# DDD 1915(c) Appendix K Operational Guidelines

## APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE MAUI WILDFIRES

Effective August 8, 2023

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# 1915(c) HOME AND COMMUNITY BASED SERVICES WAIVER

# APPENDIX K OPERATIONAL GUIDE

## What is Appendix K?

In times of a declared disaster such as the Maui wildfires, states that operate a Medicaid Section 1915(c) Home and Community-Based Services (HCBS) Waiver can apply for approval of "Appendix K: Emergency Preparedness and Response" in order to adopt flexibilities necessary to respond to the emergency. Hawaii's Appendix K application for the Maui wildfires disaster was approved by the federal Centers for Medicare and Medicaid Services (CMS) on August 25, 2023.

All services and programmatic changes taken through an approved Appendix K must be based on situations that arise from the disaster and are temporary in nature. Service changes for participants must be directly related to the Maui wildfire disaster and the flexibilities under Appendix K are only authorized for the duration of the federally declared disaster. We will issue further guidance on transitioning back to pre-emergency services and conditions.

Please note: the flexibilities in an approved Appendix K are available for the State's use as needed but are not intended to be applied in all situations.

Participants and their families should work with their case manager (CM) to determine what supports they might need during this period. One of the many challenges associated with the Maui wildfires disaster is that direct care may not be able to be provided as it normally would have (in terms of, for example, staffing ratios and locations of service). CMs will work closely with providers, participants, and families to ensure coordination and communications.

The purpose of these operational guidelines is to provide guidance on how to implement changes that will be in effect for the duration of the declared disaster for the Maui wildfires. These guidelines will be updated as necessary and will be posted on-line at https://health.hawaii.gov/ddd/.

## Timeframe

The State received approval of Appendix K from the CMS with a retroactive effective date of August 8, 2023, the date of the declared Maui wildfires disaster. The Appendix K changes explained in this operational guide are effective starting August 8, 2023. The Appendix K will be in effect until August 7, 2024 or when the declared disaster ends, whichever occurs first.

All changes made to Individualized Service Plans (ISP), required to unwind the Appendix K flexibilities at the end of the declared disaster will not be subject to fair hearing and appeal requirements.

## Guide for Determining If Appendix K Applies

All service-related changes contained in this operational guide may only be implemented for participants and providers based on participants' needs due to the Maui wildfires disaster. Changes beyond those directly related to the Maui wildfires disaster will not be authorized.

The following questions provide a guide for determining whether requests and authorizations will be covered under Appendix K. If it is determined using this guide that the requested change is a result of the Maui wildfires disaster, the Appendix K Operational Guidelines will specify the options for changes in services and service settings.

1. ***Does the participant have a Maui County case manager? Were there any changes that occurred for the participant as a result of the Maui wildfires? The participant's needs should be related to one or more of the questions listed below in a through i. Please consider these with the ISP team in determining current needs for implementing flexibilities.***

**Changes Related to Services**

a. Was the participant receiving Adult Day Health (ADH) in a setting that closed or the service is unavailable to the participant for any reason due to the Maui wildfires or evacuation?

b. Was the participant receiving community-based services, such as Community Learning Services-Group (CLS-G), Individual (CLS-Ind), or Discovery & Career Planning (DCP), that could not be provided for any reason due to the Maui wildfires?

c. Was the participant employed and using waiver services, such as Individual Employment Services (IES) or CLS-Ind, but is currently unable to work as a result of the Maui wildfires?

d. Is the participant's primary caregiver impacted (looking for resources, applying for assistance, etc.) in their ability to provide care for the participant as a result of the Maui wildfires?

e. Is the provider unable to provide staffing due to overall shortages of staffing and inability to secure additional staff as a result of the Maui wildfires?

f. Is the participant's direct support professional unable to provide services due to displacement or caring for a family member due to closure of schools or day care programs as a result of the Maui wildfires?

**Changes Related to Health**

g. Is the participant experiencing any physical or emotional health changes as a result of the Maui wildfires?

h. Is the participant's caregiver or a person with whom they live experiencing any physical or emotional health changes that affect their ability to provide care for the participant at the level prior to the disaster?

i. Is the participant's direct support professional experiencing any physical or emotional health changes that affect their ability to work with the participant at the level prior to the disaster?

***2. Is the change requested covered in this Appendix K operational guide? If not, please contact the participant's case manager for guidance.***

## Retroactive Authorizations

Services can be retroactively authorized from August 8, 2023, only if they meet the above criteria. Providers should contact the case manager to discuss the need for retroactive authorizations. The Case Management Branch Unit Supervisor is available for technical assistance if there are questions about requests.

Case managers will work with providers, participants, and families to determine if Appendix K applies to service requests and changes. Due to the need for rapid response in order to ensure participants' health and welfare and to avoid delays while waiting for approval and authorization of ISP changes, documentation of verbal approval or email approval of changes and additions to action plans will suffice as authorization. Case managers may enter the service authorization through INSPIRE retroactively. Providers should wait until after the service authorization is posted on the Department of Human Services' Medicaid On-Line (DMO) to submit their claims but may provide the service based on the verbal or email approval from the case manager.

**From Appendix K:**

To ensure participant health and safety needs can be met in a timely manner, the prior authorization and/or exception review process may be modified as deemed necessary by DOH-DDD.

a. In emergent situations where the participant's immediate health and safety needs must be addressed, retrospective authorization may be completed.

b. Documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization for provides to deliver services while awaiting data input into the case management system and MMIS.

NOTE: Two waiver services are excluded from this Appendix K Flexibility: Environmental Accessibility Adaptations and Vehicular Modifications. Those services continue to require prior authorization as described in Waiver Standards Version A and may not be authorized retrospectively.

**General Summary: Service Authorizations:**

- Authorizations related to the Maui wildfires disaster will be for the duration of Appendix K or the end of the participant's plan year, whichever is sooner. If the participant's plan year ends and the Maui wildfires disaster is still in effect, the Appendix K flexibilities can be authorized in the new plan year for the duration of the Appendix K.
- Case managers may give a verbal or email authorization to a provider at which point the provider may begin the service.
    - The case manager must document the verbal or email authorization in a contact note and create the authorization in INSPIRE as soon as possible.
    - The case manager will update the ISP and obtain signatures within seven (7) days or as soon as possible, based on participant availability or access.
- Providers are advised to check the Department of Human Services Medicaid On-Line (DMO) for prior authorization confirmation before submitting claims.
    - It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created.

# SERVICE PLAN

| ISP Process |
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| **Appendix K Flexibilities:**<br>Services included: Additional Residential Supports (ARS), Adult Day Health (ADH), Assistive Technology (AT), Chore, Community Learning Service-Individual/Group (CLS-Ind, CLS-G), Discovery & Career Planning (DCP), Individual Employment Supports (IES), Non-Medical Transportation (NMT), Personal Assistance/Habilitation (PAB), Private Duty Nursing (PDN), Residential Habilitation (ResHab), Respite, Specialized Medical Equipment and Supplies (SMES), Training & Consultation (T&C), and Waiver Emergency Services.<br><br>The State may modify timeframes or processes for completing the Individualized Service Plan (ISP) as described below.<br>1. In emergent situations where the participant's immediate health and safety needs must be addressed, retrospective authorizations may be completed.<br>2. Documentation of verbal approval or email approval of changes and additions to the ISP will suffice as authorizations for providers to deliver services while awaiting data input into the case management system and MMIS.<br>3. The use of e-signatures that meets privacy and security requirements will be added as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include the date reflecting the ISP meeting date. |

| **Operational Guidance** | |
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| Case Management | 1. Case managers may retroactively authorize services when Appendix K applies to service requests.<br>a. The provider must contact the case manager to discuss the service needs related to the Maui wildfires.<br>b. When it is determined that the request is related to the Maui wildfires, the case manager will enter the service authorization through INSPIRE retroactively. Services may be retroactively authorized from August 8, 2023.<br><br>2. Case managers may provide verbal or email approval of changes and additions to services in the ISP.<br>a. Services may start prior to the input of the authorization into INSPIRE.<br>b. The case manager must document in the ISP the date the verbal or email approval was given.<br>c. Authorization in INSPIRE should be entered as soon as possible, upon verbal or email approval.<br><br>3. The case manager will offer the participant and/or legal guardian a choice to use electronic signature or to receive a mailed updated Action Plan.<br>a. Authorized services may start while waiting for the participant and/or legal guardian's signature.<br>b. Signatures must be obtained within seven (7) days or as soon as possible.<br>c. The signature date on the Action Plan must be the date the verbal or email authorization is given and not the date when the Action Plan was signed. |
| Providers | Providers continue to be important members of the circle at the participant's ISP. ISP meetings may be done through telehealth.<br><br>1&2. ISPs with retroactive approval dates for services may be needed to mitigate harm or risk directly related to the Maui wildfires. The provider may begin delivering the service after receiving verbal or an email authorization from the CM, while the CM is waiting for the signature of the participant or legal guardian (even without the prior authorization). The provider must verify that the authorization is in Department of Human Services' Medicaid Online (DMO) before submitting any claims/billing. |

**References:** Waiver Appendix D, Standards (Version A) Section 1.5

| Individual Supports Budgets | |
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| **Appendix K Flexibilities:**<br>Grant exceptions to the individual budget limits described in Appendix C-4 when needed to accommodate changes in service need and/or availability for a variety of circumstances that may arise from the impacts of the Maui wildfires. | |
| **Operational Guidance** | |
| Case Management | CMs will not be required to submit an exceptions request if services exceed the individual supports budget due to the change in service need and/or availability, except when requests are made that are unrelated to the flexibilities in Appendix K.<br><br>For example, requests for enhanced staff ratio (2:1 or 3:1) and enhanced supports (24/7 waiver services) will require an exceptions review, including review by Clinical Interdisciplinary Team (CIT). |
| Providers | N/A |
| **References:** Waiver Appendix C-4, Standards (Version A) Section 1.5B | |

# LOC DETERMINATIONS

| Process for Level of Care | |
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| **Appendix K Flexibilities:**<br>1. Level of care (LOC) initial and annual determinations may be conducted using telehealth.<br>2. LOC annual redeterminations may be extended for up to one year past the due date of the approved DHS1150-C during the declared disaster for the Maui wildfires. | |
| **Operational Guidance** | |
| Case Management | 1. CM may conduct the initial or annual LOC assessment by telehealth.<br><br>2. CM may extend the LOC annual redeterminations up to 365 days from the previous determination date for those impacted by the Maui wildfires.<br>a. The extension may be due to the participant not being able to complete a physical exam during the declared disaster for the Maui wildfires. |
| Providers | N/A |
| **References:** Waiver Appendix B-6-f, Standards (Version A) Section 1.4.A | |

# HCBS FINAL RULE

| HCBS Final Rule | |
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| **Appendix K Flexibilities:**<br>1. Suspend the requirement for individuals' right to choose with whom to share a bedroom.<br>2. Allow for services to be provided in residential and non-residential settings that have not been validated for HCBS Final Rule compliance by the State. This only applies for settings affected by the Maui wildfires. | |
| **Operational Guidance** | |
| Case Management | If ADH or ResHab services are provided in temporary settings within the State that have not been validated by the State, the provider shall submit an attestation to the CM that the setting meets the participant's needs for health and safety.<br><br>The CM shall verify and document in the ISP that the setting meets the participant's needs for health and safety. |
| Providers | The provider shall document when either of the two flexibilities listed above are implemented and the reason why it was necessary.<br><br>If ADH or ResHab services are provided in temporary settings within the State that have not been validated by the State, the provider shall submit an attestation to the CM that the setting meets the participant's needs for health and safety. |
| **References:** Waiver Appendix Attachment #2, Standards (Version A) Section 3.2 | |

# DIRECT SUPPORT PROFESSIONAL (DSP) QUALIFICATIONS

| **DSW – Legally Responsible Relatives** | |
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| **Appendix K Flexibilities:**<br>Personal Assistance/Habilitation (PAB), Community Learning Service – Group (CLS-G), Community Learning Service – Individual (CLS-Ind), Chore, and Non-Medical Transportation (NMT):<br>Permit legally responsible relatives[1] to be hired as temporary workers in the absence of direct support professionals due to the impacts of the Maui wildfire disaster. The state assures that the services provided by legally responsible relatives are extraordinary care[2]. The state ensures payments are made for services rendered through electronic visit verification for PAB and Chore. In addition, legally responsible relatives hired by a provider must adhere to the requirements in the Waiver Provider Standards Manual. Those hired through the Consumer-Directed option must follow the requirements in the Consumer-Directed Option Overview and Requirements Handbook.<br><br>[1]**Legally responsible relatives** include the parent of a participant under the age of 18 or the spouse of a participant.<br><br>[2]**Extraordinary care** means care exceeding the ordinary care and supervision that would be provided to a person without a disability of the same age. | |
| **Operational Guidance** | |
| Case Management | All requests for providers or Consumer-Directed (CD) employers to hire a legally responsible relative to provide services for a participant must be approved by the CM prior to delivering Waiver services.<br><br>Extraordinary care needs are determined based on the participant's Inventory for Client and Agency Planning (ICAP) Service Score. Participants with ICAP Service Score that is 79 and below meet the criteria for extraordinary care, exceeding the ordinary care and supervision needs that would be provided to a person without a disability of the same age.<br><br>The CM documents in the ISP that the participant has extraordinary care needs and approves the use of the legally responsible relative to provide services. Documentation includes:<br><br>For provider agencies:<br>"During the duration of the Maui wildfires PHE, this service may be delivered by the legally responsible parent/spouse (circle one), __(name)_ , effective _(date)_. This is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br><br>For CD employers:<br>"During the duration of the Maui wildfires PHE, this service may be delivered by the legally responsible parent/spouse (circle one), __(name)_ , effective _(date)_. This individual is not the CD employer/designated representative. This is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner." |
| Consumer-Directed | 1) Consumer Directed (CD) employers must follow the requirements in the Consumer-Directed Option Overview and Requirements Handbook.<br>NOTE: If the legally responsible relative is the Designated Representative, that legally responsible relative may not hire themselves to perform the work.<br>2) CD employer is responsible to ensure that the legally responsible relative shall not work with the family member participant until receiving approval from the CM, after the CM ensures the criteria for extraordinary care needs are met.<br>3) CD PAB and Chore must follow Electronic Visit Verification (EVV) requirements to document service delivery. |
| Providers | 1) Provider is responsible to ensure that the legally responsible relative shall not work with the family member participant until receiving approval from the CM, after the CM ensures the criteria for extraordinary care needs are met.<br>2) PAB and Chore must follow Electronic Visit Verification (EVV) requirements to document service delivery. |
| **References:** N/A | |

# PROVIDER STAFF QUALIFICATIONS AND MONITORING

## Provider Qualifications

**Appendix K Flexibilities:**

1. Lower the minimum age requirement for direct support professionals to 16 years of age for provisional hires.
2. Suspend the requirement for a high school diploma or GED for provisional hires.
3. Staff qualification requirements for provisional hires other than being legally able to work in the United States (e.g., criminal history check, staff training, CPR and first aid certification, etc.) will be suspended during a declared public health emergency.
4. Providers may choose to provide training on-line rather than in-person. Trainings may also be conducted by telehealth. Telehealth that meets privacy requirements must be used to conduct participant-specific training in the ISP.

**Operational Guidance**

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| Case Management | N/A |
| Consumer-Directed | For CD Employees (Direct Support Professional)<br>Requirements remain the same as indicated in Waiver Standards (Version A) Table 3.4-1 |
| Providers | <u>Staff Qualification Requirements</u><br>Providers may choose to do a provisional hire for new staff who are unable to meet all the staff qualification requirements in Waiver Standards (Version A) during the effective period of Appendix K.<br><br>1) Mandatory requirements for a provisional hire for new staff during the effective period of Appendix K include:<br>a. At least age 16;<br>b. Able to work legally in the United States;<br>c. State Name Check (eCrim);<br>d. Not be named on the U.S. Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and the Med-QUEST excluded provider list;<br>e. TB clearance issued after the age of 16; and<br>f. Training in the participant's ISP and IP and possess the skills and knowledge to implement the plan(s).<br>2) The following requirements are at the discretion of the provider, but are not mandatory during the effective period of Appendix K:<br>a. High school diploma or equivalent<br>b. CPR and First Aid training<br>c. Fieldprint background checks<br>d. Required training topics – the provider may select modules for new staff orientation from the list of training topics in Waiver Standards (Version A) but are not required to include all topics before the staff begins providing services.<br>3) The provider must maintain documentation of all provisional hires during the effective period of Appendix K. Documentation must include the following:<br>a. Name of staff<br>b. Position<br>c. Date started providing services<br>d. Date stopped providing service, if applicable, including the reason(s)<br>e. List of requirements in Waiver Standards (Version A) that were waived or suspended due to the Maui wildfires<br>4) Staff qualification requirements will revert to the requirements in Standards (Version A), Section 3.2 after the end of the Appendix K. Post-disaster, providers will be responsible to ensure all staff fulfill requirements that were waived or suspended during the period of the Appendix K.<br><br><u>Training On-line in Lieu of In-Person Training</u><br>1) Providers may choose to provide staff training on-line or by telehealth in lieu of in-person training.<br>2) Providers must ensure privacy requirements are met when using telehealth for conducting participant-specific training in the ISP. |

**References:** Waiver Appendix C1/C3, Standards (Version A) Section 3.2

| Quality Assurance – Provider Monitoring | |
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| **Appendix K Flexibilities:**<br>For providers impacted by the Maui wildfires, annual on-site provider validations and reviews for quality management, and financial audits may be delayed during the declared disaster. Reviews by desk audit or other methods may be used as deemed appropriate by DOH-DDD.<br><br>Data collection for performance measure reporting other than those identified for the Health and Welfare assurance may be suspended. | |
| **Operational Guidance** | |
| Case Management | N/A |
| Providers | This is only for providers affected by the Maui wildfires.<br><br>1) Provider monitoring visits or reviews by desk audit originally scheduled to occur within the effective timeframe of the Appendix K for the Maui wildfires, may be rescheduled.<br>2) Providers will receive an email from CRB, notifying them of the status of their monitoring visit or review by desk audit.<br>3) If the monitoring visit or review by desk audit was completed prior to the Maui wildfires, providers may continue to submit their Corrective Action Plans (CAP) to CRB via fax or mail.<br>4) If a provider is unable to submit their CAP due to the Maui wildfires, they must contact CRB to request an extension. |
| **References:** Waiver Appendix C QIS, Standards (Version A) Section 3.8 | |

# TELEHEALTH

| Use of Telehealth | |
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| **Appendix K Flexibilities:**<br>1. These services may be provided through telehealth that meets privacy requirements when the type of supports meets the health and safety needs of the participant:<br>• Adult Day Health (ADH)<br>• Personal Assistance/Habilitation (PAB)<br>• Waiver Emergency Services – Emergency Outreach<br>2. Case Managers may use telehealth that meets privacy requirements in lieu of face-to-face meetings to conduct Individualized Service Plan (ISP) assessments and initial and annual evaluations for level of care (LOC). | |
| **Operational Guidance** | |
| Case Management | 1. The only service included in the three (3) Appendix K services above that can be consumer-directed (CD) is PAB. CD PAB may be delivered individually (1:1) or groups of one worker to two (1:2) or three (1:3) participants.<br><br><u>Request for Services via Telehealth</u><br>1) CM will discuss with participant, family/guardian, and service provider to determine if telehealth may be an option for service delivery.<br>2) If the participant requests telehealth services, with the circle of support, the CM will document the following in the ISP:<br>a) How telehealth will be used to facilitate community integration and support the participant to meet their individual person-centered goals;<br>b) An assessment of whether telehealth is an appropriate way to deliver the service for the participant and is not used solely for the provider's/CD employee's convenience;<br>c) If accommodations are needed, how they will be provided including for those who need physical assistance or assistance with use of technology; and<br>d) How the participant's health and safety will be ensured.<br><br><u>Service Authorization</u><br>1) The case manager and provider will discuss the ISP Action Plan (Maui wildfires) to identify telehealth as a method for the provider to deliver services. The frequency of assessed support needs through telehealth will be confirmed with the participant and/or family/guardian.<br>2) CM will create a new action plan to reflect the change in service delivery and authorized hours. The ISP Action Plan (Maui wildfires) will document the following: "The addition of _____ service delivered through telehealth effective _____ is temporary and time limited for the duration of declared disaster and will end when the declared disaster ends. The change in service is based on the participant's assessed need during the emergency."<br>3) Verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary.<br>4) The ISP Action Plan (Maui wildfires) must document the following: "The change in service from _____ to _____ effective _____ is temporary and time limited for duration of declared disaster and will end when the state of declared disaster ends. The change in service is based on the participant's assessed need during the emergency."<br><br>2. ISP assessments, such as ICAPs, and LOC evaluations and re-evaluations may be conducted using telehealth if chosen by the participant and/or guardian. The CM is responsible for ensuring the telehealth platform(s) being used is non-public facing and adheres to all HIPAA requirements.<br>a. According to the Health and Human Services (HHS), non-public facing platforms include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, or Skype. Such products also would include commonly used texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, Whatsapp, or iMessage. |

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| | b. According to HHS, public-facing products such as TikTok, Facebook Live, Twitch, or a public chat room are not acceptable forms of remote communication for telehealth. |
| Consumer-Directed | Additional instructions for CD PAB:<br><br>If telehealth is determined to be an appropriate option, CD PAB may be provided by telehealth. If the participant already has CD PAB, additional units (If needed) can be added to the plan year in 3-month increments. CD Respite and CD CLS dollars can also be reallocated to CD PAB. If the participant does not have CD PAB a new authorization is required.<br><br>The CM notifies the CD Office of the telehealth approval via email who will inform Acumen to have the CD employee use the appropriate place of service code on their timesheet. |
| Providers | Services Provided Through Telehealth<br>The three (3) waiver services listed in Appendix K Flexibilities are direct services that are typically delivered face-to-face. Appendix K specifies the broad service category. Some services have component parts or can be delivered individually or in groups.<br>• ADH and PAB may be delivered individually (1:1) or in a group<br>• A registered behavior technician (RBT) can deliver ADH 1:1 and PAB 1:1<br><br><u>Criteria for the Use of Telehealth</u>:<br>The provider must demonstrate that all of the following criteria are met:<br>1) Each service requested is included in the Appendix K approved list.<br>2) The participant and family or legal guardian (if applicable) express interest in receiving services using telehealth.<br>3) The provider works with the Case Manager to ensure the telehealth service meets the participant's needs and for the telehealth authorizations.<br>4) The provider explains privacy requirements and documents in the participant's record that the participant and parent or legal guardian (if applicable) consented to the use of telehealth.<br>5) The provider and participant have the equipment to deliver and receive telehealth services that meets the participant's needs.<br>6) The provider will use a non-public facing, HIPAA-compliant platform for service delivery via telehealth.<br><br><u>Use of Telehealth Services</u><br>Applies to ADH and PAB:<br>1) When the participant needs the worker to be physically present and/or to provide physical assistance to ensure the participant's health, safety and to meet habilitative needs, it is not appropriate to deliver the service via telehealth. For example, when a participant needs hands-on assistance, physical prompts or close stand-by assistance to perform activities of daily living, the service cannot be delivered via telehealth.<br>2) The provider must explain to the participant and family/guardian that receiving services through telehealth is a choice. If the participant and family/guardian decide to change from receiving services using telehealth to in-person services, the provider will work with the participant, family/guardian and CM to transition to in-person services, if applicable.<br><br>Applies to Waiver Emergency Services – Outreach:<br>1) Due to the nature of the service, responding to crisis calls may occur before the CM can authorize the service.<br>a. The provider should follow existing protocols with the CM for authorizing services retroactively (after the crisis outreach service has occurred).<br><br><u>Service Authorization</u>:<br>1) Refer to the Case Management section above for more information on the Service Authorization process.<br>2) The provider will respond within one business day to requests for additional information to support the request to use telehealth. |

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| | Service Delivery By Telehealth:<br>Applies to ADH and PAB:<br>1) At the beginning of each telehealth encounter, the provider will:<br>b. Check for health and safety of the participant; and<br>c. Inform the participant that their information is kept private and safeguards have been taken.<br>2) The provider is responsible to ensure that telehealth strategies and activities engage participants and broadly align with their ISP outcomes. Examples of general ISP outcomes that can be translated to telehealth activities are provided below for illustrative purposes only.<br>• Skill Development —> video and practicing proper hand washing, healthy snack challenge with group discussion, verbal prompting for personal care support<br>• Social Interaction —> lead discussion or activity on area of interest, coordinate activities such as virtual hangouts<br>• Communication —> discuss a shared experience based on material presented, such as a virtual tour of a museum<br>• Personal Interests —> virtual cooking class, making cards for family and friends<br>• Physical Activity/Exercise —> staff-led video fitness class, virtual dance party<br>• Community Resources/Experiences —> step-by-step how to order food online, traffic safety book and group discussion<br>• Self-determination/self-advocacy —> learning about rights and responsibilities, mapping personal goals<br>• Job Discovery/Career Planning —> creating a video resume<br>• Employment —> role playing workplace conversations with coworkers and supervisors<br><br>Applies to Waiver Emergency Service – Crisis Outreach:<br>The provider will deliver services in accordance with the Waiver Standards (Version A) using telehealth as a portion of the Crisis Outreach, in addition to face-to-face visits when such a visit can meet the individual's health and safety needs.<br><br>Service Supervision – Use of Telehealth<br>Applies to All Waiver Services with Service Supervision Requirements (including those services that are not delivered using telehealth):<br>1) Monthly service supervision or quality assurance monitoring visits may be done using telehealth for all service delivery (i.e., service delivery through telehealth and traditional face-to-face).<br>a. The provider must conduct and maintain documentation of supervisory or monitoring visits in accordance with the requirements in the Standards (Version A).<br><br>Applies to ADH and PAB:<br>1) In addition to documentation of supervisory or monitoring visit requirements in the Waiver Standards (Version A), the documentation must also demonstrate that the delivery and duration through telehealth, is appropriate and effective in meeting the participant's goals and outcomes.<br><br>Telehealth Requirements:<br>Applies to All Telehealth Services<br>1) For all direct services that would typically be delivered face-to-face, the priority approach would include technology with audio and video communication. When other technology is not available, the provider can use telephonic (audio only) communication.<br>2) The provider is responsible for ensuring the telehealth platform(s) being used is non-public facing and adheres to all HIPAA requirements.<br>a. According to the Health and Human Services (HHS), non-public facing platforms include Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, or Skype. Such products also would include commonly used texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, Whatsapp, or iMessage. |

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| | b. According to HHS, public-facing products such as TikTok, Facebook Live, Twitch, or a public chat room are not acceptable forms of remote communication for telehealth.<br><br>Documentation:<br>Applies to All Telehealth Services<br>1) The provider must complete and maintain service delivery documentation, records and reports in accordance with the requirements in the Standards (Version A).<br><br>In addition, the following applies to ADH and PAB:<br>1) Documentation during the effective period of Appendix K must also include the following:<br>a. list the name(s) of the DSW who provided the service;<br>b. include the service date, start and end times of the telehealth service;<br>c. indicate if the service was individual (1:1) or group (the DSW engaged with more than 1 participant on the telehealth session);<br>d. describe the support/activities provided to the participant(s) and participant(s) response (e.g., ability to engage or level of engagement); and<br>e. if the technology used is different from what was included on the Telehealth Assessment, document the technology used and reason.<br><br>Billing Instructions:<br>1) The provider must only bill for the time (start and end times) of service delivery when:<br>a. the DSW is actively engaging with the participant(s), i.e., this is not a passive service like remote monitoring; and<br>b. the DSW is not engaged in other duties or activities when delivering telehealth support to a participant.<br>2) If a group activity is provided, the provider will maintain documentation that lists the names of all participants who received the service (attendance log or similar). This log is not kept in a participant record but is filed and available for audit purposes.<br>3) Rates & Code Changes for Telehealth<br>a. The authorization for the service provided using telehealth will have the same code but with a unique telehealth modifier. The modifiers are included on the revised Master Rate Sheet. |
| **References:** Waiver Appendix C1/C3 and D, Standards (Version A) Section 4.1 | |

# SERVICES

| Service Definition/Limits – Additional Residential Supports (ARS) | |
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| **Appendix K Flexibilities:**<br>Appendix K permits the I/DD Waiver to expand the allowable use of the service to provide supports in licensed and certified settings when needed to replace community services that the participant cannot access due to the Maui wildfires.<br>1. May be provided for an urgent situation where the caregiver or substitute caregiver is unavailable to provide services during times when the participant would typically have been able to access daytime activities such as ADH.<br>2. May be extended beyond the short-term duration requirement during a declared PHE. | |
| **Operational Guidance** | |
| Case Management | 1. ARS for Urgent and/or Unavoidable Situations<br>a. CM will be notified by the provider when ARS is requested to support the participant in instances where the licensed or certified caregiver and substitute caregiver are unavailable to provide services during times when the participant would typically have been able to access daytime activities.<br>b. CM must document in the ISP the following: "ARS at _(hours)_ /day effective _(date)_ is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br>c. Example: ARS at 4 hours daily effective August 8, 2023 is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner.<br>d. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>e. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian.<br><br>2. CM may continue to approve ARS beyond the short-term limit, during the PHE. An exceptions review will not be required. |
| Providers | 1. ARS for Urgent and/or Unavoidable Situations<br>b. The provider will contact the CM when the participant needs ARS due to an urgent and/or unavoidable situation as a result of the Maui wildfires.<br>i. An urgent situation shall be described as an immediate, unavoidable circumstance.<br>ii. Examples of urgent and/or unavoidable situations:<br>(1) the caregiver and/or substitute caregiver being unavailable to provide services during times when the participant would typically have been able to access daytime activities.; and<br>(2) escalation in participants' behavior due to restricted or limited access to daytime activities.<br>c. ARS Tool will not be required during the PHE.<br>d. ARS may be authorized as a 1:1 or group service, depending on the number of residents in the home requiring the service.<br>e. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>f. The provider should check the DMO for prior authorization confirmation before submitting claims.<br>i. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created.<br><br>2. ARS may continue to be approved beyond the short-term limit, during the emergency. An exceptions review will not be required. |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.2 | |

| Service Definition/Limits/Location – Adult Day Health (ADH) | |
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| **Appendix K Flexibilities:**<br>1. ADH may be provided in a participants' home, whether in a licensed setting, certified setting, or a private home, or other location where the participant is temporarily located. When provided in a licensed or certified setting, the services cannot be provided by a member of the household.<br>2. Minimum staffing ratios as required by the waiver service definition, provider standards and/or specified in the Individualized Service Plan (ISP) may be exceeded due to staffing shortages.<br>3. May be provided through telehealth that meets privacy requirements when the type of support meets the health and safety needs of the participant. | |
| **Operational Guidance** | |
| Case Management | 1. ADH Provided in the Participant's Home or Temporary Location (private, licensed or certified home or other setting)<br>a. CM may authorize ADH in the participant's home or other location where the participant is temporarily located.<br>b. ADH in a participant's home or other temporary location may be authorized as ADH 1:1.<br>c. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>d. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian.<br>2. N/A<br>3. Provided by telehealth – see Telehealth section (page 14) |
| Providers | 1. ADH Provided in the Participant's Home or Temporary Location (private, licensed or certified home or other setting)<br>a. ADH 1:1 may be provided based on the participant's support needs.<br>i. The CM will work with the participant, family/guardian and provider(s) to determine support needs, including amount and frequency of services during the Maui wildfires PHE.<br>b. ADH in a licensed or certified home may not be provided by a member of the household.<br>c. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (Version A).<br>i. Documentation during the effective period of the Appendix K must also include the change in service location and/or delivery method (e.g., telehealth) and a brief description of the reason for the change (related to the Maui wildfires).<br>d. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>e. The provider should check the DMO for prior authorization confirmation before submitting claims.<br>i. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created.<br>2. Minimum Staffing Ratios<br>a. May exceed the required minimum staffing ratio of 1:6 due to staffing shortages, as long as the health and safety of the participants are ensured.<br>b. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (Version A).<br>i. Documentation during the effective period of the Appendix K must also include the staffing ratio, reason(s) if the minimum staffing ratio was exceeded.<br>3. ADH by Telehealth<br>a. ADH services may be delivered via telehealth, when appropriate.<br>i. The provider must verify that the participant's needs may be adequately supported via telehealth and ensure their health and safety.<br>b. See Telehealth section (page 184). |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.3 | |

| Service Definition/Limits – Assistive Technology (AT) | |
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| **Appendix K Flexibilities:**<br>Modify the process for procuring medically necessary AT to expedite the replacement of medically necessary AT for participants who lost their previously purchased device or equipment due to the Maui wildfires disaster. | |
| **Operational Guidance** | |
| Case Management | For situations where the participant has lost or damaged equipment, previously purchased through the Waiver, due to the Maui wildfires.<br><br>The CM process will use existing documentation on file, without requiring an updated physician prescription or an updated assessment if the participant's needs have not changed.<br><br>Note: AT must not be otherwise covered by the Medicaid state plan or the QUEST Integration health plan. |
| Providers | N/A |
| **References**: Waiver Appendix C1/C3, Standards (Version A) Section 4.4 | |

| Service Definition/Limits – Community Learning Services – Group (CLS-G) | |
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| **Appendix K Flexibilities:**<br>Minimum staffing ratios as required by the waiver service definition, provider standards and/or specified in the Individualized Service Plan (ISP) may be exceeded due to staffing shortages. | |
| **Operational Guidance** | |
| Case Management | N/A |
| Providers | The provider may exceed the required minimum staffing ratio of 1:3, due to staffing shortage, as long as the health and safety of the participants are ensured.<br><br>The provider must complete and maintain service delivery documentation, records and reports in accordance with the requirements in Waiver Standards (Version A). Documentation during the effective period of Appendix K must include the staffing ratio and reason(s) if the minimum staffing ratio was exceeded. |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.6.1 | |

| Service Definition/Limits – Personal Assistance/Habilitation (PAB) | |
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| **Appendix K Flexibilities:**<br>1. Temporarily allow authorized waiver services to be provided to participants, in accordance with the Individualized Services Plan (ISP), in any location where the participant is located due to the impact of the Maui wildfires, including the home of their direct support professional, any location where they have evacuated (such as in hotels, shelters, schools, churches, campgrounds, and other designated evacuation locations), and/or where the participant has been relocated in temporary housing (including locations on neighbor islands).<br>2. May be provided through telehealth that meets privacy requirements when the type of support meets the health and safety needs of the participant. | |
| **Operational Guidance** | |
| Case Management | 1. This is for participants who are residing in a temporary location without a licensed/certified caregiver.<br>a. CM may approve PAB to support the participant residing in a temporary location that may not be the participant's home.<br>b. CM must document in the ISP the following: "PAB at _(location)_ is authorized, effective _(date)_ to support the participant in their temporary residence, time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br>c. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>d. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian.<br><br>2. Provided by telehealth – see Telehealth section (page 14) |
| Providers | 1. This is for participants who are residing in a temporary location without a licensed/certified caregiver.<br>a. The provider will contact the CM, when the participant is residing in a temporary location and requires supports during the stay, to update the ISP and/or authorize the service.<br>b. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>c. The provider should check the DMO for prior authorization confirmation before submitting claims.<br>d. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created.<br><br>2. Provided by telehealth – see Telehealth section (page 14)<br><br>Billing Instructions:<br>If PAB is used to support a participant at a temporary location, the provider must **enter "99" in the Place of Service** field on the claim. |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.12 | |

| Service Definition/Limits – Private Duty Nursing (PDN) | |
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| **Appendix K Flexibilities:**<br>The 8-hour limit per day and 30-day short-term limit are suspended if increases in amount or duration of PDN are needed to protect participant health and safety. However, requests above these limits require review and approval by DOH/DDD.<br><br>The requirement that the participant requires less than 24 hours-per-day on an ongoing long-term basis may be suspended. | |
| **Operational Guidance** | |
| Case Management | A participant may need additional hours during the effective period of Appendix K.<br><br>1) The participant, family/guardian or provider may contact the CM to request additional PDN hours.<br>2) RN designee must review request and supporting documentation by the provider to confirm that additional PDN hours are necessary to protect participant health and safety.<br>3) RN designee will complete the functional assessment, which may be done by telehealth and/or record review, within 24 hours of the request.<br>4) Unit supervisor shall review and document in the tracking log.<br>5) Requests for PDN above the 8-hours-per day limit and 30-day short-term limit may be approved for reasons other than those listed in Waiver Standards Version A but will require an expedited review by the Clinical Interdisciplinary Team.<br>If request for PDN is approved, CM must document in the ISP the following:<br>"The increase in PDN hours from _____ to _____ hours effective _____ is temporary and time limited.<br>Example: The increase in PDN hours from 6 hours per day to 9 hours per day effective August 8, 2023 is temporary and time limited.<br>6) Retroactive and/or verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary.<br>7) The CM will offer the participant and/or legal guardian a choice to use electronic signature or to receive a mailed consent form to sign and return. |
| Providers | Providers must continue to meet the Performance Standards for PDN services, stated in the Waiver Standards (Version A), Section 4.14, in addition to the following:<br><br>1) The provider will conduct a brief screening of the participant's situation before requesting PDN or PDN above the limit.<br>a. Screening questions to help determine if PDN is needed (i.e. participant currently not receiving the service):<br>i. Is the participant 21 years of age or older?<br>ii. Does the participant have medical needs related to the Maui wildfires, such as burns, smoke inhalation, wound care, etc.?<br>NOTE: If answer "Yes" to this question, request may be sent to CM and the remaining question does not need to be answered.<br>2) After a request is submitted to the CM, the provider shall:<br>a. Work with the CM or CM unit RN designee to inform the functional assessment.<br>3) Retroactive and/or verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary.<br>4) The provider should check the DMO for prior authorization confirmation before submitting claims.<br>a. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created. |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.14 | |

| Service Definition/Limits – Residential Habilitation (ResHab) | |
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| **Appendix K Flexibilities:**<br>Temporarily allow authorized waiver services to be provided to participants, in accordance with the Individualized Services Plan (ISP), in any location where the participant is located due to the impact of the Maui wildfires, including any location where they have evacuated (such as in hotels, shelters, schools, churches, campgrounds, and other designated evacuation locations), and/or where the participant has been relocated in temporary housing (including locations on neighbor islands). Services in these expanded settings will be reimbursed based on the current rate methodology, which does not include room and board expenses. | |
| **Operational Guidance** | |
| Case Management | CM may approve ResHab to support the participant, previously residing in a licensed or certified home, temporarily relocated with the caregiver into a setting that may not be a licensed or certified. The temporary location must meet the participant's health, safety, and accessibility needs.<br><br>1) CM must document in the ISP the following: "ResHab at _(location)_ is authorized, effective _(date)_ to support the participant who relocated with the caregiver, in their temporary residence, time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br>2) Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>3) The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian.<br><br>Note: ResHab services may be provided in the temporary home without requiring the setting to be validated for compliance with the HCBS Final Rule. Services in these settings does not include room and board expenses. |
| Providers | 1) The provider will contact the CM when the participant has relocated with the caregiver to a temporary location and requires supports during the stay.<br>2) The provider must attest that the home meets the participant's need for health and safety.<br>3) Retroactive and/or verbal approval by the participant and/or legal guardian may be used temporarily in place of written signature for ISP approvals when necessary.<br>4) The provider should check the DMO for prior authorization confirmation before submitting claims.<br>a. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created. |
| **References**: Waiver Appendix C1/C3, Standards (Version A) Section 4.15 | |

| Service Definition/Limits/Location – Respite | |
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| **Appendix K Flexibilities:**<br>1. Suspend the annual limit of 760 hours of Respite when needed to address potential health and safety issues due to the unavailability of services and/or natural supports that the participant has been receiving.<br>2. Temporarily allow authorized waiver services to be provided to participants, in accordance with the Individualized Services Plan (ISP), in any location where the participant is located due to the impact of the Maui wildfires, including the participant's home (including private home, licensed or certified non-institutional setting), the home of their direct support professional, any location where they have evacuated (such as in hotels, shelters, schools, churches, campgrounds, and other designated evacuation locations, and/or where the participant has been relocated in temporary housing (including locations on neighbor islands). Services in these expanded settings will be reimbursed based on the current rate methodology, which does not include room and board expenses. | |
| **Operational Guidance** | |
| Case Management | 1. Respite Services due to the Maui wildfires<br>a. The CM shall document in the ISP the need for respite to address potential health and safety issues due to the unavailability of services and/or natural supports that participant had been receiving.<br>b. Unit supervisor shall review request, verify need for services, approve respite hours and document in the tracking log.<br>c. CM must document in the ISP the following when additional hours of respite is authorized "An increase of respite to _(hours)_ effective _(date)_ is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner".<br>i. Example: "An increase of respite to 800 hours effective August 8, 2023 is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br>d. CM must document in the ISP the following when there is a new authorization for respite: "Respite at 800 hours per year effective August 8, 2023 is temporary and time limited to the duration of Appendix K or the end of the participant's plan year, whichever is sooner."<br>e. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>f. The CM will offer them a choice to use electronic signature or to receive a mailed ISP to sign and return. CM may obtain verbal approval from the participant and/or legal guardian.<br><br>NOTE: Requests for respite above the annual limit of 760 hours will not require an Exceptions Review but will require approval by the Case Management Unit Supervisor when needed to address potential health and safety issues due to the unavailability of services and/or natural supports that the participant has been receiving.<br><br>2. Location of Respite Services<br>CM may approve hourly respite services where the participant is temporarily residing. |
| Providers | 1. Respite Services due to the Maui wildfires<br>a. The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (Version A).<br>b. Retroactive and/or verbal approval may be used temporarily in place of written signature for ISP approvals by the participant and/or legal guardian when necessary.<br>c. The provider should check the DMO for prior authorization confirmation before submitting claims.<br>i. It may take 4-5 business days for an authorization to appear on DMO from the date the authorization is created.<br><br>NOTE: Requests for respite above the annual limit of 760 hours will not require an Exceptions Review but will require approval by the Case Management Unit Supervisor.<br><br>2. Location of Respite Services |

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| | The provider must complete and maintain service delivery documentation, records and reports in accordance with requirements in Standards (Version A). |
| **References:** Waiver Appendix C1/C3, Standards (Version A) Section 4.16 | |

| **Service Definition/Limits – Specialized Medical Equipment and Supplies (SMES)** | |
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| **Appendix K Flexibilities:**<br>Modify the process for procuring medically necessary SMES to expedite the replacement of medically necessary SMES for participants who lost their previously purchased device or equipment due to the Maui wildfires disaster. | |
| **Operational Guidance** | |
| Case Management | For situations where the participant has lost or damaged equipment, previously purchased through the Waiver, due to the Maui wildfires.<br><br>The CM process will use existing documentation on file, without requiring an updated physician prescription or an updated assessment if the participant's needs have not changed.<br><br>Note: SMES must not be otherwise covered by the Medicaid state plan or the QUEST Integration health plan. |
| Providers | N/A |
| **References**: Waiver Appendix C1/C3, Standards (Version A) Section 4.17 | |

# TEMPORARY RATE ADJUSTMENTS

| **Temporary Rate Adjustments** | |
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| **Appendix K Flexibilities:**<br>Adult Day Health (ADH), Additional Residential Supports (ARS), Chore, Community Learning Services (CLS), Community Navigator, Discovery & Career Planning (DCP), Individual Employment Supports (IES), Non-Medical Transportation (NMT), Personal Assistance/Habilitation (PAB), Private Duty Nursing (PDN), Residential Habilitation (ResHab), Respite, and Training & Consultation (T&C)<br>Temporary rate adjustments (TRA) are intended to support a viable provider network in order to ensure that services are available to participants. DDD will temporarily increase the fee-for-service payment rates for the duration of the Maui wildfires disaster.<br><br>Providers in Maui County may bill the TRAs, which are the difference between the current rates and the Big Island rates for the above listed services. The additional funding is to account for additional travel time and distance as well as other increased costs due to the impacts of the declared disaster for the Maui wildfires. | |
| **Operational Guidance** | |
| Case Management | Separate codes for the TRAs were created to be billed in addition to the existing base rates for all services listed above.<br><br>The TRA will not be counted against the limits established by individual supports budgets.<br><br>Initial Authorizations<br>*The case manager will not need to input the authorizations for the initial TRAs. These authorizations will be imported into INSPIRE.*<br><br>1. An initial set of TRA authorizations will be created centrally in September 2023. Case managers did not need to take any action for those initial TRA authorizations for the period from August 8, 2023 to the end of the participant's plan year.<br>a. For every existing authorization for a service that received a TRA, a corresponding TRA authorization was established.<br>b. The number of units authorized for the TRA was equal to the number of units originally authorized for the service to which the TRA applies.<br>c. TRAs have unique codes for the above listed services. The codes are included in INSPIRE as well as in the revised Master Rate Sheet.<br><br>Service Authorization with TRA for Plan Years Beginning on or After November 1, 2023<br>1. TRA authorizations for plan years starting November 1, 2023 through August 7, 2024:<br>a. The case manager will generate the service authorization and the accompanying TRA authorization for services subject to TRA for participants with plan years that start on or after November 1, 2023.<br>i. For every authorization for a service listed above, a corresponding TRA authorization is needed.<br>ii. The number of units authorized for the TRA is equal to the number of units authorized for the service to which the TRA applies. |
| Providers | Separate codes for the TRAs were created to be billed in addition to the existing base rates and codes for the above listed services.<br><br>The TRA will not be counted against the limits established by individual supports budgets.<br><br>Service Authorization<br>See Case Manager Service Authorization section above.<br><br>Billing Instructions<br>1. For services subject to TRA, the provider must submit a claim for both the service and the accompanying TRA.<br>2. The TRA may be billed for services provided starting August 8, 2023. If providers have already billed for those services from August 8, 2023, only a claim for the corresponding TRA will need to be submitted. |

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| | 3. The TRA will be billed in addition to the rate for the service to which the TRA applies (see Authorization section).<br>a. For every service with a TRA, there will be two claims for each unit of service provided – one unit for the authorized service at the standard rate and one unit for the TRA, which reflects the additional funding.<br>b. TRAs have unique codes for the above listed services. The codes are included in the revised Master Rate Sheet.<br>4. If the provider is submitting a claim for a retainer payment in a month in which the agency is also submitting claims for services delivered and the TRA, the billing for the TRA must be counted in the calculation of the retainer (that is, the TRAs are included in the determination of the actual billing, which is subtracted from the amount that may be billed for the retainer; see the Billing Instructions for Retainer Payments). |
| **References:** N/A | |

# RETAINER PAYMENTS

| **Retainer Payments** | |
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| **Appendix K Flexibilities:**<br><u>Adult Day Health (ADH), Community Learning Services – Group (CLS-G), Community Learning Service – Individual (CLS-Ind), Discovery and Career Planning (DCP), and Individual Employment Supports (IES):</u><br>Retainer payments can be made when authorized for ADH, CLS-G, CLS-Ind, DCP, and IES in order to preserve programs and the workforce when providers are unable to deliver services due to the Maui wildfires disaster. The retainer payments may be billed for a single calendar month based on a claim equal to 90 percent of the difference between a provider's billing for a given participant in a baseline period (the average monthly billing for state fiscal year 2023) and the month of the declared disaster for which the retainer is billed.<br><br>Pursuant to federal rules, providers will only be able to bill a retainer payment for a service for an individual for a single calendar month. | |
| **Operational Guidance** | |
| Case Management | <u>Authorization:</u><br>*NOTE: The case manager will not need to input the authorizations for retainer payments for ADH, CLS-G, CLS-Ind, DCP, and IES. These authorizations will be imported into INSPIRE.*<br><br>For more information, refer to the Provider Section of this guideline where the methodology for calculating retainer payments is described. |
| Providers | ADH, CLS-G, CLS-Ind, DCP, and IES retainer payments are established to support a stable provider network and workforce during a period in which providers are unable to provide the volume of services they have historically delivered. The retainer payments are established to assist providers to retain staff, during the effective period of Appendix K, when there is likely to be a reduction of these services.<br>1) Retainer payments will be in effect until the end of the Appendix K.<br>2) The retainer payments are limited to 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed.<br>3) Retainer payments are limited to a single calendar month during the Maui wildfires disaster.<br><br><u>Authorization:</u><br>1) A retainer payment is only available when the provider has delivered that service to the participant within the last 3 months of the baseline period. That is, they must have delivered the service between April 1 and June 30, 2023.<br>2) For each existing ADH, CLS-G, CLS-Ind, DCP, or IES authorization, DDD will calculate the average amount billed during a baseline period.<br>a. DDD will total paid claims for the applicable service for the months of fiscal year 2023 (July 2022 through June 2023) and will divide that total by the number of months during this period in which the participant received one or more units of the applicable service.<br>i. For example, if a provider billed a total of $7,000 of ADH for a participant over 10 months during the fiscal year, the average amount billed would be $700 ($7,000 divided by 10 months).<br>b. DDD will report to case managers and providers the calculated average amount billed during the baseline period.<br>2) The average monthly amount billed during the baseline period will be multiplied by 90 percent, which is the amount that will be authorized by DDD for retainer payments.<br>a. Limiting the retainer to 90 percent of the lost billing is intended to account for certain reductions in provider expenses (such as reduced utility or mileage costs) and to ensure that billing does not exceed the equivalent of 30 consecutive days.<br>b. Based on the example above, the retainer authorization for ADH would be $630 ($700 multiplied by 90%).<br>3) The retainer authorization amount will be imported into INSPIRE and reported to the provider as the authorization for retainer payments.<br>NOTE: This is *not* necessarily the amount to be billed because providers still must account for the services they are providing as discussed in the Billing section. |

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| | 4) Retainer payments have unique codes for ADH, CLS-G, CLS-Ind, DCP, and IES. The codes are included in the revised Master Rate Sheet.<br>5) Retainer rates are authorized as $1.00 = 1 unit. The units/dollar amount authorized is calculated as 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed. Unit/dollar amounts per participant is rounded to the nearest dollar. Authorizations and claims are in whole units as follows:<br>b. Authorization/claim ends in $0.01 to $0.50 = Authorization/claim is 0 units<br>c. Authorization/claim ends in $0.51 to $0.99 = Authorization/claim is 1 unit<br><br><u>Billing Instructions:</u><br>1) Providers may bill for retainer payments for 90 percent of the difference between the average amount billed during a baseline period to the actual amount of service billed in the month for which the retainer is being claimed.<br>a. Providers will first determine the amount they billed for services actually provided during the month including any billing for Temporary Rate Adjustments (TRAs).<br>b. Billing for services actually provided will then be subtracted from the baseline amount, calculated by DDD, for that participant and service. Providers may bill for 90 percent of the difference calculated.<br>i. For example, if a provider billed an average of $700 per month for a participant during the baseline period and billed $200 in September 2022 (inclusive of TRAs), the difference between the baseline amount and September 2022 is $500 ($700 – $200). The provider may bill the retainer for $450 ($500 multiplied by 90%).<br>2) Any payments that are made, but that do not comply with the provisions of the Billing Instructions – such as billing for a retainer that exceeds 90 percent of the difference between the baseline amount and actual services billed – will be recouped.<br>3) Retainer payments are limited to a single month during the Maui wildfires disaster. Providers are encouraged to bill for the month that is most financially advantageous to them. For example, if a provider billed $100 for services in August and $0 in September, they should bill the retainer in September because, if they bill for August, they would need to offset the retainer claim by the $100 billed for services. |
| **References:** Waiver Appendix I, Standards (Version A) N/A | |