinary Team (CIT), which is led by a DOH physician licensed in the State of Hawaii.

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Case management units maintain a tickler system to notify the DOH case managers at least three months in advance to complete the level of care reevaluation prior to the expiration of the existing evaluation. Completed level of care reevaluation documentation is kept in each participant's chart. This is a component of case management.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluations and reevaluations are maintained in the participant's chart.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

a. Sub-assurance: *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of new waiver participants with an approved DHS 1150C prior to receipt of services.

N: # of new waiver participants with an approved DHS 1150C prior to receipt of services;

D: total # of new waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

Database - DHS 1150C

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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Performance Measure:

#/% of new waiver participants with an approved DHS 1150C prior to receipt of services.

N: # of new waiver participants with an approved DHS 1150C prior to receipt of services;

D: total # new waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants with an annual LOC reevaluation within 365 days of previous LOC evaluation. N: # of waiver participants with an annual LOC reevaluation within 365 days of previous LOC evaluation; D: total # of waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH LOC tracking log

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

#/% of waiver participants with an annual LOC reevaluation within 365 days of previous LOC evaluation. N: # of waiver participants with an annual LOC reevaluation within 365 days of previous LOC evaluation; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of new waiver participants with a completed initial LOC determination on appropriate form. N: # of new waiver participants with a completed initial LOC determination on appropriate form; D: total # of new waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

Database - DHS 1150C

Responsible Party for data	Frequency of data	Sampling Approach(check

collection/generation(<i>check each that applies</i>):	collection/generation(<i>check each that applies</i>):	<i>each that applies</i> :
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with a completed LOC reevaluation on appropriate form. N: # of waiver participants with a completed LOC reevaluation on appropriate form; D: total # of waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH LOC tracking log

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of LOC reevaluations confirmed by the DOH supervisor. N: # of LOC reevaluations confirmed by the DOH supervisor; D: total # of LOC reevaluations reviewed by the DOH supervisor

Data Source (Select one):

Other

If 'Other' is selected, specify:

DOH LOC tracking log

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
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Performance Measure:

#/% of initial LOC evaluations confirmed by DHS through peer review. N: # of initial LOC evaluations confirmed by DHS through peer review; D: total # of initial LOC evaluations reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of LOC reevaluations denied by DOH that are validated by DHS. N: # of LOC reevaluations denied by DOH that are validated by DHS; D: total # of LOC reevaluations denied by DOH

Data Source (Select one):

Other

If 'Other' is selected, specify:

DHS tracking log of reevaluations denied by DOH

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Tracking, peer and supervisory review activities assist in identifying trends and individual problems, e.g., untimely or inappropriate determinations. DOH performs remediation on an individual basis to assure that reevaluations are completed. All denials by DOH of LOC upon reevaluation are reviewed by DHS and discussed with DOH as needed and logged.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Following the submittal of an application, the DOH Intake case manager meets with the applicant and his/her guardian and reviews the requirements, including Medicaid eligibility, and DDD services available, including the waiver program. DOH Intake case managers use the Home and Community-Based Services (HCBS) for Persons with Developmental Disabilities and/or Intellectual Disability Medicaid Waiver Program brochure to explain the community-based alternatives to institutional care. The applicant and/or legal guardian signs an Acknowledgement Form which documents that the case manager has reviewed potential services with the applicant and that the brochures were provided. If the applicant chooses home and community-based services, the applicant indicates the selection by marking the appropriate box on the Acknowledgement Form.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Signed copies of the Acknowledgement Form are maintained in the participant's chart.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

DOH contracts with interpreters; there are also a number of state case managers who are multi-lingual.

DOH also produces information in alternate formats as requested. DOH follows DHS' LEP policies/procedures.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Individual Employment Supports
Statutory Service	Prevocational Services
Statutory Service	Residential Habilitation
Statutory Service	Respite

Other Service	Assistive Technology
Other Service	Chore
Other Service	Environmental Accessibility Adaptations
Other Service	Group Employment Supports
Other Service	Non-Medical Transportation
Other Service	Personal Assistance/Habilitation (PAB)
Other Service	Personal Emergency Response System (PERS)
Other Service	Skilled Nursing
Other Service	Specialized Medical Equipment and Supplies
Other Service	Training and Consultation
Other Service	Vehicular Modifications
Other Service	Waiver Emergency Services

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services generally furnish 3 or more hours per day on a regularly scheduled basis as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Activities shall include training in ADLs, IADLs, such as communication, and socialization as identified in the participant's service plan. Such activities shall be provided in both adult day health (ADH) and community settings.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services, as would transportation to community settings during ADH. The cost of this transportation is included in the rate paid to providers of adult day health services. Transportation time between the participant's place of residence and the adult day health center is not included in the ADH services time.

(The service specification was modified to add in language to clarify that transportation to and from the participant's place of residence and the the adult day health center is not included in the ADH services time. Wording on the need for the Individual Plan was deleted.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

	▲ ▼
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Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency ▼

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

	▲ ▼
--	--------

Certificate (specify):

	▲ ▼
--	--------

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Individual Employment Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Individual employment support services include activities needed to obtain and sustain paid work within the general workforce by participants and include assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the participant, transitioning the participant from volunteer work to paid employment, and assisting the participant in maintaining an individual job in the general workforce at or above the state's minimum wage, or developing and sustaining a microenterprise.

Individual employment support is conducted in a variety of settings. When individual employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. Payment does not include reimbursement for supervisory activities rendered as a normal part of the business setting.

With regard to self-employment, individual employment support services may include: (a) aiding the participant to identify potential business opportunities; (b) assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business; (c) identifying the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

Individual Employment Support: Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

The waiver does not cover incentive payments, subsidies, or unrelated vocational training expenses such as the following:

Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

Payments that are passed through to users of supported employment programs; or

Payments for training that is not directly related to an individual's supported employment program.

Medicaid funds are also not be used to defray the expenses associated with starting up or operating a business.

(The service specification was modified to describe how the service has been divided between individual employment supports and group employment supports. This service now describes individual employment supports.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are limited to a maximum of eight (8) hours per day.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Individual Employment Supports****Provider Category:**Agency **Provider Type:**

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications**License (specify):**
 
Certificate (specify):
 
Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Statutory Service **Service:**Prevocational Services **Alternate Service Title (if any):**
 

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Prevocational services are services that prepare a participant for paid employment. Services are community-based and include career assessment, person-focused career planning, benefits counseling, work trials, apprenticeships, and teaching such concepts as compliance, attendance, task completion, problem solving, safety and transportation. Career assessment and planning, and benefit counseling are focused services to engage a participant in identifying a career direction and developing a plan for achieving integrated employment at or above the state's minimum wage or for creating a microenterprise (self-employment). The outcome of this service is documentation of the participant's stated career objective and career plan used to guide individual employment support.

Teaching and training services are not job-task oriented, but instead, aimed at a generalized result (attention span, motor skills, social skills, etc.). Services are directed to habilitative rather than explicit employment objectives.

Personal care/assistance may be a component of prevocational services, but does not comprise the entirety of the service. Individuals receiving prevocational services may also receive educational, supported employment and/or adult day health. However, different types of non-residential habilitation services may not be billed during the same period of the day.

Prevocational services are provided to persons who are not expected to join the general work force or participate in transitional sheltered workshop within one year of service initiation. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Prevocational services are limited to a maximum of two years for each employment episode.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (*specify*):

Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Service:

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

Residential habilitation will be phased out for current participants over one year as an assessment is conducted and a new ISP is developed. The case manager will evaluate and authorize alternative services such as PAB.

Residential habilitation means individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation does not include general care and protective oversight and supervision which are required under the facility's license or certification requirements.

Payment is not made for the cost of room and board, the cost of building maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a residence required to assure the health and welfare of residents, or to meet the requirements of the applicable life safety code. The method by which the costs of room and board are excluded from payment for residential habilitation is specified in Appendix J.

Residential habilitation may be provided in licensed and/or certified community settings provided that such services do not duplicate services furnished to a participant as other types of habilitation.

Personal care/assistance may be a component part of residential habilitation services but may not comprise the entirety of the service.

(The service specification was modified to indicate that the service will be phased out over the first year of the renewal period.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Respite services are only provided to participants living in family homes and are furnished on a short-term basis to provide relief to those persons who normally provide care for the participant. Respite may be provided in the participant's own home, the private residence of a respite care worker, DD Domiciliary Home, DD Adult Foster Home, Adult Residential Care Home, and Expanded Adult Residential Care Home. Federal financial participation is not claimed for the cost of room and board in any of these settings. Respite is not available in long-term care facilities.

(The service specification was modified where language was revised to reduce the current limit of 30 consecutive days to specify that no single episode of respite can exceed 14 consecutive days.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Multiple episodes of respite may occur during the a year. However, any episode of respite is limited to 14 consecutive days. The DOH Utilization Review Committee (URC) will perform further authorization on a case-by-case basis.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Direct Support Worker (DSW)
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service**Service Name: Respite**

Provider Category:Individual **Provider Type:**

Consumer Directed Direct Support Worker (DSW)

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Consumer directed – meets qualifications in job description - trained and supervised by the participant/designated representative

Verification of Provider Qualifications**Entity Responsible for Verification:**

Employer/Designated Representative

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service**Service Name: Respite**

Provider Category:Agency **Provider Type:**

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

CH-05. Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive device. Assistive technology devices and services under the waiver may not replace devices and services available under the State Plan. Assistive technology that can be covered under the State Plan are covered by the State Plan through QExA health plans, including EPSDT.

Assistive technology services include:

1. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
4. Coordination and use of necessary therapies, interventions, or services with assistive technology devices such as therapies, interventions, or services associated with other services in the service plan;
5. Training or technical assistance for the participant, or where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and
6. Training or technical assistance for professional or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement
Individual	Independent contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Prior to and after service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Independent contractor

Provider Qualifications

License (specify):

State of Hawaii Department of Commerce & Consumer Affairs, if applicable

State General Excise Tax license

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work

in the United States, and able to perform the assigned tasks. Must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Prior to and after service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes services such as heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture, in order to provide safe access and egress as well as more routine or regular services such as the performance of general household tasks, e.g., meal preparation and routine household care. These services are available only to participants living independently and only when the participant, anyone else financially providing for him/her, and no other relative, caregiver, landlord, community/volunteer agency, or third party payer is not capable of or responsible for providing the same service.

Current chore services for participants who are living with family or independently with natural supports will be phased out over one year.

(The service specification was modified to put a new limit into place. Chore will only be for participants living without natural supports or living with family but the natural supports are unable to perform the chores, e.g., physically unable to perform the chores.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor
Agency	DOH Waiver Provider Agency, i.e., agency with Medicaid provider agreement
Individual	Consumer Directed Direct Support Worker (DSW)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Individual

Provider Type:

Independent Contractor

Provider Qualifications

License (specify):

State of Hawaii Department of Commerce & Consumer Affairs
 State General Excise Tax License

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Prior to and after service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Chore

Provider Category:

Agency

Provider Type:

DOH Waiver Provider Agency, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Chore

Provider Category:

Individual

Provider Type:

Consumer Directed Direct Support Worker (DSW)

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Consumer directed – meets qualifications in job description - trained and supervised by the participant/designated representative

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer/Designated Representative

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

Those physical adaptations to the participant's home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant and enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems needed to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. Adaptations are for homes owned by the participant and/or legal guardian or family. All adaptations shall be made utilizing the most cost effective materials and supplies.

(The service specification was modified to add language to clarify that a 5 year limit for services includes the previous waiver period in situations where the the job overlaps waiver renewal periods. For example, a participant gets adaption done in May 2011 (5th year of waiver period) and wants to have another adaption done in 2012 (first year of waiver renewal). The participant is not eligible for another adaptation until 2016 (5 years later). Exceptions to the 5 year limit include when there are changes to the participant's condition that was not anticipated but the modification is needed for health and safety. An example includes a change in the participant's physical and cognitive functioning where they are no longer able to assist with bathing and need the shower to be modified to a walk-in type rather than step over shower stall and a wheelchair ramp was installed 2 years ago; or the participant moves to a new home and needs the home to be renovated to accommodate the participant's needs.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limit of \$25,000 per request, one request every 5 years, including if received under previous waiver period, with exceptions made for health and safety of the participant, e.g., participant condition changes and needs a modification in order to remain in the community. Participants are always afforded the ability to address the Utilization Review Committee if they believe a modification is needed prior to the 5 year period.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Environmental Accessibility Adaptations

Provider Category:

Individual

Provider Type:

Independent Contractor

Provider Qualifications

License (specify):

State of Hawaii Department of Commerce & Consumer Affairs
 State General Excise Tax License
 Valid General Contractor's license in the State of Hawaii

Certificate (*specify*):

Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Prior to, during and after service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Group Employment Supports

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (*Scope*):

Group employment supports include activities needed to obtain and sustain paid work by participants and include assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the participant, transitioning the participant from volunteer work to paid employment, and assisting the participant in maintaining an individual job in the general workforce at or above the state's minimum wage.

Group employment supports are employment and training activities furnished in regular business and industry settings for groups of no more than four (4) workers with disabilities. Examples include enclaves, mobile crews, and other business-based workgroups employing small groups of workers with disabilities in integrated employment.

When group employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities. Payment does not include reimbursement for supervisory activities rendered as a normal part of the business setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

The waiver does not cover incentive payments, subsidies, or unrelated vocational training expenses such as the following:

Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

Payments that are passed through to users of supported employment programs; or

Payments for training that is not directly related to an individual's supported employment program.

Medicaid funds are also not be used to defray the expenses associated with starting up or operating a business.

(The service specification was modified to distinguish between individual and group employment supports. The previous waiver only had supported employment but did not make a distinction between group versus individual employment).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Services are limited to a maximum of eight (8) hours per day. Group employment supports are limited to groups of no more than four workers with disabilities.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Group Employment Supports

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Service offered in order to enable participants living independently or in family homes to gain access to waiver services only in areas, i.e., rural, where public transportation is limited or non-existent and to gain access to non-waiver community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan defined at 42 CFR §440.170(a) (if applicable) and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized. If allowed, the most cost-effective mode of transportation will be authorized.

(The service specification was modified to clarify non-medical transportation can be authorized to gain access to another waiver service only in areas where public transportation is limited or non-existent.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

--

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Valid Driver's license

P.U.C. license as appropriate

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Each agency must follow P.U.C. standards, as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Assistance/Habilitation (PAB)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

A range of assistance or training to enable program participants to assist with the acquisition, retention or improvement in skills related to living in the community. These supports may include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, social and leisure skill development. Services may also

include training to increase independence as well as developing natural supports and relationships. This may take the form of hands-on assistance (actually performing a task for the person), training, or multi-step instructional cueing, as a part of a plan to prompt the participant to perform a task.

PAB may include assistance and/or training in the performance of Activities of Daily Living (ADL) skills, e.g., bathing, dressing, toileting, transferring, maintaining continence, and Instrumental Activities of Daily Living (IADLs) that are more complex life activities, e.g., personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication and money management. Such assistance also may include active supervision (readiness to intervene as necessary) and interaction with participants.

Personal assistance/habilitation (PAB) services may be provided on an episodic or on a continuing basis.

PAB services may also be provided while the participant is temporarily institutionalized in an acute hospital or nursing facility when participant behavior interferes with medical care and treatment and will result in the administration of chemical and/or physical restraints.

(The service specification was modified to include the types of activities currently provided under Residential Habilitation since PAB will be the replacement service in many instances when Residential Habilitation is phased out. In addition to PAB services being limited to 30 days in an acute hospital or nursing facility, the State added a limit of 14 calendar days when the participant is out-of-state unless approved.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

In situations where the individual is temporarily institutionalized in an acute hospital or nursing facility, PAB services cannot exceed 30 days unless assessed to be necessary.

Out-of-State PAB services cannot exceed 14 days unless assessed to be necessary.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
 Provider managed

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed Direct Support Worker (DSW)
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Assistance/Habilitation (PAB)

Provider Category:

Individual ▼

Provider Type:

Consumer Directed Direct Support Worker (DSW)

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (specify):

Consumer directed – meets qualifications in job description - trained and supervised by the participant/designated representative

Verification of Provider Qualifications**Entity Responsible for Verification:**

Employer/Designated Representative

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Assistance/Habilitation (PAB)

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

PERS is a system that enables waiver participants to secure help in an emergency and maintain safety in the community. As part of the system, a participant may also wear a portable “help” button to allow for mobility. The system is connected to the participant’s phone and programmed to signal a response center once a “help” button is activated. The response center is staffed by trained professionals, as specified herein. The response center may also provide daily reminder calls to participants or respond to other environmentally triggered alarms, e.g., motion detectors, etc., in the household. Service includes on-going monitoring of the system.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider , i.e., agency with Medicaid provider agreement

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response System (PERS)

Provider Category:

Provider Type:

DOH Waiver Provider , i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Skilled nursing services include services listed in the service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the state.

Skilled nursing services under the waiver may not replace the services available under the State Plan. Medically necessary skilled nursing services that can be covered under the State Plan are covered by the State Plan through the QExA health plans, including EPSDT medically necessary skilled nursing for waiver participants under age 21.

Skilled nursing through the waiver is provided on an intermittent or part-time basis.

(The service specification was modified by revising the language to delete vocational nurse, added language to not replace services available under the State Plan and clarified language on reporting. Language was also added that skilled nursing is intended to be intermittent or part-time and that the Utilization Review Committee (URC) and the DOH Clinical Interdisciplinary Team (CIT) will be actively reviewing cases when skilled nursing hours reach certain thresholds.)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The DOH Utilization Review Committee (URC) and the DOH Clinical Interdisciplinary Team (CIT) will be actively involved in the review of participants when skilled nursing hours reach certain thresholds. The URC and CIT will also assess whether these participants still meet criteria for and can benefit from the waiver or whether intense medical needs make them more appropriate for QExA HCBS services.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person

- Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Each agency must follow the Hawaii State Administrative Rules regarding the Hawaii Nurse Practice Act.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Specialized medical equipment and supplies include:

1. Devices, controls, appliances, equipment and supplies, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live;
2. Items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items;
3. Such other durable and non-durable medical equipment not available under the State Plan that are necessary to address participant functional limitations; and
4. Necessary medical supplies.

Specialized medical equipment and supplies under the waiver may not replace the medical equipment and supplies covered under the State Plan through the QExA health plans, including EPSDT medically necessary equipment and supplies for waiver participants under age 21. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

Nutritional diet supplements, such as Ensure and Pediasure, are only covered by the waiver if the participant is able to eat by mouth (no feeding tube) and is at risk for weight loss that will adversely impact the participant's health. Prior to authorization, the plan includes a request from a medical provider and measurable weight goals and a follow-up plan. Additional diapers, pads and gloves over the amount covered by the State Plan may be covered by the waiver only on a temporary or intermittent basis.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e. agency with Medicaid provider agreement
Individual	Independent Contractor
Agency	Medical Supply Company

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:Agency **Provider Type:**

DOH Waiver Provider, i.e. agency with Medicaid provider agreement

Provider Qualifications**License (specify):**

State of Hawaii Department of Commerce & Consumer Affairs, if applicable

Certificate (specify):**Other Standard (specify):**

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Prior to, during and after the service delivery

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**Individual **Provider Type:**

Independent Contractor

Provider Qualifications**License (specify):**

State of Hawaii Department of Commerce & Consumer Affairs, if applicable

State General Excise Tax license

Certificate (specify):**Other Standard (specify):**

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Prior to, during and after the service delivery

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Medical Supply Company

Provider Qualifications**License (specify):**

State of Hawaii Department of Commerce & Consumer Affairs, if applicable

State General Excise Tax license

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Prior to, during and after the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training and Consultation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Training and consultation services for individuals who provide ongoing support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, e.g., family member, neighbor, friend, companion, co-worker, who provides care, training, guidance, companionship or support to a waiver participant. Except for the initial training for implementation of a plan, this service may not be used to train paid workers. Training includes instruction about treatment regimens and other services included in the service plan, use of equipment specified in the service plan, and included updates as necessary to safely maintain the participant at home. All training shall be identified and included in the service plan.

(The service specification was modified to add language to clarify that this service allows initial training of paid workers only during the implementation of a plan (behavior modification, physical therapy, etc)).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Time limited, intermittent, and consultative. Not a direct service.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent contractor
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Training and Consultation

Provider Category:

Individual ▼

Provider Type:

Independent contractor

Provider Qualifications**License** (specify):

State of Hawaii Department of Commerce & Consumer Affairs
 State General Excise Tax License
 All professionals meet appropriate licensing requirements

Certificate (specify):
Other Standard (specify):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.
 Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

Prior to and after service delivery

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Training and Consultation

Provider Category:

Agency ▼

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications**License** (*specify*):

All professionals meet appropriate licensing requirements

Certificate (*specify*):
Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicular Modifications

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (*Scope*):

Adaptations to an automobile or van to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the individual;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modification.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

\$15,000 per request, one request every 7 years, including if received under previous waiver period.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent contractor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicular Modifications

Provider Category:

Individual ▼

Provider Type:

Independent contractor

Provider Qualifications

License (*specify*):

State of Hawaii Department of Consumer Affairs, if applicable

State General Excise Tax license

Certificate (*specify*):

Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure standards.

Must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications

Entity Responsible for Verification:

DOH

Frequency of Verification:

Prior to and completion of service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service ▼

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Waiver Emergency Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Waiver emergency services (outreach) shall be defined as immediate on-site crisis support for situations in which the individual's presence in their home or program is at risk due to the display of challenging behaviors that occur with intensity, duration, and frequency, that endangers his/her safety or the safety of others, or that results in the destruction of property.

Waiver emergency services (crisis respite) shall be defined as emergency out-of-home placement for individuals with potential for danger to self or others and their significant support systems due to the individual's challenging behaviors. The goal of the emergency services (crisis respite) shall be to provide a stabilizing environment to preserve the individual's living situation.

Waiver emergency services (crisis shelter) shall be defined as emergency out-of-home placement of individuals in need of intensive intervention in order to avoid institutionalization or more restrictive placement and in order to return to the current or a new living situation once stable. Waiver emergency services (crisis shelter) shall include discharge planning at the point of admission.

This benefit is primarily aimed at adults.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The DOH Utilization Review Committee (URC) and Clinical Interdisciplinary Team (CIT) will be actively involved in the review of participants when crisis respite and shelter hours reach certain thresholds.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Waiver Emergency Services

Provider Category:

Agency

Provider Type:

DOH Waiver Provider, i.e., agency with Medicaid provider agreement

Provider Qualifications

License (specify):

Certificate (specify):

	 
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Other Standard (*specify*):

Meet Standards in Provider Services Agreement, e.g., staff must pass criminal history check, be able to work in the United States, and able to perform the assigned tasks. Each provider agency must be approved by DOH and DHS in order to provide the waiver service and adhere to staffing qualifications in terms of training, education and certification/licensure stated in waiver standards.

Each agency must be licensed to do business in the State of Hawaii and able to enter into contracts with the State.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DOH

Frequency of Verification:

1st month of service for initial evaluation and every succeeding 12th month thereafter

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

State Department of Health, Developmental Disabilities Division Case Managers

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

(a) All supervisors and direct support workers (DSW) employed through an agency or individual providers (independent

contractors)

(b) State and Federal

(c) Provider agencies must obtain background checks from the Criminal History Data Center (CHDC) which is part of the State’s Department of the Attorney General. The background check must be stamped “certified.” The CHDC performs a screen match of the providers’ fingerprints and name against both the FBI and State of Hawaii database for criminal activity. The provider must obtain the CHDC check within five calendar days of initial hire and then within 12 months of initial CHDC check. The provider performs the name checks bi-annually thereafter.

DOH monitors to ensure compliance by checking employee records to verify that background checks have been completed. Quarterly provider reports on the status of clearances are sent to DHS by the DOH. Clearances are required initially, annually for the first two years of employment, and every other year thereafter. If the worker has not received initial clearance, the worker may not provide waiver services. If DOH finds the agency in non-compliance, DOH requires the agency to obtain required checks within a specified time limit. If the agency refuses to comply, DOH may suspend or terminate the agency.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Insights to Success (ITS), an entity contracted by several agencies in the State of Hawaii Department of Human Services

(b) All supervisors and direct support workers (DSW) employed through an agency

(c) Provider agencies to complete Adult Protective Services (APS)/Child Protective Services (CPS) background checks and fingerprinting as specified in provider agreements. DOH staff monitor and check agency records to ensure that mandatory screenings have been conducted. DOH submits reports to DHS for review.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**
 - i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type
Adult Foster Home
Special Treatment Facility/Transitional Living Program
Special Treatment Facility
Adult Residential Care Home

Expanded Adult Residential Care Home (E-ARCH)
Developmental Disabilities Domiciliary Home

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Up to five individuals with DD can live in certified or licensed residential settings such as developmental disabilities domiciliary homes (DDDH), and adult residential care homes (ARCH), and up to six individuals in expanded adult residential care homes (E-ARCH). The administrative rules governing the operations of each of these settings (Chapters 89 and 100.1) impose rules that promote health, well being, as well as community living. These rules require the operators of these facilities to promote community integration and membership, social interaction/relationships, e.g., continued visits with family, and involvement in community activities, e.g., recreation, work, health, social. For example, Hawaii Administrative Rule (HAR) Chapter 100.1 governing ARCHs and E-ARCHs requires the resident to be “up and out of bed, appropriately dressed” unless there are physician orders indicating otherwise; operators are required “to provide social and recreational activities for residents on a regular basis.”

These homes are located throughout the islands in single family home neighborhoods. Participants are allowed to choose the home that they live in, reside in a bedroom with a door that can be shut for privacy as well as have access to a bathroom with a door that can be shut. If they share a room, the participant can choose the roommate and choose to eat when everyone else eats or later. They have their meals at a dining room table with other residents or can choose to eat elsewhere, e.g., family room in front of the television.

Individuals residing in a special treatment facility with up to 8 residents are also located in single family neighborhoods and typically resemble a single family dwelling. These homes are typically 2 levels to accommodate the need for more bedrooms but the bedrooms have doors that shut for privacy and also have bathrooms with doors that can shut for privacy. They are very much like the other homes in that they have bedrooms, a kitchen and dining area, living room with television, etc. Participants are able to choose their roommate and room changes are made when a particular pairing is not working.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Foster Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>

Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

2 participants

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Special Treatment Facility/Transitional Living Program

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

1-5 participants

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>

Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>
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When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Special Treatment Facility

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

1-8 participants

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following

topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Care Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>

Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input checked="" type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

Type 1 (1-5); Type 2 (6+)

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services
C-2: Facility Specifications

Facility Type:

Expanded Adult Residential Care Home (E-ARCH)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input checked="" type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

2 E- ARCH level participants

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>

Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>
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When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Developmental Disabilities Domiciliary Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>
Assistive Technology	<input checked="" type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>
Waiver Emergency Services	<input checked="" type="checkbox"/>
Residential Habilitation	<input checked="" type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

Facility Capacity Limit:

5 participants

Scope of Facility Standards. For this facility type, please specify whether the State's standards address the following

topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State

policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Services provided are authorized based on person centered planning. The services are identified before the provider is selected.

Parents and legal guardians of minor children are not paid to provide services. Relatives or family members who may provide waiver services to minor participants are defined as natural or hanai (Hawaiian tradition of taking in and caring for an individual without going through formal adoption procedures) brother, sister, aunt, uncle, cousin, grandfather or grandmother.

Spouses of participants are not paid to provide services. Relatives, or family members, who may provide waiver services to adult participants are defined as natural, adoptive, step, in-law, or hanai father, mother, brother, or sister, son or daughter, and grandfather or grandmother. Guidelines for authorizing waiver services which may be provided by a family member include:

1. The family member is unable to provide the service(s) without reimbursement; and
2. The family member is the most qualified provider; or
3. The family member is the only available provider of care.

Relatives/legal guardians employed through provider agencies or the consumer directed method are subject to the same monitoring and supervision requirements as non-relatives/legal guardians. Under the consumer directed model, a legal guardian for an individual may not provide the services for which he or she serves as the designated representative.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Providers are enrolled on an ongoing basis. There are no enrollment period restrictions. Application packets are sent to interested persons upon request which includes information on provider requirements and the process.

All providers may provide one or more services based on their ability to meet provider qualifications.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's

methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of licensed/certified providers (by standard) that meet required licensing, certification & other state standards. N: # of licensed/certified providers (by standard) that meet required licensing, certification & other state standards; D: total # of licensed/certified providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review of Hawaii's Waiver Providers

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

#/% of licensed/certified providers (by standard) that meet required licensing, certification & other state standards. N: # of provider on-site reviews conducted jointly with DOH that are validated by DHS; D: total # of provider on-site conducted jointly with DOH

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider on-site reviews

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and	<input checked="" type="checkbox"/> Other

	Ongoing	Specify: Reviews conducted for validation
	<input checked="" type="checkbox"/> Other Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of non-licensed/non-certified/consumer directed providers that meet waiver requirements. N: # of non-licensed/non-certified/consumer directed providers that meet waiver requirements; D: Total # of non-licensed/non-certified/consumer directed providers sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

Agency		
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of non-licensed/non-certified/consumer directed providers that meet waiver requirements. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

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Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. *Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance

complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of licensed/certified providers that meet training requirements. N: # of licensed/certified providers that meet training requirements; D: total # of licensed/certified providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review of Hawaii's Waiver Providers

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of licensed/certified providers that meet training requirements. N: # of provider on-site reviews conducted jointly with DOH that are validated by DHS; D: Total # of provider on-site reviews conducted jointly with DOH

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider on-site reviews

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Reviews conducted for validation
	<input checked="" type="checkbox"/> Other Specify: Semi-annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
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<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

Performance Measure:

#/% of non-licensed/non-certified/consumer directed providers that meet training requirements. N: # of non-licensed/non-certified/consumer directed providers that meet training requirements; D: total # of non-licensed/non-certified/consumer directed providers sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of non-licensed/non-certified/consumer directed providers that meet training requirements N: # of non-compliant records validated by DHS D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DOH performs annual on-site reviews of licensed/certified providers to verify that providers meet waiver requirements. For non-licensed/non-certified consumer/consumer directed providers, DOH gathers information on compliance as part of their QA/QI Review for Case Management Services. If a provider is non-compliant with waiver requirements, e.g. agency personnel did not receive required training from the provider agency, DOH is responsible to ensure that the agency provides the training and to track and document this when completed. DOH, in consultation with DHS, may issue appropriate sanctions to the provider for the period of non-compliance, e.g., recoupment of billed services, suspension of services, termination.

Results of the on-site and record reviews are submitted to DHS quarterly. DHS accompanies DOH on a sample of on-site reviews.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input checked="" type="checkbox"/> Other Specify: Semi-annually

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No**
 Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
 Applicable - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

- (a) All waiver services, except for PAB, must be provided in-state only. PAB is the only service that can be provided out-of-state.
- (b) Since all waiver services are available in the State, there is no need for a participant to receive waiver services out-of-state. PAB services up to the limit of 14 consecutive days may be authorized should a participant require the service when travelling out of state. The participant's PAB worker accompanies the participant and provides the service. The DOH does not pay for any of the PAB worker's travel costs as those are borne by the participant and/or guardian.
- (c) Unless the DOH identifies situations that require changes to the limit, the DOH does not anticipate adjusting the limit.
- (d) In unusual circumstances, in order to safeguard the participant's health and welfare, the DOH may authorize waiver services out-of-state, e.g., crisis or another PAB worker should circumstances render the primary caregiver unable to care for the participant. As with other emergencies, the DOH has identified certain individuals within the organization with the authority to approve services and/or additional units of services.
- (e) Participants and their guardians are able to contact their case managers to explain unusual or unexpected situations that require authorization of out-of-state services. As noted in (d), services may be authorized above the limit by certain individuals within the organization.
- (f) Participants are notified that all services, except for PAB, must be provided in-state when they are accepted into the waiver program. The providers are aware of the requirement as it is written in the Provider Standards.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title: Individualized Service Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):
- Registered nurse, licensed to practice in the State**
 - Licensed practical or vocational nurse, acting within the scope of practice under State law**
 - Licensed physician (M.D. or D.O)**
 - Case Manager** (qualifications specified in Appendix C-1/C-3)
 - Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Case managers must meet the qualifications of either social worker, human services professional, or registered professional nurse.

Social Workers (SW) are those with a MSW or a BSW from a program of study accredited by the Council on Social Work Education, or a doctorate degree in social work from a college or university accredited by the Western Association of Schools and Colleges, or a comparable regional accreditation body. A SW with a bachelor's degree must have minimally 1 year of specialized experience in a social/human/health service type of setting.

Minimum qualification requirements for Human Service Professional (HSP) is graduation from an accredited 4 year college or university with a bachelor's degree which included a minimum of 12 semester credit hours in courses such as counseling, criminal justice, human services, psychology, social work, social welfare, sociology or other behavioral

sciences. For the level required by case managers, the HSP must also have minimally 1.5 years of specialized experience in a social/human/health service type of setting.

Social Worker.

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Participants receive information regarding person-centered planning in both written and oral formats. Family members receive "A Guide to Person-Centered Planning for Families" brochure that includes self determination principles.

A Case Management and Information Services Branch (CMISB) brochure outlines the supports and services funded by DOH. Participants also receive the "Home and community Based Services (HCSB) for persons with developmental disabilities and/or intellectual disability Medicaid Waiver Program" brochure, which provides information on eligibility and services offered under the HCBS waiver as well as other services offered in the community.

(b) The participant is the center of the planning process. Hawaii Revised Statutes (HRS) § 333F governing services for people with developmental disabilities and/or intellectual disability provides the statutory mandates for person-centered planning and self-determination. HRS § 333F-1 defines the individualized service plan (ISP) as the "written plan required by HRS § 333F-6 that is developed by the individual, with the input of family, friends, and other persons identified by the individual as being important to the planning process. The plan shall be a description of what is important to the person, how any issue of health and safety shall be addressed, and what needs to happen to support the person in the person's desired life."

Appendix D: Participant-Centered Planning and Service Delivery

B. SERVICE PLAN DEVELOPMENT (40%)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The DOH case manager assists in the development of the (ISP). According to statute, the ISP is the written plan required by HRS § 333F-6. The participant identifies persons to participate in the planning process. This “circle of support” include parents/guardians, siblings, friends, service provider(s) and the QUEST Expanded Access (QExA) service coordinator. An ISP is initiated after eligibility for services administered by the DOH and completed annually. The ISP is reviewed at least quarterly with the participant and/or guardian; updates are done at any time when a participant’s needs change.

(b) Assessment information is gathered from persons whose professions, disciplines, or service areas are relevant to identifying the participant’s needs and designing services and supports to meet the needs and goals of the participant. Sources can include information/reports/status updates/recommendations from the participant, family members, medical/health professionals, residential care providers, service providers, friends, etc.

Types of assessments used by the case managers include a health monitoring assessment summary, service(s) planning assessment, e.g., Inventory for Client and Agency Planning (ICAP), and the ISP.

(i) The health monitoring summary assists in identifying the participant’s health and safety needs for care providers;

(ii) The service planning assessment identifies general needs and behaviors of concern to be addressed; and

(iii) The ISP identifies the participant’s circle of support, positive reputation (description of the person’s attributes), how the participant communicates, what is important to the participant, priority goals and the action plan.

(c) Participants are informed of services available through the waiver in a variety of ways. The case manager reviews the HCBS brochure with each participant. The HCBS brochure lists the waiver services, eligibility criteria, other available services, and the process and timelines for admission into the waiver program. Each participant receives a copy of this brochure.

Participants are also given a copy of the Medicaid Waiver Providers in Hawaii booklet, which lists the services and the agencies that provide each service, including the geographic areas served by each agency. The booklet also contains questions the participant and/or legal guardian may want to ask the potential provider agency to help with service and agency choices. The booklet is updated periodically to reflect changes in waiver services and provider agencies.

Waiver services are also listed on the CMISB website.

The DOH provides outreach and informational sessions to various community groups.

(d) The ISP shall be a written description of what is important to the participant, how any issue of health and safety shall be addressed, and what needs to happen to support the participant in their desired life. The ISP identifies:

(i) The support team (chosen by the participant as important to the planning process) who collaboratively identifies what is important to the participant; how the participant communicates and a brief profile (positive reputation of the eligible participant);

(ii) Health and safety issues/concerns;

(iii) Priority goals; and

(iv) The service plan and activities needed to meet the participant’s goals.

(e) Services are coordinated through discussion during the ISP meeting. As needed, the participant’s QExA health plan and/or DHS are included to facilitate any medically necessary coordination. Waiver services shall not supplant or duplicate other Medicaid services outside of this waiver. Waiver services shall not supplant or duplicate services provided by another State agency to include but not limited to the Department of Education or Vocational Rehabilitation.

(f) The service plan identifies: who will do what by when and/or how often.

- (i) During the ISP meeting, responsibilities are assigned and frequency of services are agreed upon to meet the participant's goals.
 - (ii) Service plans are given to the participant and/or legal guardian for signature and consent, e.g., to verify agreement made during the planning process. Should the participant and/or legal guardian elect not to sign or consent to the ISP, the case manager shall include supporting documentation within the participant's contact log describing the efforts to resolve any discrepancies. A Notice of Action suspending waiver services will be issued to the participant and/or legal guardian that includes appeal rights.
 - (iii) A copy of the service plan is also given to the circle of support members to verify agreements/assignments and conditions of what needs to happen, as needed.
 - (iv) Case managers are responsible for the quarterly monitoring of the plan.
- (g) As stated in (a), the plan is initiated after eligibility for services is determined by DOH. Following the administrative rules governing targeted case management (HAR 1738), case managers make at least quarterly at face-to-face contacts and periodic telephone contacts with the participant and/or collaterals to assess/re-assess the participant's status. ISPs are completed annually and can be updated at any time when a participant's needs/goals change or there are changes in service delivery.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Chapter 333, HRS, and Hawaii Administrative Rule Chapter 1738 identify the critical case management functions of assessment, planning, and ongoing monitoring and service coordination.

- Assessments are used to identify existing or potential risk factors:

The assessments, which are completed annually and as the participant's needs or preferences changes, identify the participant's abilities, deficits and needs, including potential or existing risk factors or conditions that are then addressed in the participant's service plan. For example, the health assessment summary will identify the participant's general health status and identifiable health risk factors which are in turn addressed in the individual's service plan. Other assessments such as the service planning assessment, e.g. ICAP identify the maladaptive behaviors, cognitive and communication abilities; these are used to identify potential or existing behavior issues and concerns. The quarterly reports from providers and AERs may also identify other issues which need to be addressed in service planning review or update meetings.

- Mitigation of risk factors incorporated into the individual service plan:

Within the service plan there is a pertinent information section identifying contingency plans for participants in the event of natural disaster or any emergency, crisis support services available for the participant in the event of a behavioral crisis, health information identifying conditions and contact persons, physician contact numbers, medications/dosages and the purpose of each medication, list of allergies, special diets, use of any adaptive or specialized equipment, financial information, guardian or family/friends contacts and medical insurance plan information. The DOH Clinical Interdisciplinary Team is the forum for discussion of issues representing medical and/or behavioral challenges/dilemmas.

Provision of "back up" service in the individual plan of care:

ISPs include "contingency plans" developed to ensure identification of persons or agencies responsible for various actions and activities; as part of person-centered planning, the roles and responsibilities of the circle of support members may include the identification of a natural support, e.g., family member or neighbor, willing to provide back-up supports. Particularly for individuals with challenging behaviors, a crisis contingency plan is developed to ensure that there is clear communication of what needs to happen in a crisis.

The provider agreements include the requirement that the agency must have a plan identifying risk and safety factors, e.g. available reliever or back-up staff when the assigned primary direct service worker is unavailable. Further, when necessary, a second provider agency (which is also authorized to render the service required by the service plan) may be identified as "back up" provider agency at the service plan meetings at which time the details of contacts and other arrangements are

clarified. This second agency would be used when the primary agency, as a result of unforeseen circumstances, may be unable to serve the participant – copies of the service plan are provided to each agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Upon admission to the waiver, participants receive information regarding the availability of qualified providers of each service in each geographic location. As described in Appendix D-1d(c) participants are informed of services available through the waiver in a variety of ways. The case manager reviews the HCBS brochure to each participant. The HCBS brochure lists the waiver services, eligibility criteria, and the process and timeline for admission into the waiver program. Each participant receives a copy of this brochure. Participants may also use the Medicaid Waiver Providers in Hawaii booklet, which lists the services and the agencies that provide each service. Waiver services are also listed on the DOH website. Case managers encourage participants to call and visit agencies and to discuss particulars with agency representatives; the Waiver Providers in Hawaii booklet includes a list of questions participants or potential participants may wish to ask when speaking with potential service providers.

Participants may choose one or more service providers for one or more services. The choice of providers is presented during the ISP. Participant's choice of providers is documented on the ISP Action Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

On an annual basis, DHS will validate a sample of ISPs by reviewing 10% of the non-compliant ISPs reviewed by DOH.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager

Other*Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) DOH case managers will monitor the implementation of the individualized service plan (ISP) and participant's health and welfare.

(b) DOH case managers at minimum perform quarterly face-to-face visits with the participant and make contact with care givers, parents, guardians, providers, teachers, and employers to assess/review the participants' health, welfare, and services authorized in the ISP. During these contacts, case managers monitor the implementation of the service plan with the participant and/or legal guardian, service and care providers, and other persons and entities involved with the participant. Case managers are required, by HAR §1738, to do "periodic observations of service delivery to ensure that quality service is being provided" as well as "evaluate whether a particular service is effectively meeting the needs of the recipient."

Case managers obtain information from the participant and service provider (waiver or other service provider). For waiver services, quarterly reports are provided by the HCBS providers. The case managers are able to review the participant's progress and determine if the goals and outcomes are being met. This information is also used for discussion and potential service plan updates.

Adverse Event Reports sent to the case managers are reviewed for critical event, actions taken (or not taken), and corrective action plans. Upon notification of an adverse event that may pose jeopardy to health and welfare, the case manager will immediately follow up to ensure the participant health and welfare. In situations where there is an informal report or question concerning appropriate action(s) to be taken, case managers will follow up with the person(s) or agency(ies) as necessary.

Completed Adverse Event Reports are sent to the DOH staff who review the actions and plans of corrections. DOH staff may also do follow up reviews with case managers and providers (residential and/or waiver). DOH staff also work with DHS staff (including APS and CPS) to address issues of common concern. Joint visits may be done to review and address a situation of concern with the provider.

(c) Monitoring of service plans is done at three levels: 1) at the individual level, by the DOH case manager; 2) at the program level, by the DOH; and 3) at the oversight and system level, by DHS.

Monitoring at the individual level by case managers is done with minimally quarterly face-to-face visits and periodic contacts with collaterals to review ISP, updating assessments, status, and progress towards achieving outcomes. Case managers assess information obtained on a participant's status, e.g., health/medical, ADLs, IADLs, progress towards achieving outcomes, satisfaction of services delivered, and the need for additional or other entitlements and generic community resources.

Case managers (and other DOH staff) may make follow up visits or calls in response to issues identified by a participant, legal guardian, interested party, or provider, at any time. Case managers, DOH staff, and DHS staff may also respond to and follow-up on issues of concern identified from Adverse Event Reports. Examples of these may include: providing participant related information to case managers for their follow up, requiring corrective action plans from providers or DOH staff and ensuring corrective action plans have been implemented.

DOH will also monitor a representative sample of the service plans on an annual basis (see performance measures). DHS will oversee the DOH monitoring and review non-compliant records. Programmatic and systemic reviews are completed by DOH and DHS to identify areas of concern. Systemic changes/improvements may include revision of operational procedures, modification of forms or training procedures and identification of new training topics, among others.

- b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants whose ISP includes services and supports that align with their needs as indicated in their assessments. N: # of waiver participants whose ISP includes services and supports that align with their needs as indicated in their assessments; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP includes services and supports that align with their needs as indicated in their assessments. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP includes supports to ameliorate assessed risk factors. N: # of waiver participants whose ISP includes supports to ameliorate assessed risk factors; D: total # of waiver participants sampled whose ISP identifies risk factors

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP includes supports to ameliorate assessed risk factors. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP supports the participant's personal goals. N: # of waiver participants whose ISPs support the participants' personal goals; D: total # of

waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP supports the participant's personal goals. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
--	----------------------------------

Performance Measure:

#/% participants who report: case managers ask about their preferences & help them get what they need; have adequate transportation; make choices about housing, roommates, routines, jobs, case manager, staff or providers & social activities; & needed services are available. N: # participants who responded positively to the questions; D: total # participants who responded to the questions

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant survey

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant interview

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by

which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants whose ISP is based upon a completed Inventory for Client and Agency Planning (ICAP) assessment. N: # of waiver participants whose ISP is based upon an ICAP assessment; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants whose ISP is based upon a completed Inventory for Client and Agency Planning (ICAP) assessment. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with a signed ISP by the participant or authorized representative. N: # of waiver participants with a signed ISP by the participant or authorized representative; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with a signed ISP by the participant or authorized representative. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. *Sub-assurance: Service plans are updated/revise at least annually or when warranted by changes in the waiver participant's needs.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants with an ISP updated within 365 days of previous ISP. N: # of waiver participants with an ISP updated within 365 days of previous ISP; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval =

		5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with an ISP updated within 365 days of previous ISP. N: # of non-compliant records validated by DHS; D: total # of non-compliant records

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update N: #/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update D: total # of waiver participants sampled who had a change in their needs/condition requiring an ISP update

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants who had a change in their needs/condition requiring and resulting in an ISP update. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants whose services (type, amount, frequency, duration) were provided as specified in their ISPs. N: # of units of paid claims for each waiver participant; D: total # of units of prior authorizations for all waiver participants

Data Source (Select one):

Other

If 'Other' is selected, specify:

Prior authorization claims report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver participants with documentation of choice offered between institutional care and HCBS. N: # of waiver participants with documentation of choice offered between institutional care and HCBS; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered between institutional care and HCBS. N: # of non-compliant records validated by DHS; D: total # non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager. N: # of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative

		Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered among waiver services for which there has been an assessed need by the case manager. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered among available providers. N: # of waiver participants with documentation of choice offered among available providers; D: total # of waiver participants sampled

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data	Frequency of data	Sampling Approach(check
----------------------------	-------------------	-------------------------

collection/generation(<i>check each that applies</i>):	collection/generation(<i>check each that applies</i>):	<i>each that applies</i> :
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered among available providers. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants with documentation of choice offered to self-direct if applicable. N: # of waiver participants with documentation of choice offered to self-direct if applicable; D: total # of waiver participants sampled receiving services for which self-direction is an option

Data Source (Select one):

Other

If 'Other' is selected, specify:

QA/QI Review for Case Management Services

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Other
Specify:

Performance Measure:

#/% of waiver participants with documentation of choice offered to self-direct if applicable. N: # of non-compliant records validated by DHS; D: total # of non-compliant records reviewed

Data Source (Select one):

Other

If 'Other' is selected, specify:

Record review

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 10% of non-compliant records
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Scheduled record reviews and satisfaction surveys performed by DOH assist in identifying individual as well as systemic problems. If a record is found to be out of compliance, e.g., ISP was not updated, DOH is responsible to ensure that the ISP is updated and to track and document this when completed.

DOH submits the record review and survey results to DHS. DHS performs its own review of 10% of the records reviewed by DOH that were determined to be out of compliance.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies,

and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**
- No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.
- (a) Under the Consumer Directed Service option, participants and/or their guardians may hire, train, supervise, and fire their direct support workers. In this application, the Consumer Directed Services option will include chore, personal assistance/habilitation and respite.
- (b) Participants and/or their guardians are informed of this option during the ISP development process. If the consumer-directed option is elected, the participant and/or his designated representative must attend a consumer-directed orientation. The participant and/or his designated representative receives a consumer directed services handbook. Prior to hiring, the participant or his designated representative signs all required forms, e.g., Employment Eligibility Verification (I-9). The case manager assists in obtaining and submitted all required forms to the Consumer Directed Specialist. The Consumer Directed Specialist ensures all forms are appropriately completed and signed before beginning services.
- (c) Participants and/or designated representative hire the workers and provide training. Participants receive ongoing support from case managers and the Consumer Directed Specialist to complete monthly vouchers, add, or delete employees, and assure that workers are performing the services that they are hired to complete. If the participant is unable to direct his/her workers, they may use the support of a designated representative. The designated representative may be a family member or friend who will support the administrative employer requirements as well as respect participant preferences regarding service implementation. Payroll processing services are provided through a limited fiscal agent contracted by the state Medicaid agency for its Consumer Directed Services to process paychecks, withhold employee taxes, pay employer taxes, and mail the paycheck to the participant to disseminate to his/her worker.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities

responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) Information about participant direction opportunities are provided by the DOH case managers when discussing services and supports available, particularly in developing or reviewing the ISP. The Consumer Directed Brochure is shared with participants. This option is also mentioned in the HCBS brochure and the Developmental Disabilities Council Guide for participants receiving HCBS.

If the participant and/or his designated representative(s) is/are interested in receiving consumer directed services, the participant and/or his designated representative(s) is/are required to attend an orientation prior to hiring the consumer directed worker(s). Each participant and the designated representative receive consumer directed services handbook that is used and reviewed in the orientation. The orientation includes distinguishing between employer and employee responsibilities, providing techniques and examples to recruit, screen, and hire direct support workers, identifying potential liabilities and necessary tax and other employer required forms. As needed, the case manager provides support to the participant to complete necessary forms.

(b) The DOH Consumer Directed Specialist or Case Manager furnishes the necessary information to the participant and/or designated representative and employee(s).

(c) Information is presented at service planning meetings, at least annually or upon request. As stated, this option is included in HCBS brochure which is also distributed upon admission into the waiver and as applicable.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

During the person-centered planning process, the choice of consumer directed services may be made. In such situations, if there is no legal representative of the person or if the adult person freely chooses a non-legal representative, the circle members should assist to ensure that this non-legal representative chosen by an adult participant is someone who supports choices and decisions by the participant and who will not directly (or indirectly) benefit financially. Ideally, the non-legal representative is one who has a personal interest and relationship with the adult participant.

In order to minimize potential conflict of interest and to provide safeguards for the participant, the DOH has affected policies and procedures defining who may not be designated representatives. For example, DOH cannot pay the representatives, who may direct waiver services on behalf of the participant. As situations arise, DOH provides technical assistance and supports to the case manager to address how and what supports may be provided to ensure that the participant receives quality services in a manner desired by the individual and in the individual's best interests.

The Consumer Directed Specialist assists case managers and individual participants and/or designated representatives regarding procedures for enrollment and payment. The DOH monitors consumer-directed providers as part of its quality monitoring. DHS oversees DOH's monitoring of consumer-directed providers.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Personal Assistance/Habilitation (PAB)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chore	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

DHS contracts with a private vendor to serve as the payroll processing agent for the consumer directed services. This contractor, based on Oahu, provides all payroll processing functions for the consumer-directed service participants

throughout the state. Procurement was effected in accordance with the Hawaii State Procurement code

- ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The agent is paid a flat fee per check issued. Compensation to the payroll agent is fully state-funded.

- iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assists participant in verifying support worker citizenship status
- Collects and processes timesheets of support workers
- Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- Other

Specify:

Generate and mail paycheck to the participant for distribution.

Supports furnished when the participant exercises budget authority:

- Maintains a separate account for each participant's participant-directed budget
- Tracks and reports participant funds, disbursements and the balance of participant funds
- Processes and pays invoices for goods and services approved in the service plan
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- Other services and supports

Specify:

Additional functions/activities:

- Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- Other

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

Fiscal oversight is provided by the DHS-MQD Finance Office which reviews various summary reports that are produced in conjunction with the monthly payroll process.

Appendix E: Participant Direction of Services

Participant Services

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

During the participant-centered planning process, case managers explain services and service options including consumer directed services as defined in E-1-e. The Consumer Directed Specialist will provide ongoing support to the participant and his/her case manager throughout the participant’s use of this option to process and submit required documentation.

The participant may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their selection at any time.

The case managers monitor the delivery of consumer-directed services on a quarterly basis.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (*check each that applies*):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Assistance/Habilitation (PAB)	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Adult Day Health	<input type="checkbox"/>
Individual Employment Supports	<input type="checkbox"/>
Vehicular Modifications	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>
Chore	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Personal Emergency Response System (PERS)	<input type="checkbox"/>
Group Employment Supports	<input type="checkbox"/>
Training and Consultation	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Waiver Emergency Services	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The case manager works with participants during the person centered planning process to identify the type and amount of supports needed. Participants may use consumer directed personal assistance exclusively or in conjunction with agency managed services. They may change their delivery method at any time; in general, back-up plans are required for participants using the consumer directed option, including identifying back-up natural supports, consumer directed workers and agency provider(s). When participants voluntarily terminate the consumer directed option, the case manager re-assesses the needs of the participant and authorizes the appropriate number of agency hours.

The case manager will assure health and welfare of the participant; no services are terminated until needed substitute services, either by an agency or natural supports, are being provided.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Circumstances:

- (a) When participant's preferred direct support worker is unable or unwilling to provide the service and there are no options desired by the participant;
- (b) When participant's preferred direct support worker has been confirmed as a perpetrator of abuse (including financial)

and/or neglect of the participant;

(c) When the participant’s preferred direct support worker(s) do not or cannot provide appropriate services, potentially endangering the participant’s health and welfare;

(d) When there is no back-up available; and

(e) When the participant or his designated representative continually fails to meets consumer directed program requirements, e.g., untimely submittal of vouchers, submittal of incorrect vouchers, failure to deliver payment to workers, failure to maintain service records, failure to train and monitor workers, failure to follow the ISP activities and authorized hours, etc.

For participants who utilize the consumer directed option, the case manager generally is the first line of quality assurance, providing regular ongoing monitoring. Prior to starting consumer directed services, the participant and/or his designated representative shall have a back-up plan in place. Back-up plans include natural supports, other consumer directed workers and/or a provider agency to assure ongoing supports – it is preferable to have at least two natural supports and/or consumer directed workers and a provider agency, as a final back-up to provide services. In situations where the participant’s health and welfare may be in jeopardy, the case manager may immediately effect the implementation of the back-up plan after discussion with the participant and/or designated representative; the case manager may take other appropriate action if necessary (including referral for protective services assistance). The case manager will, during the transition, facilitate access, coordinate, monitor and assess the need for supports, e.g., other waiver services or other types of services.

The case manager will assure health and welfare of the participant, arranging for agency provided services or natural supports as soon as the case manager is aware of the need.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	600	
Year 2	650	
Year 3	700	
Year 4	750	
Year 5	800	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*
- Recruit staff**
 - Refer staff to agency for hiring (co-employer)**
 - Select staff from worker registry**
 - Hire staff common law employer**
 - Verify staff qualifications**
 - Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If desired by the participant, criminal history checks may be viewed at no cost using local registry sites.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- Determine staff wages and benefits subject to State limits**
- Schedule staff**
- Orient and instruct staff in duties**
- Supervise staff**
- Evaluate staff performance**
- Verify time worked by staff and approve time sheets**
- Discharge staff (common law employer)**
- Discharge staff from providing services (co-employer)**
- Other**

Specify:

Participants may choose to hire consumer-directed workers who have known criminal conviction records.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. **Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. **Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*
- Reallocate funds among services included in the budget**

- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The individual (or his/her legal representative) is informed of the opportunity to request a fair hearing at various points in the process of admission and service delivery. All applicants have the opportunity to learn about and elect home and community-based services (HCBS) during the first meeting with the DOH case manager. At that meeting, the DOH Case Manager explains the difference between institutional and home and community-based services, explains the waiver program and the requirements for the application (Medicaid eligible, meet ICF/MR level of care, information requirements, etc.), and gives the applicant a choice between institutional or HCBS.

If the applicant elects HCBS, the DOH case manager provides the DDD HCBS and Grievance and Appeals brochures. Both brochures provide information on the process for appealing any adverse action taken by the DOH on waiver services. All participants and/or their legal representatives have the option to go through an informal process with DOH first and then to appeal to DOH or

DHS. Participants are informed that the DHS decision is final and thus, they may want to first seek resolution from the DOH informal review and/or formal administrative appeal first.

During the course of reevaluating the level of care, and assessing and reassessing needs and services, the DOH case manager informs participants of their right to appeal whenever there is an adverse action, e.g., when the participant is suspended or terminated, or when services are discontinued or decreased. The participant and/or guardian are informed of their right to be notified in advance before the action is taken, the right for an informal discussion with staff from DOH, and the right to ask for an administrative hearing before a DOH Hearing Officer or the right to request a formal administrative hearing before a DHS Hearing Officer. The participant and/or legal representative are apprised of options for representation if needed. Finally, the participant and/or legal representative are informed that services may continue, if requested, until the administrative decision is received. The participant and/or guardian is informed of their right to forgo the informal discussion with staff from DOH and proceed directly to a fair hearing with either DOH or DHS at any time.

In the case when the participant is suspended or terminated, or when services are denied, reduced or terminated, the case manager completes a Notice of Action form that informs the participant of the adverse action and the reason for the action. The appeals process and timeframe are explained on the Notice of Action form. The Notice of Action form is sent at least 10 days prior to the action being taken, except in circumstances as defined in §17-1713(c) where adequate notice shall be sent not later than the date of the action. A copy of the Notice of Action form is kept in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates an additional dispute resolution process**
- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. **Operation of Grievance/Complaint System.** *Select one:*
- No. This Appendix does not apply**
 - Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**
- b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The DOH handles grievance/complaints relating to the DDD eligibility and waiver services.

- c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS

upon request through the Medicaid agency or the operating agency (if applicable).

a) The DOH has a “Consumer Services Office” (CSO) (formerly known as the DDD Ombudsman) that is responsible for receiving concerns/complaints/appeals for DDD services. These are issues that have not been resolved at either the case management unit level, provider level, or system level. These issues may include complaints against case managers, about a process or processes that did not occur as perceived by the complainant, about service delivery, and about decisions affecting service delivery. The DOH is responsible for receiving the complaints/concerns and tracking them to ensure they are handled in a timely manner.

b) Complaints may be registered verbally or in writing. Initial response to complaints is within 24 hours, or the next working day following receipt. Timeline for resolution of complaints is one month.

c) The CSO gathers information related to the complaint from the case manager, provider or other party with information about the complaint. The CSO attempts to resolve the complaint by identifying the action(s) that could improve the situation. Sometimes, there is no action required. If the complaint is related to a DOH employee, if appropriate, the complainant is referred to the Department of Health Personnel policies and procedures regarding labor relations.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

All waiver providers, case managers, and individuals involved with the participants, e.g., families and workers, are required to report occurrences of the following adverse/critical events: all incidents of abuse, i.e., physical abuse; psychological abuse; financial exploitation; neglect; sexual abuse pursuant to Chapter 346, HRS, (Dependent Adults) and Chapter 587, HRS, (Child Protective Services); any bodily injury requiring medical treatment, i.e., treatment by a physician; injuries of unknown cause; all medication errors and/or unexpected reaction to medications or treatment; changes in the participant’s health condition requiring medical treatment; death of a participant and when the whereabouts of a participant are unknown.

All adverse events are reported to the DOH Case Manager. Providers must make a verbal report within 24 hours of the critical event and submit a written report within 72 hours (exclusive of weekends and holidays) to the DOH Case Manager. The DOH Case Manager must complete his/her review of the report and submit the results of this review, including follow up actions, within 5 working days of receiving the written report from the Provider.

The occurrence of adverse events must be reported by all service providers, families, caregivers and other individuals who are involved in the care and well being of the participant. The definition of an adverse event includes the reporting of changes to the participant’s physical or emotional condition that are used to indicate that the participant’s physical health or safety may be at risk, as well as all situations where the participant required medical treatment. More specifically, it includes the mandatory reporting of all occurrences of potential (suspected) abuse including exploitation, changes to the participant’s health condition and behavior, all injuries of an unknown origin (cause), all medication and treatment errors whether or not there was an adverse reaction, all deaths, occurrences of participants whose “whereabouts” are unknown (missing), and any

hospitalization.

A data base is maintained by DOH and includes specific participant information to include but not limited to type of incident, location, frequency and/or patterns of incidents, etc., to identify possible actions that may be taken to prevent or minimize future occurrences including reassessing the participant and revising his/her plan of care.

DOH uses a database to capture information on AERs. Data fields include but are not limited to:

- General information, including information on participant and reporter, location of event, individuals present, who was notified, what was done;
- Nature or type of adverse event being reported, including suspected abuse/neglect (type of abuse/neglect), bodily injury sustained by participant for which medical treatment is necessary, injury of unknown cause, medication errors and/or unexpected reaction to medication or treatment, participant's behavior (new behavior, change in behavior, use of restraints, nature of new or change in behavior), changes in the participant's health condition that required medical treatment, death of participant, participant's whereabouts unknown, and hospitalization; and
- Actions taken by agency, case manager, and supervisor.

The provider specific reports include information to include but not limited to frequency of all incidents, frequency and/or pattern of each type of incident, gender of participants, types of, and locations of the incidents, etc., that will be used to monitor the adequacy of supervision given to the participant, quality of services rendered, the adequacy of actions taken to prevent future occurrences, and the sustainability of improvements implemented. In this regard, technical assistance will be given to all providers and caregivers to develop and implement a proactive Quality Assurance/Quality Improvement program. The Quality Assurance/Quality Improvement program should address that processes for both current and potential problems are established, verify that corrective actions are taken, assure that the problems are resolved, and monitor that these actions are sustained. The processes must also identify those situations where additional action must be taken to assure the safety of the participants and provision of quality services to the participant.

There is independent follow-up on allegations by DHS Adult Protective Services (APS) or Child Protective Services (CPS) and DOH tracks and monitors all reports and follow-up. Specific DOH programmatic section (Program Supports-QA, Contracts, Certification and Monitoring for certified or licensed residential homes) staff independently may follow up on the inquiry. Each agency apprises the other of results and actions to be taken.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

A DOH brochure on rights and responsibilities of a person with DD is available. Included in this brochure is a section on abuse including rights, signs, and actions to be taken. This brochure is shared with case managers for use as part of their discussions with participants and/or their legal guardians or designated representatives. This brochure is also incorporated in training for stakeholders, e.g., individuals (to be shared as part of self advocacy training), families, case managers, providers, and other interested stakeholders.

Whenever allegations of abuse are made, the DOH case manager informs the participant and/or legal guardian/designated representative of the allegations, concurrently explaining reportable events according to the CPS and APS laws. The case manager, in further follow up discussions and queries with the participant or the participant's legal/designated representative, will discuss more fully, the participant's rights and the actions or inactions that are considered to be abuse, exploitation, or neglect.

The waiver providers are required to inform the participant and/or the legal guardian or designated representative of participant's rights, including being free from exploitation, neglect, and abuse. Additionally, the participant signs an acknowledgement form annually which reviews these rights.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

All instances of suspected abuse and neglect must be reported to the DHS Adult Protective Services (APS) or Child Protective Services (CPS) intake units. DHS has policies and procedures to address the reports and resolutions. For waiver provider agencies, the Provider Service Agreement stipulates that they must inform the DOH case manager and DHS (APS or CPS) within 24 hours of the occurrence of a critical event and submit a written report within 72 hours.

For all other types of critical events or incidents as defined in G-1-b, the following process will be followed. When DOH case

managers are notified of critical events, they are required to complete the Adverse Event Report (AER). The DOH case managers assess the information related to the adverse/critical event(s) that is submitted by the individual or agency, e.g. waiver Provider. Case managers are required to respond to critical incidents within the first working day; coordination with DHS (APS or CPS) is done as necessary to ensure coordinated service planning. Case managers provide follow-up activities by contact, through telephone calls or face-to-face meetings or both, with the participant or the participant's legal or designated representative, to insure that the participant is safe. They obtain additional information required to determine what follow-up actions may be necessary, i.e., alternate placement of participant into another living environment, revising the service plan, arranging for a medical evaluation/follow-up treatment, providing more information to enforcement agencies, coordinating training or other supports, etc. Follow-up actions may include conducting on-site reviews and interviews with the collaterals. This may include a review of the provider in consultation with DHS to determine that corrective actions (for participant and by provider) are adequate. Following completion of interviews and fact finding, case managers inform the participant and/or guardian of the results, including recommended actions to be taken by the case manager, as these often include presenting options for different providers of particular services, e.g., residential, agency, direct support worker, etc. Investigations will be completed as soon as possible but typically within 30 days.

Data relating to critical events are analyzed and statistical reports prepared, e.g., information on trends, patterns, indicators of how services are rendered to each participant, etc. and reviewed by DOH for identification of issues of concern, i.e., trending analysis, corrective action plans (agency, case manager, supervisors) and follow-up action, e.g., monitoring, training, etc. In addition to responding to individual occurrences of adverse/critical events, emphasis would be on the adequacy of the Providers' ongoing Quality Assurance activities. Areas of deficiencies will be addressed by DOH and monitored by DHS.

For adverse/critical events, case managers and agency staff are expected to respond immediately to begin information gathering or the investigative processes. The timelines for reporting are previously addressed in this document. Actions taken by the direct support worker, agency, case manager, and/or APS or CPS are expected to be driven by the nature of the critical event and agency policies and procedures. Of foremost concern is the health and welfare of the participant.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Providers submit adverse/critical events on an Adverse Event Report (AER) report form. These are collected, tracked, and reviewed by DOH using the database mentioned above. DOH follows guidelines that are issued by DHS and follows established policies and procedures.

DOH and DHS are responsible for overseeing that adverse/critical events, including all incidents of abuse and neglect, are reported and are satisfactorily addressed and resolved. The frequency of quality assurance reviews by DOH and reports received by DHS varies depending on the specific type of information gathered. Refer to Quality Improvement sections located at the end of this appendix for specific information and frequencies. An overview of this oversight includes:

- 1) Review of all AERs submitted by DOH, which will comprise of an aggregation and analysis of 100% of AERs received. DHS will notify DOH if further remediation, corrective action, or system improvement is needed.
- 2) Detailed review of AER Reports for all deaths.
- 3) Detailed review of AER Report for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process for providing ongoing monitoring, quarterly assessments and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. **Use of Restraints or Seclusion.** (*Select one*):

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Aversive procedures such as chemical restraint, mechanical restraint, physical restraint, time-out and seclusion shall only be used when there is imminent danger to self or others and the following criteria are met:

- Shall be part of a behavior support plan following a behavior assessment, e.g., functional behavioral assessment, psychological evaluation, psychiatric evaluation, to also include staff training with specific procedures for each restraint utilized with appropriate documentation and supervision;
- Shall be approved by the participant and/or guardian, caregivers and direct staff who will implement the restraint in accordance with the plan and there will be documentation in the participant's ISP and record of its use;
- Shall require a physician's order;
- Shall be used in circumstances after less restrictive and intrusive approaches have been tried and proved ineffective;
- Shall be designed or applied to cause the least possible discomfort with discontinuation if pain or potential injury ensues; and
- Shall be reviewed and approved by the Behavioral Supports Review Committee prior to implementation.

DOH is in the process of developing a Behavioral Supports Review Committee. Reviews by this Committee will be required before any aversive procedure is used. The Committee will approve or reject all restrictive or aversive behavioral methods including those in behavior support plans.

The Behavioral Supports Review Committee will meet quarterly and will include as committee members a parent of a waiver participant, a community member with no direct involvement with waiver provider programs, a waiver participant, DOH facilitator with experience or training in best practices to support behaviors of individuals with developmental disabilities, DOH staff member from case management with experience in supporting participants with behavior concerns and a waiver provider who provides at least two services to participants.

For immediate situations where an aversive procedure may be necessary when there is imminent danger to the participant or others, the DOH Clinical Interdisciplinary Team (CIT) led by a state licensed physician along with other licensed professionals, e.g., nurse, psychologist, behavior specialist, social worker, will review the aversive procedure request and determine a temporary decision until the next scheduled Behavioral Supports Review Committee meeting.

Case managers complete ICAP assessments upon admission and annually thereafter. The maladaptive behavior score in conjunction with the results that indicate the participant's cognitive and communication skills provide the initial indicators that a behavioral assessment should be done to address behaviors of concerns

AERs with notations of bruising or other "unexplained injuries" are scrutinized and reviewed for possible abuse and/or inappropriate use of restraints.

The DOH case managers will provide annual and periodic monitoring of participants in residential settings as well as quarterly monitoring of waiver services including service delivery.

- The DOH also completes annual and as needed residential certification and monitoring of all DOH adult foster homes serving participants with developmental disabilities.
- All DOH adult foster home caregivers are required to complete a 40-hour training which includes a positive behavioral supports module, a module on values to promote ethical treatment of persons with developmental disabilities, as well as a personal care and safety module, provided by a licensed nurse, which includes medication

administration, documentation and monitoring.

- DOH quality assurance staff provides at least annual and on-going monitoring of the participants.
- DOH provider monitoring staff reviews waiver providers annually ensuring proper credentialing continuing education, adequate training and other documentation requirements are met for provider Training and Consultation services.

DOH has registered nurses statewide who serve as consultants to case managers regarding participant health status on a case-by-case basis. The CIT is also available to the case managers for consultation.

The Utilization Review Committee (URC) provides guidelines to DOH staff regarding the review of waiver services. Reviews include participants that exhibit challenging behaviors. The CIT and URC serve as “checks and balances” safeguards for waiver services as well as general community health services and supports.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Both DHS and DOH are committed to ensuring that the use of restraints and seclusion are only used to protect the participant from immediate harm to self and others.

As described above, DOH has multiple committee reviews to address various issues, human rights, behavior protocols, and implementation of plans. The DOH Behavior Supports Review Committee will approve or reject all restrictive or aversive behavioral methods including those in behavior support plans submitted by waiver providers.

The CIT, URC, or DOH sections will review AER reports, make recommendations and follow through on the implementation of corrective actions. This collaborative effort is intended to identify, review and track efforts to ensure health and well being.

DHS reviews Adverse Events reporting by DOH to monitor any events related to restraints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. **Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

- The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

See response provided in G-2-a-i.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

See response provided in G-2-a-ii.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (do not complete the remaining items)

Yes. This Appendix applies (complete the remaining items)

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

For all individuals:

The DOH case manager, as part of their assessment/reassessment and monitoring responsibilities, reviews the individual's records in a certified or licensed setting when home visits are done. DOH policy is that the case managers are required to make at least one home visit annually.

For individuals receiving medications as part of waiver services, the service supervisor (registered professional nurse) is expected to comply with the Nurse Practice Act; quarterly service reports should include confirmation of medications administered. The DOH service supervisor will communicate with the Primary Care Provider (PCP), as necessary.

AERs identifying medication administration problems are submitted and reviewed by DOH and monitored by DHS. Follow up actions are made as necessary, including increased monitoring and/or training requirements.

The DOH Clinical Interdisciplinary Team (CIT) is available to discuss issues and concerns with medication issues, including polypharmacy, chemical restraints, etc. All cases identified as potentially at risk, e.g., polypharmacy, psychotropic usage, challenging behaviors, will be brought forth for discussion.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

a) For certified and licensed residential settings, the DOH certifying/licensing staff is responsible for the annual reviews to ensure that participant medications are managed appropriately by the certified/licensed caregiver. As part of the review, the certifying/licensing staff reviews the participant's home records, home operational practices regarding medications and health areas in terms of compliance with regulations, e.g., storage, physician's orders, administration, disposal of medications, including medical reports and medication administration flow sheets. If staff identifies any problems or concerns, follow up actions may include: a) informing the case manager of such concerns and requesting assistance with follow-up of participant's physician/guardian, etc.; b) citation and requirement for plan of correction; c) referral for DOH follow up. The certifying/licensing staff will follow up on corrective actions taken (or not taken) and may pursue continued certification/licensure, probation, or termination of license or certificate.

b) AERs identifying those areas of potentially harmful practices are tracked to ascertain appropriate follow up action. This may include training, consultation sessions, sanctions, etc. Follow up of CIT reviews will also be done to ensure both appropriate follow up on individual situations and to identify system needs for training, consultation, or information sharing with community physicians.

c) Both DOH and DHS will collaborate on follow up and oversight. DHS is responsible for overseeing that critical events are reported and satisfactorily addressed and resolved. The oversight includes a review of quarterly AERs summary reports submitted by DOH as well as detailed review of any AER involving a death and AERs in participants

and/or providers for which a concerning trend has been identified. Both DOH reviews and DHS oversight together comprise aggregation and analysis of 100% of AERs received. DOH will work on remediation with waiver providers and DHS will work with DOH on remediation and system(s) change(s).

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.**
(complete the remaining items)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Waiver providers who administer medications as part of waiver services can only do so with a physician's order and by a registered nurse or as part of nurse delegation. The following is taken from the State Department of Health Standards for DD Medicaid Waiver Program:

J. Medications

1. The following shall apply to medications ingested or administered during the hours the participant is in Waiver Program or Waiver Program services from a provider.
 - a. Physician prescribed medications may be self-administered by a participant when the participant is physically and cognitively able to do so.
 - b. The participant may self-inject prescribed medications when the physician has written orders to permit this.
 - c. The participant may be assisted with medications when:
 1. The medication has been pre-measured;
 2. The medication is in individual doses;
 3. The container is clearly labeled by the participant's caregiver, pharmacist, physician, RN or LPN with the participant's name and the time and route for the medication; and
 4. The participant is able to take the single dose of medication independently. The provider staff assisting with the medication shall not place the medication in the participant's mouth.
2. Assistance with medication includes, but is not limited to, the following:
 - a. Placing the labeled container with the pre-measured medication in the participant's hand;
 - b. Assisting the participant with opening the container and dropping the medication into the participant's hand when needed;
 - c. Instructing the participant to take the medication;
 - d. Helping the participant to drink a liquid in order to swallow the medication;
 - e. Watching and observing the participant to ensure that the medication has been swallowed; and
 - f. Documenting the assistance with medication in the participant's chart.
3. Medication administration shall be performed by an RN or and LPN under the supervision of an RN
 - a. When the participant is unable physically or cognitively to self-administer his or her own medications, even with assistance; and
 - b. For injectable medications except when the physician has written orders to permit this as specified in paragraph 1.b.
4. The participant's record shall include the following information for each prescribed medication that the participant will take during the provider's service hours:
 - a. General information on recommended dosages and the medication's effect;
 - b. Instructions for participant monitoring;

- c. Potential drug or food interactions; and
- d. The provider shall follow the procedures for reporting Adverse Events (see provider Continuous Quality Assurance) observed by the provider, including medication errors and unexpected reactions to drugs or treatment, as specified in the standards.

iii. **Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

All medication errors must be reported as an adverse event report. Such reports are sent to DOH for review.

- (b) Specify the types of medication errors that providers are required to *record*:

All medication errors – missing a dose, giving a wrong dose at the wrong time or to the wrong individual, not complying with physician’s orders, adverse reactions to medications (over the counter and prescribed), unexpected reactions to drugs or treatment - must be reported as an adverse report. Such reports are sent to DOH for review.

- (c) Specify the types of medication errors that providers must *report* to the State:

All medication errors and unexpected reactions to drugs or treatment.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DOH staff review reports of medication errors and follow up as necessary on correction action. Medication errors and unexpected reactions to drugs or treatment by the provider agencies are reported using the AER form. Data is collected and summarized to identify trends, remediation, and opportunities for system improvement, such as additional training for provider or a medical assessment for the participant or a change in DOH policy. DHS receives and reviews a summary of the AER reports quarterly

Providers submit medication errors on an AER form. Copies of all adverse events reports are submitted to DOH for review. The reports are logged into the DOH database, tracked, and trended. Remediation activities are identified and followed-up as a result of each AER. DOH follows guidelines that are issued by DHS and follows established policies and procedures.

DHS is responsible for overseeing that all adverse events, including all medication errors, are reported and are satisfactorily addressed and resolved. An overview of this oversight includes:

- 1) Review of quarterly AER Summary Reports submitted by DOH, which will comprise of an aggregation and analysis of 100% of AERs received. DHS will notify DOH if further remediation, corrective action, or system improvement is needed.
- 2) Detailed review of AER Reports for all deaths.
- 3) Detailed review of AER Reports for participants or providers that raise concerns based on monitoring trends.

All waiver providers are required to have an Internal Quality Improvement program that includes a process that provides for ongoing monitoring, quarterly assessment and trending of Adverse Events for appropriateness of action taken, follow-up and preventive actions to be taken.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of adverse event reports (AERs) by: provider; participant; and type. N: # of AERs by: provider; participant; and type; D: total # of AERs submitted

Data Source (Select one):

Other

If 'Other' is selected, specify:

AER summary report

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of adverse event reports (AERs) reported within required timeframe. N: # of AERs reported within required timeframe; D: total # of AERs submitted

Data Source (Select one):

Other

If 'Other' is selected, specify:

AER summary report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/> <input type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of adverse event reports (AERs) reported to appropriate authorities if applicable. N: # of AERs reported to appropriate authorities if applicable; D: total # of AERs submitted that necessitated a report to an appropriate authority

Data Source (Select one):

Other

If 'Other' is selected, specify:

AER summary report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

#/% of adverse event reports (AERs) resulting in appropriate immediate corrective action by the provider agency to safeguard participant as assessed by the case manager. N: # of AERs resulting in appropriate immediate corrective action by the provider agency to safeguard participant as assessed by the case manager; D: total # of AERs submitted

Data Source (Select one):

Other

If 'Other' is selected, specify:

AER summary report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of adverse event reports (AERs) resulting in appropriate secondary corrective action by the provider agency and case manager as assessed by the DOH supervisor. N: # of AERs resulting in appropriate secondary corrective action by the provider agency and case manager as assessed by the DOH supervisor; D: total # of AERs submitted

Data Source (Select one):

Other

If 'Other' is selected, specify:

AER summary report

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

		<input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of reportable deaths that required follow-up corrective action for which follow-up was completed. N: # of reportable deaths that required follow-up action for which follow-up was completed; D: total # of reportable deaths that required follow-up corrective action

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants who report that: most support staff treat them with respect; they feel safe in their home and neighborhood; and their basic rights are respected by others. N: # of waiver participants who responded positively to the questions; D total # of waiver participants who responded to the questions

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant survey

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant interview

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

#/% of participants in developmental disabilities domiciliary home (DDDH) or foster homes who report they are satisfied: with where they live; with the privacy they have; and able to see families/friends when they want. N: # of participants in DDDH or foster homes who responded positively to the questions; D: total # of participants in DDDH or foster homes who responded to the questions

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant survey

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Participant interview

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DOH is responsible for reviewing all adverse or critical event reports and ensuring that each adverse event is addressed and resolved appropriately. If remediation is needed, DOH confirms the completion and documentation of the remediation activities. For service provider agencies, remediation activities may include re-training of its staff and increasing the frequency of on-site quality reviews by DOH.

On a quarterly basis, DOH submits the Adverse Events Reporting Summary Report to DHS which includes a summary of each adverse event report, the remediation activities and results of the performance measures listed in the previous section. This report is reviewed and analyzed by DHS to aid in identifying trends and need for systems improvement.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The DHS Quality Strategy was recently approved by CMS. It is a comprehensive strategy that includes the monitoring of Home and Community-Based Services and is the framework for monitoring of the waiver. The strategy describes implementation of a Quality Flow Process, which ensures reviewing of monitoring reports followed by immediate remediation, trending, prioritizing, and implementing system changes.

DHS receives and reviews all quarterly monitoring and quality reports from the DOH. Standardized reporting and review tools have been developed to allow for improved oversight and trending over time. Findings from the reports will be presented to the Quality Strategy Committee as the reports are received and reviewed according to a monitoring calendar. The Committee is composed of representatives from the Quality Strategy Leadership Team, technical experts for the waiver, and the reviewer(s). The committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committee will recommend feedback to the DOH, and corrective action will be requested if needed. Findings and recommendations will be properly documented. The Leadership Team will also meet quarterly to review the findings and recommendations from the Committee, analyze trends, and set priorities, focusing on critical and high impact issues requiring system(s) change(s) that relate to meeting established goals and objectives. At least semi-annually and as needed, the Leadership Team will meet collaboratively with DOH. These Quality Collaboratives will allow opportunity of dialogue, feedback, follow-up of corrective actions, exchange of information, and identification of best practices.

For example, a set of monitoring reports were reviewed recently and identified that annual reevaluations were performed in a timely manner in certain units, but not in other units. DOH completed 100% remediation to ensure that each participant had a completed annual re-evaluation. DHS is also working with DOH to monitor these units, trending their performance over time, and instituting system(s) change(s), such as improved tracking and training.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State’s targeted standards for systems improvement.

DHS

A Quality Strategy Leadership Team meets regularly to review the findings and recommendations from Quality Strategy Committees. The Leadership Team will also meet collaboratively with DOH on a regular basis to allow for dialogue, feedback, and follow-up of corrective actions, performance improvement projects, exchange of information, and identification of best practices. System improvements will be identified and monitored as a result of these collaborative reviews of monitoring trends, results of remediation, and best practices. The following shows a summary of the Quality Strategy Oversight.

Summary of the Quality Strategy Oversight (entities, membership and responsibilities):

Entity: Quality Strategy Leadership Team (QSLT)

Membership:

- MQD leadership from several MQD branches and offices
- MQD Medical Director or Physician Designee
- EQRO consultant as needed

Responsibilities:

- Lead the development, review, and revision of Quality Strategy
- Oversight for review of quality data and monitoring reports
- Oversight for quality improvement recommendations and implementation of these recommendations by the waiver program
- Meets quarterly and more often as needed
- Meets semi-annually in Collaboratives with the waiver program

Entity: Quality Strategy Committees (QSC)

Membership:

- QSLT representative
- MQD technical expert(s) in the waiver
- MQD HCBS reviewer(s)

Responsibilities:

- Committees include the waiver committee
- Review of quality data and monitoring reports from the waiver program
- Recommendations for corrective actions, quality improvement, and system changes
- Follow-up of corrective actions and quality improvement recommendations
- Meets in a monthly rotation

Entity: Quality Collaboratives

Membership:

- QSLT representative(s)
- MQD technical expert(s)
- Waiver program representative(s)
- EQRO consultant if needed

Responsibilities:

- Serves as forum between MQD and the waiver program for dialogue, feedback, follow-up of corrective action, PIPs, best practices
- Meets semi-annually

DOH

Two groups meet regularly to ensure quality across the spectrum of the waiver. Both groups meet on a weekly basis. One group is the Utilization Review Committee (URC). This committee reviews a variety of issues related to over/underutilization with regards to participant services. The committee makes recommendations for adjustment, approval, or denial of services. Another group is the Clinical Interdisciplinary Team (CIT). This team is composed of staff from multiple disciplines, led by a DOH physician. The team reviews and makes recommendations regarding a variety of utilization and clinical issues. In addition, DOH also has a Mortality Review Committee, which reviews every death in the waiver program and makes recommendations for system(s) change(s) as needed.

DOH, with representation from DHS, conducts regular quarterly meetings with the Waiver Policy Advisory Committee (PAC). This group includes participants, families, providers, DD Council and DOH staff. Any changes to the waiver, including changes related to quality monitoring, are discussed in these stakeholder meetings. In addition, DHS maintains a website that will hold information about the waiver program, including performance on quality monitoring. The DHS Quality Strategy is also available to the public for comment every five years and whenever there are significant changes made. A public notice is posted in major newspapers, informing the public of their access to the quality strategy document and allowing for a 30 days period for public input.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Strategy is a dynamic system, which both DHS and DOH will be continually reviewing to assess the effectiveness of the waiver monitoring.

The Quality Strategy, including DOH monitoring, will be reviewed at least annually by the Quality Strategy Leadership Team and revised, if necessary. However, the Quality Strategy Committees may suggest changes to the Leadership Team throughout the year that will be reviewed to identify whether a suggested change necessitates a review and

revision of the Quality Strategy sooner than the appointed time. At each review and revision of the strategy, the Leadership Team will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that may impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. At least once every 5 years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

The Quality Strategy will be reviewed with criteria such as: a) ongoing validity of data; b) extent to which the discovery data is actionable; c) efficiency of data collection; d) utility and frequency of monitoring reports; e) utility of remediation efforts; and f) need for addition of other measures and data gathering methods based on identified trends and priorities.

The Quality Strategy will also be reviewed to ensure that system(s) change(s), e.g. policy changes, training, technical assistance, etc. are effective. The Quality Committees and Leadership Team will regularly review and assess system(s) change(s) to ensure implementation and effectiveness in the light of measurement trends. DHS and DOH together will also discuss the implementation and effectiveness of system(s) change(s) in regular Collaborative meetings.

A Work Plan is written annually to supplement the Quality Strategy during the annual review and revision process. Part of the Work Plan will include a specific section on any revisions to waiver monitoring. The development of the Work Plan specific to waiver monitoring begins with an assessment of accomplishments and challenges from the previous year's Work Plan and summary analyses/input from the Quality Strategy Committee's review of monitoring reports. The Work Plan development also incorporates input from other sources such as the DOH, the managed care health plans, participants, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Provider agencies that bill for services less than \$500,000 per year shall be reviewed as described below in item (b). In addition to item (b) described below, provider agencies that bill for services in excess of \$500,000 shall be responsible to procure an annual end-of-the year audit conducted by an independent CPA.

(b) The DOH reviews all waiver providers at least annually. For each provider, the DOH selects a statistically valid random sample of the participants served during a one-year period. For the participants selected for review, the DOH reviews the ISP to ensure the services were authorized (service level and number of units) and compares the paid claims information (from HPMMIS, the Medicaid MMIS) against the authorized services. The DOH verifies that the service code, units and payment match the authorizations. The DOH verifies that the paid services were actually delivered by conducting a provider on-site visit. While there, the DOH verifies timesheets signed by the provider of services, reviews attendance logs and examines other records, as appropriate to ensure the claim paid matches what was billed. If necessary, the DOH may contact the participant or his/her representative to verify the delivery of services by the provider agency.

(c) DHS reviews the DOH quarterly monitoring reports. The DOH provides a report detailing the findings of each provider review to DHS, and all reports shall be reviewed by DHS. Any cases requiring remediation and/or follow-up action will be handled by the DOH. In addition, the DHS will validate a sample of DOH provider on-site reviews semi-annually.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's

methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

#/% of waiver providers in HPMMIS with a valid Medicaid provider agreement. N: # of waiver providers in HPMMIS with a valid Medicaid provider agreement; D: total # of waiver providers in HPMMIS

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS audit

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

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Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver claims paid in a timely manner as specified in the Provider Agreement. N: # of waiver claims paid in a timely manner as specified in the Provider Agreement; D: total # of waiver claims paid

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS report

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

#/% of waiver participants correctly suspended. N: # of waiver participants correctly suspended; D: total # of waiver participants who should have been suspended

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Other
Specify:

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver claims paid with cost share errors. N: # of waiver claims paid with cost share errors; D: total # of waiver claims paid for participants with a cost share

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
 DHS identifies individual problems through quarterly reports received from its fiscal agent and DOH. For claims not paid in a timely manner, technical assistance is provided to the fiscal agent to improve timely processing of claims. For a claim paid with a cost share error or for a suspended participant, remediation is specific to the problem, i.e., incorrect suspension dates inputted or cost share information not provided, and payment is recouped. In addition, DHS shall provide training to DOH as needed to assure that financial processes are managed correctly.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The reimbursement rates for waiver providers are authorized by the DHS to assure the rates are consistent with other Medicaid providers offering similar services in the Medicaid FFS program for home and community based services.

The current rates were calculated using the direct care staff wages as the base with a percentage of add-ons to cover payroll taxes and benefits and general and administrative cost. The standard percentage used by the State of Hawaii to cover payroll taxes and benefits adjusted for pension and retirement cost was applied. The mean (average) calculated from the providers' financial statement to cover general and administrative cost was also used.

Public comment is secured through the DDD Waiver Policy Advisory Committee as waiver services are discussed.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

All services, regardless of payment processing, are prior authorized by the DOH case managers.

Agency Services excluding Consumer Directed Personal Assistance

All waiver services are prior authorized by the DOH case managers and forwarded to the DHS fiscal agent. DOH claims processing/payment follows the same process as the State's Medicaid Fee-For-Service program. The DHS Fiscal Agent enters the prior authorizations into HPMMIS, the State's MMIS. Providers render the services and send their claims for the services to the DHS Fiscal Agent for processing. Providers have the option of submitting claims electronically or manually on a CMS 1500 form. The DHS Fiscal Agent provides an electronic HIPAA-compliant interface that enables providers to send claims electronically. If the providers want to file manual claims, the claims are sent to the DHS Fiscal Agent's office located on Oahu for processing. HPMMIS adjudicates claims on a daily basis and processes payments on a weekly basis. Prior to the checks being generated, the DHS Fiscal Agent will notify DHS of the funds required for the week's payment. DHS informs DOH of the required funds for waiver week's payments by the MQD Fiscal Agent for the week's payments. Checks are generated at the end of each week. Providers have the option of receiving their payment electronically (deposited directly into the provider's bank account) or by mail. Providers also have the option to receive their remittance advices electronically or by

mail with the check.

Consumer Directed-Personal Assistance Option

DHS or its designee will perform payroll processing functions to pay claims for consumer directed personal assistance services. The invoice for the participant's employee's hours or days worked for the previous month is received by DOH. Following a review of the invoice, the information is inputted electronically to the limited fiscal agent or designee for payroll processing. The limited fiscal agent sends a summary of the consumer directed personal assistance payments to the DHS Finance Office, which creates a bill of collection that is sent to DOH for payment of the non-federal share of the payment.

Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies that require unique pricing; Vehicular Modifications, Assistive Technology, One-Time Cleaning under Chore

Following the delivery of service, providers submit invoices to and are paid by DOH. The invoices are processed following the State of Hawaii Department of Accounting and General Services (DAGS) policies and procedures to generate a state purchase order. Quarterly, a file containing all the items paid for by DOH is submitted to DHS for Medicaid eligible waiver recipients. Upon receipt, DHS will send a bill of collection to DOH for the state portion. DOH will then voucher the state share to DHS. DHS will pay DOH the total invoice at a later date. Subsequently, DHS will draw down the federal share from CMS.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial

participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

All services are identified in the participant's service plan, prior authorized before service delivery and processed for payment. The following describes the different payment methods for waiver services:

1) Non-Consumer Directed-Personal Assistance Waiver Services

The DHS fiscal agent processes these payments. HPMMIS contains individual Medicaid eligibility information, reference tables of approved waiver services, (procedure codes, modifiers and payment rates), prior authorizations, and qualified provider information. All claims are adjudicated according to edit checks, e.g., participant is Medicaid eligible and "enrolled" in the waiver at the time of service, prior authorization is in the system, dates and procedure codes are valid, etc., and priced using the rates in HPMMIS. Based on system rules, HPMMIS denies claims that fail the edit checks, e.g., claim for a participant not Medicaid eligible or no prior authorization in the system for service will automatically deny. HPMMIS generates paid claims reports to validate the claims for Federal reimbursement.

2) Consumer Directed-Personal Assistance option

These claims are paid outside of the HPMMIS system. DOH validates Medicaid eligibility on the date of service, reviews that the units of services are within the authorized amount in the participant's ISP, assures provider certification requirements are met and enters all information necessary to authorize payment directly into the contracted limited fiscal agent's electronic payroll system. DOH reviews and transmits the information to the limited fiscal agent for this payroll processing. This limited fiscal agent generates the summary of the consumer directed payments and the participant's checks for delivery to DOH for mailing to the participants. Submittal of the bill of collection is then routed to DOH for remuneration of the non-federal share of the payments.

3) Environmental Accessibility Adaptations, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology, Personal Emergency Response System

These claims are paid through purchase orders processed by the DHS Fiscal Office. Following the delivery of the service, the vendor invoice is sent to the DOH case manager to confirm the service was delivered, verify that the participant was Medicaid eligible on the date of service, the service was prior authorized, the billed amount is within the authorized amount and the provider is certified and/or licensed to provide services. If the invoice is approved, the DOH case manager submits the invoice for payment to the DOH Fiscal Office. The DOH Fiscal Office prepares a purchase order and processes the invoice for payment compliant with the DAGS policies and procedures. DAGS mails the check to the vendor.

The annual claims audit performed by the DOH Monitoring Section staff is used to verify that the billed services were actually authorized in the service plan, provided by the provider, employee or vendor. If the DOH monitoring staff identifies unsubstantiated or erroneous billings, the staff informs the DOH Fiscal Office. The Fiscal Office sends a formal letter to the provider, employee or vendor seeking recovery of the overpayment. In the case of claims, the DHS fiscal agent is able to adjust the claim and recoup the overpayment. In the case of payroll and invoices, the employee/vendor must return a check for the overpayment to the DOH Fiscal Office.

A log of money collected by the DOH Fiscal Office is sent to the DHS Finance Office to ensure proper crediting back to the federal government on a quarterly basis.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended

outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

a) The only waiver services that are not paid through an approved MMIS are environmental accessibility adaption, certain specialized equipment that require unique pricing, vehicular modification, assistive technology, and consumer directed services.

b) & c) Environmental accessibility adaption, certain medical equipment requiring unique pricing, vehicular modification, and assistive technology:

Payment for these items are paid by the DOH with 100% State funds. DOH sends copies of the purchase order and payment to DHS to support the federal FFP reimbursement. After verifying the payment, DHS transfers the FFP to DOH. The following identifies the steps taken to substantiate payment:

- 1) The DOH case manager authorizes services in the participant's services plan, sends hard copy notifications to authorized provider for service type to be rendered with the participant's specific information.
- 2) After rendering the services, the provider submits an invoice for payment to DOH case manager who confirms that the participant was Medicaid eligible at the time the work was performed or service delivered, and the invoice is within the prior authorize amount. If the invoice can be paid, the DOH case manager authorizes the invoice for payment and sends the invoice to the DOH Fiscal Office.
- 3) The DOH fiscal staff processes the invoice for payment following the authorized Department of Accounting and General Services (DAGS) policies and procedures. DAGS will prepare and mail the check directly to the provider.
- 4) The DOH fiscal staff generates a summary worksheet on a quarterly basis and submits it to DHS. The supporting documents (service authorization, invoice and purchase order) as proof of payment with 100% State funds are maintained with the DOH fiscal office and are available for DHS to review if necessary.
- 5) DOH reviews the summary worksheet prior to sending it to DHS to ensure there are no duplicate invoices.
- 6) DHS will send DOH a Bill of Collection for the non-federal portion for all transactions for above services. DOH will voucher over the non-federal portion for all transaction for above services. DOH will voucher over the non-federal share to DHS.
- 7) Payment to DOH is based on submission of a Bill of Collection by services which is based on the quarterly summary submitted by DOH as follows: a) reimbursement shall be allowed on invoices deemed payable; b) reimbursement shall be journal vouchered to DOH based on normal State fiscal timelines; c) reimbursement shall be determined on the fee that is notated on the paid invoices per supporting documentation submitted with the Bill of Collection.
- 8) Any services or work denied by DHS are returned to DOH for resolution.
- 9) A spreadsheet reflecting the paid invoices is attached to processed journal voucher and returned to DOH along with the original DOH worksheet for reconciliation purposes.

Consumer Directed Waiver Services: The DOH transfers the state match for CD services to DHS. DHS transfers the FFP to DOH. The following identifies the steps taken to substantiate payment:

- 1) DOH case manager authorizes services in the participant's service plan and notifies the DDD-CD specialist.
- 2) DOH specialist processes necessary payroll paperwork with the participant and sends the paperwork to the appropriate fiscal agent. DOH specialist coordinates meeting/training to participant/designated representative.
- 3) DOH specialist reviews all vouchers submitted by CD services participants to ensure the participant is Medicaid eligible and the services have been authorized.

● **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

DHS through a contract with a limited fiscal agent pays for waiver services (CD-PA/HAB, CD-Respite, and CD-Chore) in the Consumer Directed Option. The limited fiscal agent performs general payroll functions on behalf of the participants' employees.

The limited fiscal agent's services are primarily payroll activities such as withholding of applicable taxes. The limited fiscal agent, at direction of DOH, generates special deduction checks (levys, child support, etc.). Oversight activities include the review of system summary reports as described in Appendix E-a and other quality activities conducted by DHS staff. DOH staff enters employee service data directly into the limited fiscal agent's system for processing of paychecks on the participant/employer's behalf. The DOH staff assures that human errors are kept at a minimum by conducting reviews at various stages: hours worked are verified against authorizations, check amount is validated, etc.

The DOH Fiscal Office submits to DHS a Bill of Collection for the State portion of the total payments made for the CD option. The charged amount is verified by a Summary Warrant Voucher report. The amount that is paid each month is recorded on the voucher log maintained by DHS and included in the CMS 64 report for each quarter.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency,

economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any**

supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of

qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- (a) DOH
- (b) Funds are directly expended by DOH as IGTs for Environmental Accessibility Adaptation, Specialized Medical Equipment & Supplies, Vehicular Modifications, Assistive Technology, and Personal Emergency Response System. DHS transfer FFP for all other waiver services processed through the fiscal agents.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
- Applicable**

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**

Check each that applies:

- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

SSI payments are used for room and board costs in adult foster homes, DD domiciliary homes, and adult residential care homes, expanded adult residential care homes.

All services rates that are billed by providers exclude room and board costs. The fiscal agent will only pay the rates that are loaded into HPMMIS and cannot override the rates to allow for any room or board costs.

When a participant receives respite, the participant's pro-rated SSI room and board costs that are normally paid by the participant to the routine caregiver are paid to the respite caregiver.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal

financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**
 - ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.**
 - iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

- a. Co-Payment Requirements.**
 - iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	42446.50	4971.03	47417.53	114533.47	3223.16	117756.63	70339.10
2	43726.85	5070.45	48797.30	116824.14	3287.62	120111.76	71314.46
3	44569.17	5171.86	49741.03	119160.63	3353.37	122514.00	72772.97
4	45631.00	5275.30	50906.30	121543.84	3420.44	124964.28	74057.98
5	46446.91	5380.80	51827.71	123974.72	3488.85	127463.57	75635.86

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR

Year 1	2878	2878
Year 2	3028	3028
Year 3	3178	3178
Year 4	3328	3328
Year 5	3478	3478

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay of 354 Days is based on WY4 2009-2010 length of stay.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D was calculated by reviewing the actual utilization of services over the last 4 years of services and projecting forward utilization of services. In addition, the State is adding Prevocational Services and Group Employment to the waiver. While the State is removing Residential Habilitation, service utilization will shift to Personal Assistance/Habilitation (PAB) and it is expected that PAB service utilization will initially increase until the case manager can better assess service needs after the first one to two years of transition.

Rates for most services were increased by 2% per year as it was felt in order to maintain the availability of service providers. Adult Day Health service rates increased due to increased staffing costs and the provision of transportation in the daily rate.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' projections are based on actual costs for WY4 2009-2010 (\$4,778) then increased by 2% for WY5 and each year of the waiver renewal, based on the Healthcare Cost Review Report utilized by DHS-MQD to calculate the inflation factor for Hawaii PPS Rates.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G projections are based on actual costs for WY4 2009-2010 (\$110,086) then increased by 2% for WY5 and each year of the waiver renewal, based on the Healthcare Cost Review Report utilized by DHS-MQD to calculate the inflation factor for Hawaii PPS Rates.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' projections are based on actual costs for WY4 2009-2010 (\$3,098) then increased by 2% for WY5 and each year of the waiver renewal, based on the Healthcare Cost Review Report utilized by DHS-MQD to calculate the inflation factor for Hawaii PPS Rates.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Health
Individual Employment Supports
Prevocational Services
Residential Habilitation
Respite
Assistive Technology
Chore
Environmental Accessibility Adaptations
Group Employment Supports
Non-Medical Transportation
Personal Assistance/Habilitation (PAB)
Personal Emergency Response System (PERS)
Skilled Nursing
Specialized Medical Equipment and Supplies
Training and Consultation
Vehicular Modifications
Waiver Emergency Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						29137500.00
Adult Day Health	Day	1400	225.00	92.50	29137500.00	
Individual Employment Supports Total:						259200.00
Individual Employment Supports	Hour	54	80.00	60.00	259200.00	
Prevocational Services Total:						51200.00
Prevocational Services	Hour	50	32.00	32.00	51200.00	

Residential Habilitation Total:						4580064.00
Residential Habilitation	Day	360	180.00	70.68	4580064.00	
Respite Total:						2765098.00
Respite-Hourly	Hour	225	525.00	18.00	2126250.00	
Respite -Daily	Day	160	28.00	142.60	638848.00	
Assistive Technology Total:						11410.35
Assistive Technology	Unit	5	1.00	2282.07	11410.35	
Chore Total:						220125.00
Chore	Hour	50	375.00	11.74	220125.00	
Environmental Accessibility Adaptations Total:						175000.00
Environmental Accessibility Adaptations	Unit	7	1.00	25000.00	175000.00	
Group Employment Supports Total:						583200.00
Group Employment Supports	Hour	54	200.00	54.00	583200.00	
Non-Medical Transportation Total:						255120.00
Transportation Miles	Mile	105	1600.00	0.94	157920.00	
Transportation Trips	Trip	150	120.00	5.40	97200.00	
Personal Assistance/Habilitation (PAB) Total:						79213800.00
Personal Assistance/Habilitation (PAB)	Hour	2350	1200.00	28.09	79213800.00	
Personal Emergency Response System (PERS) Total:						1440.00
Personal Emergency Response System (PERS)	Month	3	12.00	40.00	1440.00	
Skilled Nursing Total:						2990682.50
Skilled Nursing	Hour	65	850.00	54.13	2990682.50	
Specialized Medical Equipment and Supplies Total:						270000.00
Specialized Medical Equipment and Supplies	Unit	150	4.00	450.00	270000.00	
Training and Consultation Total:						1251036.00
Training and Consultation	Session	155	90.00	89.68	1251036.00	
Vehicular Modifications Total:						25000.00
Vehicular Modifications	Unit	1	1.00	25000.00	25000.00	
Waiver Emergency Services Total:						371160.00
Crisis	Day	23	30.00	364.00	251160.00	
Outreach	Hour	50	30.00	80.00	120000.00	

GRAND TOTAL:	122161035.85
Total Estimated Unduplicated Participants:	2878
Factor D (Divide total by number of participants):	42446.50
Average Length of Stay on the Waiver:	354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						29932537.50
Adult Day Health	Day	1350	235.00	94.35	29932537.50	
Individual Employment Supports Total:						477360.00
Individual Employment Supports	Hour	65	120.00	61.20	477360.00	
Prevocational Services Total:						146880.00
Prevocational Services	Hour	75	60.00	32.64	146880.00	
Residential Habilitation Total:						4452840.00
Residential Habilitation	Day	350	180.00	70.68	4452840.00	
Respite Total:						3125042.00
Respite-Hourly	Hour	250	530.00	18.36	2432700.00	
Respite -Daily	Day	170	28.00	145.45	692342.00	
Assistive Technology Total:						16296.00
Assistive Technology	Unit	7	1.00	2328.00	16296.00	
Chore Total:						213963.75
Chore	Hour	55	325.00	11.97	213963.75	
Environmental Accessibility Adaptations Total:						250000.00
Environmental Accessibility Adaptations	Unit	10	1.00	25000.00	250000.00	
Group Employment Supports Total:						1170450.00
Group Employment Supports	Hour	85	250.00	55.08	1170450.00	

Non-Medical Transportation Total:						335750.00
Transportation Miles	Mile	125	1650.00	0.96	198000.00	
Transportation Trips	Trip	200	125.00	5.51	137750.00	
Personal Assistance/Habilitation (PAB) Total:						86603220.00
Personal Assistance/Habilitation (PAB)	Hour	2640	1145.00	28.65	86603220.00	
Personal Emergency Response System (PERS) Total:						1958.40
Personal Emergency Response System (PERS)	Month	4	12.00	40.80	1958.40	
Skilled Nursing Total:						3246348.00
Skilled Nursing	Hour	70	840.00	55.21	3246348.00	
Specialized Medical Equipment and Supplies Total:						439776.00
Specialized Medical Equipment and Supplies	Unit	160	6.00	458.10	439776.00	
Training and Consultation Total:						1440652.50
Training and Consultation	Session	175	90.00	91.47	1440652.50	
Vehicular Modifications Total:						25000.00
Vehicular Modifications	Unit	1	1.00	25000.00	25000.00	
Waiver Emergency Services Total:						526830.00
Crisis	Day	25	35.00	371.28	324870.00	
Outreach	Hour	55	45.00	81.60	201960.00	
GRAND TOTAL:						132404904.15
Total Estimated Unduplicated Participants:						3028
Factor D (Divide total by number of participants):						43726.85
Average Length of Stay on the Waiver:						354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						33835578.00

Adult Day Health	Day	1435	245.00	96.24	33835578.00	
Individual Employment Supports Total:						546175.00
Individual Employment Supports	Hour	70	125.00	62.42	546175.00	
Prevocational Services Total:						199740.00
Prevocational Services	Hour	100	60.00	33.29	199740.00	
Residential Habilitation Total:						0.00
Residential Habilitation	Day	0	0.00	0.01	0.00	
Respite Total:						3596328.00
Respite-Hourly	Hour	270	530.00	18.60	2661660.00	
Respite -Daily	Day	225	28.00	148.36	934668.00	
Assistive Technology Total:						37984.00
Assistive Technology	Unit	8	2.00	2374.00	37984.00	
Chore Total:						257936.25
Chore	Hour	65	325.00	12.21	257936.25	
Environmental Accessibility Adaptations Total:						300000.00
Environmental Accessibility Adaptations	Unit	12	1.00	25000.00	300000.00	
Group Employment Supports Total:						1314612.00
Group Employment Supports	Hour	90	260.00	56.18	1314612.00	
Non-Medical Transportation Total:						384442.50
Transportation Miles	Mile	140	1650.00	0.98	226380.00	
Transportation Trips	Trip	225	125.00	5.62	158062.50	
Personal Assistance/Habilitation (PAB) Total:						94567608.00
Personal Assistance/Habilitation (PAB)	Hour	2790	1160.00	29.22	94567608.00	
Personal Emergency Response System (PERS) Total:						2996.64
Personal Emergency Response System (PERS)	Month	6	12.00	41.62	2996.64	
Skilled Nursing Total:						3642130.80
Skilled Nursing	Hour	77	840.00	56.31	3642130.80	
Specialized Medical Equipment and Supplies Total:						778770.00
Specialized Medical Equipment and Supplies	Unit	170	10.00	458.10	778770.00	
Training and Consultation Total:						1595430.00
Training and Consultation	Session	190	90.00	93.30	1595430.00	

Vehicular Modifications Total:						25000.00
Vehicular Modifications	Unit	1	1.00	25000.00	25000.00	
Waiver Emergency Services Total:						556083.50
Crisis	Day	25	35.00	378.70	331362.50	
Outreach	Hour	60	45.00	83.23	224721.00	
GRAND TOTAL:						141640814.69
Total Estimated Unduplicated Participants:						3178
Factor D (Divide total by number of participants):						44569.17
Average Length of Stay on the Waiver:						354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						37055400.00
Adult Day Health	Day	1510	250.00	98.16	37055400.00	
Individual Employment Supports Total:						606456.75
Individual Employment Supports	Hour	75	127.00	63.67	606456.75	
Prevocational Services Total:						224070.00
Prevocational Services	Hour	110	60.00	33.95	224070.00	
Residential Habilitation Total:						0.00
Residential Habilitation	Day	0	0.00	0.01	0.00	
Respite Total:						4845636.00
Respite-Hourly	Hour	360	550.00	18.97	3756060.00	
Respite -Daily	Day	240	30.00	151.33	1089576.00	
Assistive Technology Total:						43586.64
Assistive Technology	Unit	9	2.00	2421.48	43586.64	
Chore Total:						283237.50

Chore	Hour	70	325.00	12.45	283237.50	
Environmental Accessibility Adaptations Total:						300000.00
Environmental Accessibility Adaptations	Unit	12	1.00	25000.00	300000.00	
Group Employment Supports Total:						1442527.50
Group Employment Supports	Hour	95	265.00	57.30	1442527.50	
Non-Medical Transportation Total:						429975.00
Transportation Miles	Mile	150	1625.00	1.00	243750.00	
Transportation Trips	Trip	250	130.00	5.73	186225.00	
Personal Assistance/Habilitation (PAB) Total:						99037320.00
Personal Assistance/Habilitation (PAB)	Hour	2865	1160.00	29.80	99037320.00	
Personal Emergency Response System (PERS) Total:						3565.80
Personal Emergency Response System (PERS)	Month	7	12.00	42.45	3565.80	
Skilled Nursing Total:						3955778.40
Skilled Nursing	Hour	82	840.00	57.43	3955778.40	
Specialized Medical Equipment and Supplies Total:						981246.00
Specialized Medical Equipment and Supplies	Unit	175	12.00	467.26	981246.00	
Training and Consultation Total:						1884168.00
Training and Consultation	Session	220	90.00	95.16	1884168.00	
Vehicular Modifications Total:						25000.00
Vehicular Modifications	Unit	1	1.00	25000.00	25000.00	
Waiver Emergency Services Total:						741983.80
Crisis	Day	26	40.00	386.27	401720.80	
Outreach	Hour	70	55.00	88.38	340263.00	
GRAND TOTAL:					151859951.39	
Total Estimated Unduplicated Participants:					3328	
Factor D (Divide total by number of participants):					45631.00	
Average Length of Stay on the Waiver:						354

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically

calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						41259452.00
Adult Day Health	Day	1585	260.00	100.12	41259452.00	
Individual Employment Supports Total:						675480.00
Individual Employment Supports	Hour	80	130.00	64.95	675480.00	
Prevocational Services Total:						238947.00
Prevocational Services	Hour	115	60.00	34.63	238947.00	
Residential Habilitation Total:						0.00
Residential Habilitation	Day	0	0.00	0.01	0.00	
Respite Total:						5414150.00
Respite-Hourly	Hour	375	560.00	19.35	4063500.00	
Respite -Daily	Day	250	35.00	154.36	1350650.00	
Assistive Technology Total:						49400.00
Assistive Technology	Unit	10	2.00	2470.00	49400.00	
Chore Total:						577850.00
Chore	Hour	130	350.00	12.70	577850.00	
Environmental Accessibility Adaptations Total:						350000.00
Environmental Accessibility Adaptations	Unit	14	1.00	25000.00	350000.00	
Group Employment Supports Total:						1607375.00
Group Employment Supports	Hour	100	275.00	58.45	1607375.00	
Non-Medical Transportation Total:						1634100.00
Transportation Miles	Mile	150	1625.00	5.84	1423500.00	
Transportation Trips	Trip	300	130.00	5.40	210600.00	
Personal Assistance/Habilitation (PAB) Total:						104569920.00
Personal Assistance/Habilitation (PAB)	Hour	2940	1170.00	30.40	104569920.00	
Personal Emergency Response System (PERS) Total:						4156.80
Personal Emergency Response System (PERS)	Month	8	12.00	43.30	4156.80	
Skilled Nursing Total:						1244825.00
Skilled Nursing	Hour	85	250.00	58.58	1244825.00	

Specialized Medical Equipment and Supplies Total:						1000923.00
Specialized Medical Equipment and Supplies	Unit	175	12.00	476.63	1000923.00	
Training and Consultation Total:						2052819.00
Training and Consultation	Session	235	90.00	97.06	2052819.00	
Vehicular Modifications Total:						25000.00
Vehicular Modifications	Unit	1	1.00	25000.00	25000.00	
Waiver Emergency Services Total:						837940.00
Crisis	Day	28	40.00	394.00	441280.00	
Outreach	Hour	80	55.00	90.15	396660.00	
GRAND TOTAL:						161542337.80
Total Estimated Unduplicated Participants:						3478
Factor D (Divide total by number of participants):						46446.91
Average Length of Stay on the Waiver:						354