AMENDMENT TO THE 1915(C) I/DD WAIVER FOR HCB SERVICES FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

PUBLIC COMMENTS AND RESPONSES REGARDING PROVIDER RATES

– PREPARED BY –

DEVELOPMENTAL DISABILITIES DIVISION
HAWAII STATE DEPARTMENT OF HEALTH

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BACKGROUND

The State of Hawaii provides Medicaid-funded home and community based services to persons with intellectual and developmental disabilities through a 'waiver' program authorized under Section 1915(c) of the Social Security Act. Such waivers must be renewed every five years and the State's most recent extension occurred in 2016. The federal Centers for Medicare and Medicaid Services (CMS) conditioned the renewal on the completion of a comprehensive provider rate study and the subsequent submission of an amendment to the waiver.

The agency responsible for operating the waiver – the Department of Health's Developmental Disabilities Division (DOH-DDD) – led the rate study with the assistance of the national consulting firm Burns & Associates, Inc. (B&A). The rate study encompassed several tasks, including:

- A detailed review of service requirements, billing rules, and DOH-DDD's policy objectives
- Multiple meetings with service providers, including a provider advisory group established to offer feedback at key points of the project
- On-site visits with three agencies to observe services firsthand
- Development and administration of a provider survey that was emailed to all providers to collect information regarding service designs and costs
- Identification and research of other available data to inform the development of the rate models, including cross-industry wage and benefit standards
- Analyses of claims data.

Based on this work, detailed rate models were developed. The models included the specific assumptions regarding the costs that providers face in the delivery of each service, such as direct support workers' wages, benefits, and billable time; staffing ratios; travel; and agency overhead.

The proposed changes to provider payment rates based on the rate study and other clarifications to the waiver were released for public comment in early January 2017. A dedicated website was established to house rate study materials, DOH-DDD conducted eight forums to explain the changes to the waiver, and B&A recorded and posted online a webinar to explain proposals related to rates. In compliance with federal requirements, interested parties were given 30 days to submit written comments.

In total, comments were received from more than 50 organizations and individuals. Most comments were thoughtfully written and constructive, and DOH-DDD appreciates all those who took time to provide feedback.

In response to the public comments, DOH-DDD has made a number of changes to the proposed rates:

- The assumed wage for staff providing Personal Assistance/ Habilitation services was equalized with the wage assumption for Community Learning Service and Adult Day Health services (with assumed wage increase for PAB and decreasing for ADH and CLS).
- The assumed wage for registered behavior technicians was increased 19 percent.
- The minimum wage assumed in the consumer-directed rate models was increased from $9.25 per hour to $10.10 to reflect the minimum wage that will become effective January 1, 2018.

- The productivity adjustment for training in the Community Learning Service rate models was increased.
- Productivity adjustments for driving time outside of the Big Island were increased to account for more traffic congestion on Oahu.
- Travel time and mileage was added to the Benefit Planning rate models.
- DOH-DDD decided to hold-harmless the rate for occupational therapists working on environmental accessibility adaptations and vehicle modifications.

The remainder of this document provides DOH-DDD's response to each specific comment related to changes to provider payment rates, organized by service:

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GENERAL

Rate-Setting Process

1. Several commenters expressed concern that DDD has not provided sufficient information and time for individuals, families, and providers to understand the proposed rates.

DOH-DDD has been and remains committed to meaningful public engagement.

Even before the draft waiver amendment was released, DOH-DDD worked to convey information to providers and other stakeholders. During the rate-setting process, a provider advisory group was

established to offer feedback at key decision points. The group was also specifically asked to represent the larger community of providers, sharing information with them, answering questions, and bringing their input back to DOH-DDD. The rate review was also discussed on several occasions with the Waiver Policy Advisory Committee, which is comprised of providers and other stakeholders.

The public review process has complied with federal requirements. The rate models and all supporting documentation were posted online and stakeholders were given 30 days to offer comments. The consultant assisting DOH-DDD in this project, B&A, recorded and posted online a webinar to explain the proposals. At the request of several providers, B&A hosted a live webinar during which providers could ask questions. DOH-DDD has conducted eight community meetings across the State.

Implementation of the new fee schedule does not begin until July 2017. In the intervening months, DOH-DDD will continue to provide information regarding systems changes to stakeholders, including individuals and families, case managers, and providers.

2. One commenter noted that the Legislature did not fund a budget request related to the rate study in 2016 and asked whether DDD's decision to move forward with the rate study impacted services. Two commenters asked what steps would be taken if the Legislature does not provide funding recommended for the fiscal year 2018 budget.

The rate study was a condition of CMS approval of the State's 1915(c) waiver application (the authority through which the State receives federal funding to provide home and community based services). The 2016 budget request referenced by the commenter was not to pay for the rate study, but was intended to provide for an interim rate increase as DOH-DDD recognized that many rates needed to be increased. The cost of the rate study was paid from DOH-DDD's administrative funds and had no impact on services.

DOH-DDD has requested $2.8 million in state funding for fiscal year 2018 to begin the three-year implementation of the new rates. This request is the net amount after accounting for the proposed elimination of the domiciliary home subsidies and would draw down $5.9 million in federal funds. When fully phased-in, the proposed rates will increase waiver spending by $26.5 million, with $10.8 million needed from State funds. DOH-DDD is optimistic that the request will be funded. However, DOH-DDD does not have the resources to fully implement the new rates without the budget request so, if it is not funded, the rates will have to be scaled back to match available funding.

3. One commenter stated that the rate models rely on 2014 statistics and that the "waiver period begins 3 years later extending an additional 8 years." Two commenters also stated that rate models do not account for cost of living changes over the course of the waiver.

Of necessity, the rate models rely on retrospective data, although data was more recent than 2014 (one data point for health insurance costs – the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey – was from 2014, but has been updated to reflect 2015 results that are available). Wage assumptions reflect the May 2015 Bureau of Labor Statistics (BLS) datasets, the most current available at the time of the study. Benefit assumptions are derived from the 2015 BLS data as well as various datasets from 2015 and 2016. The cost of mileage is based upon the Internal Revenue Service's 2017 mileage rates. Provider survey responses that informed the rate models reflected each provider's most recently completed fiscal year.

Using these data sources, DOH-DDD is proposing an aggregate rate increase of more than $26 million, an increase of nearly 25 percent. Further, the rate models are established in such a manner that they can be updated over time. By outlining the specific assumptions and detailing the source of

these assumptions, targeted adjustments to the rate models can be made as new data becomes available. For example, the BLS wage data is published each year so DOH-DDD has the ability to update the rate models with the newer data as it becomes available. Any increases in the rates, however, would be subject to the availability of funding.

4. ***One commenter asked whether there was any comparison of the rate structure between the last three waivers.***

   Service definitions and billing units in the current and previous waiver served as a starting point for the renewed 1915(c) waiver. DOH-DDD also considered evolving practices in the field of intellectual and developmental disabilities, including the impact of the home and community based services rule and trends in employment-related supports. In terms of the rate study, rate models were built 'from the ground up' based on service requirements and expectations, and cost data from multiple sources.

5. ***One commenter stated that rate models rely too heavily on data from the mainland, which "differs greatly in cost, in culture, and in service availability." Another commenter suggested that the rate study did not account for the high value that the local culture places on caring for loved ones at home. A third commenter stated that Bureau of Labor Statistics data is not specific to Hawaii.***

   The rate models are based on the service requirements established in Hawaii's waiver. Cost assumptions in the rate models were based on data from Hawaii providers as well as other data specific to the State, such as wage data from the BLS that is compiled from data collected from employers in Hawaii.

   DOH-DDD recognizes the value of families and natural supports, and the waiver is predicated on supporting participants to live at home to the greatest extent possible. To that end, the proposed rate for the primary PAB services – which are intended to support participants at home – is recommended to increase 13 percent outside of the Big Island and 31 percent on the Big Island. The rate for Respite services that allow caregivers to take a break from caring for their loved one is recommended to increase 28 percent outside of the Big Island and 30 percent on the Big Island. The waiver also includes the addition of a new Community Learning Service with rates even greater than PAB to help individuals access the community.

6. ***One commenter stated that the provider survey reflects only 25 percent of waiver providers and that their agency was not one of the providers asked to participate.***

   A provider survey was conducted in order to collect information from providers regarding the services that they deliver and the costs associated with those services. The survey was emailed to *all* providers who delivered services in fiscal year 2015, using the email addresses they had on record with DOH-DDD. Providers were given four weeks to complete and submit the survey, but any survey submitted after the deadline was also accepted. B&A provided technical assistance throughout the survey period including a recorded webinar that was posted online, contact information for staff to whom questions could be directed, and a page-by-page review of each submitted survey and corresponding follow-up with participants when clarification was needed.

   Of 60 providers who billed for one or more services included in the rate study in fiscal year 2015, 25 submitted a survey for a submission rate of 42 percent. These providers accounted for 60 percent of total spending on surveyed services, meaning that the survey encompassed the majority of services delivered. DOH-DDD believes that this participation rate was sufficient to provide useful data that was one of the primary considerations in the development of rate model assumptions.

Island Differential

7. One commenter expressed support for higher rates for services provided on the Big Island. Several commenters asked whether other factors were considered, such as traffic congestion on Oahu or limited providers on Kauai. Another commenter suggested that there be higher rates on Lanai and Molokai due to geographic challenges.

The proposed rate models include higher rates for services delivered on the Big Island in order to account for greater distances between providers and participants, which impacts costs associated with mileage as well as billable time. Certain other potential cost differences were also considered. Direct care worker wage and benefit costs were assumed to be consistent across the State, as data from the Bureau of Labor Statistics data did not show significant differences in different areas. The rate models for other islands include higher facility space costs to reflect more expensive space on Oahu (see the response to comment 45) and a higher general excise tax.

In response to these comments, the productivity adjustment for travel time in the rate models for services outside of the Big Island was increased to account for slower speeds due to congestion. Specifically, the average assumed driving speed was reduced from approximately 40 miles per hour to about 35 miles per hour.

DOH-DDD also notes that, in general, the rates for services on the other islands are increasing compared to current rates, although the increases are not as large as rates on the Big Island. These increases are intended to address the types of issues mentioned by the commenters, including service availability.

Direct Care Staff Wages, Benefits, and Productivity

8. Two commenters noted that the State's minimum wage will be increasing during the period that the rates are being phased-in and stated that the rates should be increased to reflect these changes. Another commenter stated that the minimum wage was "incorrect for the intended and stated projected increase during the period of this waiver." The latter commenter also stated that the rates for Respite and Chore services are below the minimum wage.

The wage assumptions in the rate models are generally tied to Bureau of Labor Statistics wage data for occupations that reflect the requirements of each service. The BLS data is published on an annual basis and is state-specific, so the assumptions reflect wages for employees in Hawaii.

The wage assumptions resulting from the BLS data were checked to ensure that they were no less than the State's current minimum wage of $9.25 per hour. The lowest wage assumptions in any of the rate models for agency-delivered services are $10.61 for Respite services and $12.02 for Chore Services. The lowest wage assumption for a habilitative service is $12.33 in the Residential Habilitation rate model. All of the wage assumptions for agency-directed services exceed both the current minimum wage and the $10.10 minimum wage that will become effective on January 1, 2018. Compared to this higher minimum wage, the Residential Habilitation wage assumption is 22 percent greater.

For consumer-directed services, the rate models produce a range of rates to allow consumers the ability to negotiate a wage with staff. This range is based on the minimum wage and the wage assumed in the corresponding agency-directed rate model. The minimum wage was based on the current $9.25, but has been adjusted to reflect the $10.10 minimum that will become effective on January 1, 2018.

Additionally, the BLS data is updated annually and DOH-DDD intends to review the data to ensure the ongoing appropriateness of the rates. Any rate adjustments, however, would be subject to available funding.

9. One commenter asked what will be the requirements for registered behavior technicians.

DOH-DDD is revising the Waiver Standards Manual to describe the requirements for registered behavior technicians (RBT). The rate models account for the staff qualifications through a higher productivity adjustment for more training hours and a wage assumption that is 31 percent greater than the wage assumed for staff providing PAB services.

10. One commenter noted that employee benefits are essential to employee recruitment and retention, especially given a low unemployment rate and a workforce shortage. Two commenters stated that the assumption related to employee health insurance in particular is too low. One of these commenters also stated that $50 per month for other benefits is inadequate.

DOH-DDD recognizes the importance of employee benefits to a professional and stable workforce. For that reason, the proposed rate models include a comprehensive benefits package. The specific benefit assumptions, with a comparison to the effective costs reported by respondents to the provider survey, are noted in Figure 1.

Figure 1: Comparison of Rate Model Assumptions for Employee Benefits to Provider Survey

Benefit	Rate Model Assumption	Provider Survey Average[1,2]
Social Security/ Medicare Taxes	7.65% of Wages	7.65% of wages
Federal Unemployment Insurance	0.60% of First $7,000 in Wages	0.60% of First $7,000
State Unemployment Insurance	2.40% of First $42,200 in Wages	1.30%
Workers' Compensation	2.00% of Wages	3.63%
Employment & Training Assess.	0.01% of First $42,200 in Wages	0.01% of First $42,200
Paid Time Off (Holiday, Vacation, Sick)	23 Days per Year	9.3 Days
Health Insurance	$400 per Month	$221 per Month
Other Benefits	$50 per Month	$9 per Month

[1]Reflects effective average across all full-time workers.

[2]The provider survey did not ask providers to report Social Security, Medicare, federal unemployment, and Employment and Training Assessment taxes as these amounts are fixed across all employers.

Excluding paid time off, which is incorporated in the rate models as a productivity adjustment, these assumptions were translated to a benefit rate as a percentage of wages. In total, the benefit rates included in the rate model are substantially greater than the benefit rates calculated based on costs reported by provider survey participants. For example, for an employee earning $15 per hour, the rate

model includes a benefit rate of 29.5 percent compared to a 21.5 percent rate based on provider survey responses for full-time staff. Reported benefits for part-time staff – which were reported to account for about one-third of the overall workforce across all services – are much less than assumed in the rate model.

For health insurance specifically, the rate models include an assumption of $400 per month for each direct care worker. This assumption is intended to provide for the cost of an individual health insurance policy and is based on data from the Bureau of Labor Statistics (which reported an average employer contribution of $407 per month for employees in the Pacific region), the U.S. Department of Health and Human Services' Medical Expenditure Panel Survey (which reported an average employer contribution of $415 for employees in Hawaii), and the $262 cost for the benchmark plan through the State's health insurance exchange for a 40 year-old non-smoker in Honolulu.

Providers who participated in the provider survey reported an average monthly health insurance contribution of $450 per *participating* employee. However, they also reported that about half of their full-time workers do not participate in their health insurance plan. Thus, the effective monthly cost of health insurance across *all full-time* employees is $221 (since the cost for non-participating employees is zero). When considering the part-time workforce, the effective cost to providers would be even less. Since the rate model assumes 100 percent participation, the effective monthly cost is still $400, nearly double the cost reported.

As with all rate model assumptions, the assumed benefits package is intended to reflect a provider's reasonable costs. For any given provider, it may certainly be true that costs for one or more benefits are higher than assumed in the rate model, but other benefits (or other cost factors, such as wages) may be less than assumed.

Operating and Overhead Costs

11. One commenter asked whether supervisors of staff providing services to individuals with medical needs will still be required to be registered nurses.

DOH-DDD is eliminating the requirement that registered nurses supervise staff providing services to participants with medical needs. Rather, a new Training and Consultation service for registered nurses is being established that can be billed for nurses to train direct support workers. This change is intended to ensure nurses spend their time on nursing-related, rather than administrative, tasks.

Supports Intensity Scale (SIS)

12. One commenter asked several questions related to the SIS pilot. Questions included whether the SIS will replace the ICAP entirely and, if so, when the ICAP will be discontinued; how "results from an assessment tool that has not yet been approved in our Waiver" will be used; whether individuals included in the pilot study will be reassessed; whether anyone has had services "cancelled"; whether participants are advised of an appeals process; and whether DOH-DDD will be releasing statistics from the pilot. This commenter also stated that families are reporting that the SIS is being used to postpone level of care service changes "until after the approval date" of the SIS.

DOH-DDD is in the process of conducting a pilot study of the Supports Intensity Scale (SIS) and is administering the assessment to approximately 600 waiver participants. Information collected through these assessments – the administration of which does not require federal approval – will be used to understand the needs profile of the overall waiver population, how that profile varies based on

residential placement, and how support needs and current utilization patterns are related. DOH-DDD intends to release results once the study is complete.

Ultimately, SIS assessment results – coupled with additional supplemental questions – will be the basis for determining the rate 'tier' to which individuals will be assigned for Residential Habilitation, Adult Day Health, and Community Learning Service-Group services. This process is not beginning until July 1, 2017.

Pilot study assessments are being conducted by trained and certified assessors and are therefore valid and will not be redone. Participants will continue to be informed of their appeal rights, including once DOH-DDD begins instituting the new services standards and fee schedule based on the implementation schedule discussed in the section beginning with comment 19.

13. One commenter stated that participants and family members need to be adequately educated on the SIS before it is adopted.

DOH-DDD recognizes the importance of educating stakeholders about the Supports Intensity Scale. A number of trainings have been held statewide, and letters were mailed to the approximately 600 participants and their families who are in the pilot study discussed in the response to comment 12. DOH-DDD is in the process of developing a communications plan to include additional training and mailings to families with comprehensive information on what the SIS is and how it will be used.

14. One commenter noted the importance of the timely completion of SIS assessments.

DOH-DDD agrees with the commenter. As discussed in the section beginning with comment 18, Supports Intensity Scale assessments will be administered over a three-year cycle, with approximately one-third of waiver participants being assessed each year. The SIS assessment should be completed in advance of each participant's individual service plan year – beginning with their 'cohort' year – so that the planning team has the benefit of the information collected in the SIS and knows the tier to which members will be assigned for Residential Habilitation, Adult Day Health, and Community Learning Service-Group services, as applicable.

DOH-DDD continues to expand its scheduling, assessment, and coordination capacity in order to ensure that participants receive their assessment prior to their planning meeting.

15. One commenter expressed concern about the consistency and objectivity of case managers in using the SIS to authorize services.

The Supports Intensity Scale does not determine what services will be authorized. Decisions regarding the services that a participant will receive will continue to be determined as part of an annual planning process.

The rate tier to which participants will be assigned for Residential Habilitation, Adult Day Health, and Community Learning Service-Group services will be determined by the SIS based on specified criteria. These criteria will be fixed across all participants and cannot be changed by case managers.

16. One commenter stated that all circle members should be present for the SIS assessment rather than only a minimum of two respondents.

Accurate assessments depend on the inclusion of respondents who know the individual being assessed. These respondents will often include paid staff, but that will not always be true and it is also not necessarily required that all service providers participate in the assessment. SIS schedulers work

with the participant, their family, and/or their case manager to ensure the appropriate respondents are included in the assessment.

DOH-DDD is complying with the assessment guidelines established by the publisher of the Supports Intensity Scale, the American Association on Intellectual and Developmental Disabilities. These guidelines recommend that the assessment include two or more respondents who have known the participant for at least three months and have had recent opportunities to observe the individual in one or more environments for substantial periods of time

17. ***Two commenters suggested that results from SIS assessments be shared with the participant, their family, and service providers.***

    The results of Supports Intensity Scale assessments, most particularly a participant's assigned level will certainly be made available to participants, their families, and providers. DOH-DDD is in the process of determining how this information will be communicated.

18. ***Noting that participants will receive a SIS assessment every three years, one commenter asked what happens if an individual experiences a significant change in condition.***

    As the commenter notes, participants will be scheduled to be assessed every three years. However, if an individual experiences a significant change in condition within that three-year period, they can receive an assessment outside of this schedule. DOH-DDD is developing policies to describe the circumstances that warrant an off-cycle assessment.

Implementation

19. ***Several commenters expressed concern regarding the plan to phase-in services. Specific concerns or suggestions included:***

    - ***The phase-in schedule delays rate increases for too long a period***
    - ***The rates for a given service should be changed on the same day for all individuals rather than phased-in over the course of a year***
    - ***Rate increases for PAB services should not wait until 2019***
    - ***All Adult Day Health Services should be implemented in the first year***
    - ***Whether participants and providers are being treated consistently and whether the phase-in approach is legal***
    - ***What liability providers will have as they balance two sets of service standards and rates for a period of time***

    DOH-DDD intends to phase-in the new rates over the next three years. DOH-DDD is developing materials to further detail the phase-in process, but the major elements include:

    - Waiver participants are divided into three 'cohorts'. The first includes individuals who receive Residential Habilitation services; the second includes those who do not receive Residential Habilitation, but do receive Adult Day Health, and the third includes everyone else.
    - The new rates for most services will be effective for all participants regardless of cohort for their ISP years between July 1, 2017 and June 30, 2018. The major exception to this rule is

agency-directed Personal Assistance/ Habilitation services. Services that are no longer covered will not be renewed in any plans that begin after July1, 2017.

- The Residential Habilitation rates will be phased-in during the first year of implementation based on participants' ISP years between July 1, 2017 and June 30, 2018.
- All participants will transition to 15-minute rates for Adult Day Health in the first year of implementation based on participants' ISP years between July 1, 2017 and June 30, 2018. If a participant has received a Supports Intensity Scale assessment (that is, they are in the first cohort), they will be assigned to a rate tier based on SIS results. For those without a SIS, they will be assigned to the rate tier that they have historically received. The same approach applies to rate tiers for Community Learning Service-Group.
- Participants in the second cohort will be transitioned to the new Personal Assistance/ Habilitation rates based on their ISP years between July 1, 2018 and June 30, 2019 and the third cohort will transition to the new PAB rates based on their ISP years between July 1, 2019 and June 30, 2020.

This phased-in approach has been adopted for three primary reasons. First, several services employ 'tiered' rates that require a SIS assessment and it will take DOH-DDD three years to complete the assessments. Second, this approach allows the cost increases to the State to be spread over several years rather than requiring that the full cost of implementation be funded immediately. Third, this gradual approach allows for any issues to be addressed without impacting every provider and participant.

DOH-DDD recognizes that providers will have to balance two sets of rates during this implementation period and is committed to working with providers to ensure a successful transition.

20. One commenter expressed concern that participants' budgets will not increase so that, if rates do increase, individuals will have to reduce the amount of services they receive in order to remain within their budget. This commenter suggested that participants should receive an annual budget that they could spend "any way they want."

The rate increases will not affect participants' access to services as, in general and consistent with a person-centered planning process, the authorized amounts for each participant will be increased to reflect the new rates as they are phased-in, which is why DOH-DDD has requested additional funding to implement the rates.

PERSONAL ASSISTANCE/ HABILITATION AND COMMUNITY LEARNING SERVICES-INDIVIDUAL

21. One commenter asked whether PAB and CLS-Individual are distinguished based on the location of service. Another commenter stated that the proposal did not indicate whether there will be a difference in rates for home-based and community-based services.

The first commenter's inference is correct. Community Learning Service-Individual is primarily distinguished from Personal Assistance/ Habilitation based on the location of services: away from the home in the community. The CLS-Individual service also includes additional staff training requirements in order to understand the purpose of the service in supporting participants in the community through development of relationships and socially-valued roles. Personal Assistance/ Habilitation will continue to be billed for services delivered in the home.

The second commenter is incorrect in stating that the proposal did not include the rates to be paid for the two services. The proposed rate models that accompanied the waiver amendment showed that the proposed CLS-Individual rate is about nine percent greater than the PAB rate outside of the Big Island and 12 percent greater on the Big Island.

Personal assistance and habilitation supports are being divided between these services for several reasons. The establishment of higher CLS-Individual rates is intended to compensate providers for higher costs associated with delivering supports in the community associated with planning, staff training, and mileage. Higher CLS-Individual rates, in turn, should remove the cost barrier to community-based services, which should increase community-based options for participants consistent with the federal home and community based services rule. Additionally, separating personal assistance and habilitation into these two services will allow DOH-DDD to monitor the extent to which participants are receiving integrated services in the community.

22. Several commenters expressed concerns related to dividing current PAB services into PAB and CLS-Individual due to differences in staff qualifications, differences in goals, and the need to track the location of service. One commenter noted that the proposal stated that home-based and community-based services may be provided by different staff, but that this is not realistic because some individuals will participate in both on the same day and the specific hours for each service may not be set.

DOH-DDD recognizes that separating Personal Assistance/ Habilitation and Community Learning Service-Individual services is a significant change that will require providers to revise some internal practices. However, DOH-DDD does not believe these changes will be overly burdensome and that the benefits outlined in the response to comment 21 outweigh the costs.

In terms of staff qualifications, workers providing CLS-Individual services will be expected to have received specialized training in community integration. It is possible that some staff may provide only one service or the other, but given that it is expected that most participants will receive both home-based and community-based services, it is likely that most staff will provide both services and will, therefore, receive the required training. Recognizing this, DOH-DDD has equalized the wage assumptions in the PAB and CLS-Individual rate models, which raised the assumed wage for PAB services and lowered it for CLS and Adult Day Health services. Additionally, the commenter is correct that staff will have to track the location of service delivery during the course of the day, but DOH-DDD does not believe that is unreasonable.

23. One commenter suggested that the PAB rate for individuals living independently should be billed at the CLS-Individual rate because "most of the hard work is done in the home."

As discussed in the response to comment 21, the Community Learning Service-Individual rate is higher than the PAB rate in order to reflect training, planning, and mileage-related costs associated with delivering services in the community. Although the amount and scope of Personal Assistance/ Habilitation services delivered to someone living independently may differ from the services provided to someone living with family, the cost structure on the basis of a staff-hour is assumed to be consistent (for example, staff are not assumed to be paid more when working with someone living independently than when working with someone living with family).

Thus, providers must bill the PAB rate when delivering services in the home regardless of whether the participant lives independently or with family. However, it should be noted that the proposed PAB rates for the majority of individuals are greater than current rates, often by a substantial amount. For example, the rate for individuals currently receiving Level 1 services outside of the Big Island (the

largest group of PAB recipients) will increase 13 percent while the rate for those currently receiving Level 1 services on the Big Island will increase 31 percent.

24. One commenter asked how services will be determined and how requirements will be communicated to participants. This commenter and another asked how the split between PAB and CLS-Individual supports participant choice that may occur during a service day and how "'flexible" services will be with regard to authorizations.

As with all services, decisions regarding the Personal Assistance/ Habilitation and Community Learning Service-Individual services that a participant will receive will be discussed during the annual service planning meeting, which is fully supportive of individual choice. There will be separate authorizations for PAB and CLS-Individual and participants will be able to receive both services on the same day. Separate authorizations may necessitate a reallocation between the two services during a participant's plan year, but DOH-DDD is exploring options to minimize the frequency of these changes.

25. Two commenters objected to the elimination of rate 'levels' for PAB services, stating that providers must provide more training and/or pay to staff who work with participants with significant needs.

Rate 'levels' are being eliminated for Personal Assistance/ Habilitation services as standards will no longer include different levels with varying staffing and supervision requirements. Since service expectations will be the same for all participants, there will be a single rate for all individuals. Furthermore, participants in the provider survey did not report any significant differences in training or wages paid to staff providing 'Level 2' services.

Even with this policy change, provider rates are increasing. The proposed rates on all islands are higher than the current Tier 2 rates. The only one-to-one rate that will decrease is the current Level 3 rate for islands outside of the Big Island, which accounts for about one-half of one percent of total billing. Further, for participants who require nurse-delegated tasks, providers will be able to bill the new Training and Consultation service for registered nurses for nurse delegation activities.

26. One commenter stated that the multi-staff rates do not reflect the cost of added staff. This commenter also stated that the proposed two-to-one rates are less than current rates.

The current two-to-one rates are based on a doubling of the one-to-one rates. However, providers' costs do not automatically double only because a second staff is added. For example, certain administrative costs remain the same regardless of whether an individual is served by one or two staff. Consequently, the proposed rates seek to quantify the costs that will increase when a second staff is added, rather than simply doubling the one-to-one rate.

The proposed rate models do provide for the cost of a second and third staff. In particular, these rates include the same wage and benefit costs for the second and third staff as in the one-to-one rate model. Productivity assumptions are slightly less for the second and third staff because it is assumed that only one staff needs to attend ISP meetings and complete medical notes. The rate model also does not add additional program support funding or mileage, but does provide additional administrative funding.

It is not true that the resulting two-to-one rates are less than the current rates. In fact, the proposed two-to-one rates exceed the current Tier 1 two-to-one rate, but are less than the Tiers 2 and 3 two-to one rates.

27. One commenter asked whether the multi-staff rates for registered behavior technicians require that the second and third staff also be RBTs.

The rate models for a registered behavior technician with multiple staff does not assume that the additional staff are also RBTs. In other words, the primary staff would be an RBT, but any additional staff support would be 'typical' direct support workers.

28. One commenter stated that the rate for services provided by registered behavior technicians is too low and is less than paid by insurance companies.

The commenter did not provide specific suggestions regarding changes to the rate model assumptions, which are based on market wages for psychiatric aides, a comprehensive benefits package as outlined in the response to comment 10, similar productivity expectations as for staff who are not registered behavior technicians, and the same overhead assumptions incorporated in all other rate models.

However, DOH-DDD reviewed the rate model and decided to make one revision, increasing the assumed wage. Specifically, the assumed wage was based on Bureau of Labor Statistics data for psychiatric aides in Hawaii. The psychiatric technician occupation is probably a better fit for this position, but wage data was not published for Hawaii. DOH-DDD therefore looked at the national difference between wages for psychiatric aide and psychiatric technicians and then applied this difference (18.9 percent) to the Hawaii-specific wage for psychiatric aides. This had the effect of increasing all RBT rates; as an example, the RBT rate for Personal Assistance/ Habilitation services delivered outside of the Big Island increased about 15 percent.

RESIDENTIAL HABILITATION

29. One commenter asked how the elimination of the additional payments for domiciliary homes will be communicated to service providers. This commenter also asked whether providers will be able to assess additional fees to participants in order to cover housing costs.

Certain providers that own domiciliary homes receive a state subsidy that is in addition to participant's Social Security Income and the State Supplemental Payment program. The subsidy is inequitable across providers, with some receiving no funding at all. Additionally, DOH-DDD believes that a portion of these payments were subsidizing the cost of waiver services. With the increase in Residential Habilitation rates – which do not include room and board costs, consistent with federal requirements – the subsidies are no longer necessary. For the same reason, providers will not be able to charge additional fees to participants beyond the allowable share of their SSI and the SSP program.

30. One commenter suggested that rates that vary by home size are inconsistent with statements that rates reflect individuals needs because it will take the same amount of time and effort to care for an individual in a three-person home as in a five-person home.

There are three rate 'tiers' for Residential Habilitation services based on individual needs as determined by the Support Intensity Scale (SIS, which is discussed in the section beginning with comment 12). As the commenter notes, the rates further vary by home size, with different rates for homes with three, four, or five participants. There is no inconsistency in rates that are based both on an individual's level of need and the number of participant in the home.

Rates vary by home size because certain costs are assumed to be fixed. Thus, as the number of participants increase, the cost *per home* increases, but the cost *per participant* decreases. This is most evident in the cost of the live-in home manager, which is assumed to be about $62,700 annually for wages and benefits. On a per-participant basis, this fixed cost translates to about $402 per week in a three-person home, but only $241 per week in a five-person home. The allocation of these fixed costs across different sizes of homes produces the variances in rates for different home sizes, independent of an individual's level of need.

Other participant-specific costs do vary based on level of need. Specifically, those with a greater level of need are assumed to receive more direct care from staff that assist the home manager. Thus, within a given home size, a provider receives a higher rate for supporting those with more significant needs.

31. One commenter expressed concern regarding the proposal to limit billing to 344 days per year and asked what "liability [is] associated during non-billable days" and asked how the policy "supports accountability and encourages client wellness." The commenter suggested that DDD establish a "bed hold" rate that providers could bill when an individual is out of the home.

The rate model estimates an annual cost of service. Then, to determine the daily rate, the annual cost is divided by 344 days rather than 365. This approach is intended to protect providers against lost revenue due to members' occasional absences. In brief, the rates are 'inflated' so that providers are fully compensated for 365 days of service over 344 billing days.

As an example, the Tier 1 rate for a home with three or fewer beds assumes a weekly cost of $797.62 per participant, which translates to $113.95 per day. Over 365 days, the annual cost is $41,591.75. The daily billing rate is determined by dividing this amount by 344, yielding $120.91. Thus, rather than billing the 'true' daily rate of $113.95, the provider bills the inflated rate of $120.91.

After 344 days of billing, the provider has earned $41,591.75 – the full annual cost of service. The provider therefore cannot bill additional days even if the individual is in the home for 365 days. Since the provider has been paid for a full year of service after billing for 344 days, they are still expected to provide service for the remaining 'non-billable' days in the member's plan year. If DOH-DDD adopted the true daily rate and allowed 365 days of billing as suggested by the commenter, a provider would lose revenue that it would never recover whenever an individual is away from the home for even one day. Under the proposed approach, a provider does not lose revenue until a member has been absent for more than 21 days (as the first 21 absences are 'paid for' by using a 344-day billing year).

This approach provides the same outcome as allowing providers to bill 'bed-hold' days; that is, to provide funding to cover costs that are fixed in the short-term even when a member is absent and has been approved by the federal Centers for Medicare and Medicaid Services in several other states' waiver programs. DOH-DDD believes this approach is superior to a bed hold rate because the latter strategy requires that the State pay for a service that is not delivered, which is generally contrary to Medicaid rules.

32. One commenter recommended that the rates be based on "defined service hours."

The rate models are predicated on assumed staffing patterns that are detailed in the models. In particular, each residence includes a live-in home manager and an assumption regarding additional staff hours that are based on size of the home and the individual's assigned level of need. As with other rate model assumptions, however, the assumed number of staff hours is not a mandate and a provider's operations may differ. For example, a provider could conclude that fewer hours are needed, but they need to be delivered by more qualified and highly paid staff. However, providers who wish to access the Additional Residential Supports rate must first be delivering all of the hours assumed for the members in a given home.

ADDITIONAL RESIDENTIAL SUPPORTS

33. One commenter asked what type of services Additional Residential Supports is intended to cover and whether it includes Training and Consultation.

The Residential Habilitation rate models include assumptions regarding the number of hours of support that participants receive from staff other than the live-in home manager. It is recognized that there may be instances in which certain participants need a greater amount of supports. The Additional Residential Supports service is being established to provide for that need.

If a provider believes that an individual needs more support than assumed in the rate model, it may request Additional Residential Supports. The provider must first demonstrate that it is providing the staffing hours already funded in the Residential Habilitation rate model *across all residents in that home.* The evaluation is based on total staffing funded in the rates for each participant because staff hours are generally shared across residents. The provider will also submit documentation outlining the reasons for needing additional staff hours and a plan for phasing-out the extra staff hours. If approved, Additional Residential Supports compensates a provider for delivering more direct support staff hours in the home. The service is intended to be short-term with approvals limited to 60 days at a time.

Additional Residential Supports does not cover the cost of professional staff providing Training and Consultation services. Providers may bill directly for Training and Consultation services provided to participants receiving Residential Habilitation services.

34. One commenter suggested that Additional Residential Supports be billed using a daily rate rather than in 15-minute increments to align with Residential Habilitation.

As discussed in the response to comment 33, Additional Residential Supports will be available to participants who require more staff support than assumed in their Residential Habilitation rate. Unlike Residential Habilitation, which uses a daily service rate, Additional Residential Supports will be billed in 15-minute increments for two reasons.

First, the amount of Additional Residential Support that a participant needs will vary from individual to individual. Further, the number of hours that a given participant may need may vary from day to day; for example, they may need more supports on the weekend when they may not be going to work or attending an Adult Day Health program. Since the number of hours will vary by participant, and potentially by day, it is impossible to establish a fixed daily rate.

Second, the use of a 15-minute unit ensures that there is no duplication of service, which is not permitted by Medicaid. The Additional Residential Support rate covers services in excess of what is funded in the Residential Habilitation rate. By billing in 15-minute units, a provider will have to be able to demonstrate that it delivered the total hours funded in the Residential Habilitation rates for all

home residents (evaluated by week) and that the Additional Residential Support billing is only for hours in excess of that total.

OUT-OF-HOME STABILIZATION

35. One commenter asked why Out-of-Home Stabilization is not available to children and whether the only alternative for children is a hospital.

The goal of Waiver Emergency Services is to maintain the placement of the participant and prevent any out of home placement. Because this is especially important for children, DOH-DDD has strengthened many services to better support children to remain in their homes so this can be the first resort. Previously, when children were place out of home, it most often happened for extended periods of time.

Crisis mobile outreach services, open to participants of any age, will provide 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.

Training and Consultation services, if the family needs additional support beyond Crisis Mobile Outreach, can be provided, and DOH-DDD has expanded the provider types that can provide supports families need to regain their stabilization and learn new skills to prevent future crises. If children need a short-term time away from their family until their behaviors can stabilize, DDD case managers can approve Respite services, and bring in additional supports through Personal Assistance/ Habilitation.

DOH-DDD is committed to avoiding hospitalization of children with intellectual and developmental disabilities, and believes a wrap-around approach that includes family supports will prevent the need for out of home placements.

RESPITE

36. Two commenters objected to the elimination of the Daily Respite service, noting the importance of the service to families. Both commenters stated that staff who providers Respite services are not subject to overtime requirements.

DDD recognizes the importance of Respite services to families who are caring for loved ones with disabilities. Respites services remain available, but will be billed on a 15-minutes basis. A participant will be able to receive up to 760 hours – more than 31 full days – of Respite per year.

DDD made the decision to eliminate Daily Respite for two reasons. First, the service was not aligned with service delivery as a provider delivering 12 hours of Respite was paid the same amount as a provider delivering 24 hours. Billing in 15-minute increments ensures that providers are paid equitably for services actually delivered. Second, a daily rate makes it more difficult to ensure that staff are not working overtime or, if they are, that they are being paid appropriately. Contrary to the commenters' statements, overtime protections do apply to agency staff providing services.

37. One commenter suggested that the wage assumption in the Respite rate model should be the same as in the PAB model, noting that staffing qualifications are the same.

Although the staffing qualifications are the same for Respite and PAB services, the expectations of the services differ. Staff providing respite are expected to provide supervision and assistance with personal care as needed, but there is less of a habilitative focus. Additionally, it is expected that Respite services will include more downtime, such as overnight hours. DOH-DDD therefore believes that a lower wage assumption is appropriate for Respite. Even with this wage assumption, the rate for Respite services would increase 26 percent outside of the Big Island and 30 percent on the Big Island.

ADULT DAY HEALTH AND COMMUNITY LEARNING SERVICES-GROUP

38. Two commenters asked whether ADH and CLS-Group are distinguished based on the location of service. One of these commenters asked whether there are differences in staffing and supervisory requirements.

The commenters' inference is correct. Community Learning Services-Group is being established for day program services delivered in the community (that is, away from a center or facility). Adult Day Health will continue to be billed for services delivered at a center or facility.

Day program supports are being divided between these services for several reasons. The establishment of higher CLS-Group rates are intended to compensate providers for higher costs associated with delivering supports in the community associated with more intensive staffing (that is, fewer participants per worker), planning, staff training, and mileage. Higher CLS-Group rates, in turn, should remove the cost barrier to community-based services, which should increase community-based options for participants consistent with the federal home and community based services rule. Additionally, separating day program supports into these two services will allow DOH-DDD to monitor the extent to which participants are receiving integrated services in the community.

Staffing qualifications are generally the same between the two services except that staff who provide CLS-Group services will be expected to have additional training in order to understand the purpose of the service in supporting participants in the community through development of relationships and socially-valued roles. There are no differences in the requirements for staff supervisors. As discussed in the response to comment 40, there are differences in staffing ratios with more intensive staffing in the community given that this is a less-controlled environment.

39. One commenter objected to the change from a daily (or half-day) rate to 15-minute units.

The conversion to 15-minute billing is intended to better align provider payments with the services they actually provide. Currently, a provider receives the same payment if they provide three or five hours of support to an individual. Further, the move to 15-minute billing is necessary in order to allow for the establishment of separate Adult Day Health and Community Learning Services-Group rates, which as discussed in the response to comment 38, is intended to produce more opportunities for community involvement. Since an individual may receive both ADH and CLS-Group services on the same day, it is not feasible to allow daily billing for these services.

40. Two commenters objected to the staffing ratios included in the ADH rate models, stating that a one-to-six ratio is too large (that is, there should be fewer participants per worker). One of these commenters noted that a one-to-six ratio is not appropriate for individuals currently receiving Level 2 services. The second commenter asked how staffing changes are anticipated to affect the

quality of services and whether group services in general are consistent with the federal home and community based services rule. This commenter asked how changes will be communicated to participants and what "liability" DHS has.

Figure 2 compares existing Adult Day Health staffing allowances to the staffing assumptions in the rate models for ADH and Community Learning Services-Group.

Figure 2: Comparison of Current Staffing Allowances to Proposed Rate Model Assumptions (Number of Participants per 1 Staff)

	Current ADH	**Proposed ADH**		**Proposed CLS-Group**	
	Max. Allowed	Max. Assumed (Before Absences)	Funded (Adj. for Absences)	Max. Assumed (Before Absences)	Funded (Adj. for Absences)
Level 1	4	6	5.1	3	2.55
Level 2	3	4	3.4	2	1.7
Level 3	2	3	2.55	1.5	1.25

It is neither accurate that staffing ratios are going to increase for all participants nor is it true that all services will be delivered at a one-to-six ratio, for several reasons.

First, the current ADH service standards apply to both center-based and community-based services whereas under the proposals, there are separate rates for these two settings with different staffing assumptions. *All* of the proposed CLS-Group rates assume more intensive staffing than currently assumed in the corresponding ADH rate. In other words, all participants should be receiving more intensive staffing when participating in community services.

Second, although the rate models assume a maximum staffing ratio, they *fund* a lower ratio based on an assumed attendance rate. For example, as Figure 2 demonstrates, the proposed Tier 1 rate for ADH allows for a one-to-six ratio, but providers are actually paid for an approximately one-to-five ratio.

Third, the current rate levels are not necessarily analogous to the rate tiers that will be based on Supports Intensity Scale assessments. It is expected that there will be fewer participants assigned to the lowest level of need and more individuals assigned to the second and third levels. In other words, a sizable number of participants currently receiving Level 1 services are anticipated to ultimately be assigned to Tier 2 or Tier 3 (it is likely that the reverse will also occur – individuals being assigned to a lower level than they currently are – but this is expected to be less frequent).

41. One commenter asked whether there will still be a requirement of at least 3 formal ADH goals.

The requirement that an individual plan for Adult Day Health must have three goals is being eliminated.

42. One commenter stated that participants are provided "informal training" to maintain skills already learned and asked whether this activity will be billable.

Services must be consistent with a participant's individual service plan in order to be billed. If the 'informal training' referenced by the commenter is covered in the ISP, it can be billed; if not, it cannot be billed.

43. Several commenters asked whether transportation remains the responsibility of ADH providers. This commenter suggested that, if so, such transportation be billable. One provider asked whether a provider can bill if a participant is waiting for a late Handi-Van.

As is currently true, Adult Day Health providers are responsible for transporting participants to their programs. Consistent with current practices, rather than billing specifically for transporting members, the rate models include both mileage costs and a productivity adjustment to account for staff time.

Only direct service delivery is billable. Supervising someone waiting for Handi-Van is not a billable activity under Adult Day Health services.

44. Two commenters stated that the cost of supplies included in the rate model is too low.

The rate models include $1 per day per participant for program supplies; assuming that individuals attend 212 days per year, this assumption translates to $212 annually. This compares to an average of $180 per year reported by participants in the provider survey. The commenters did not offer any specific data or offer an alternative suggestion, but based on survey results, DOH-DDD believes the assumption is reasonable.

45. One commenter stated that the facility cost is not reflective of Hawaii market rates.

The rate models include $15 per square foot for facility space on the Big Island and $18 per square foot on the other islands to reflect higher costs on Oahu. This assumption is based on a review of advertised facility space and the provider survey, in which respondents reported an average cost of about $14 per square foot across all islands. The providers did not offer any specific data or offer an alternative suggestion. DOH-DDD believes the assumption is reasonable.

46. One commenter asked several questions in relation to the proposal to eliminate the requirement that Adult Day Health programs provide lunch to participants. In particular, the commenter asked whether an ADH program could bill for time associated with meal preparation, meal time, and feeding assistance. The commenter also asked whether a program could charge a participant for a lunch they provide. Another commenter asked that this change be reconsidered.

DOH-DDD is eliminating the requirement that Adult Day Health programs provide a lunch to provide more flexibility and choice for agencies and participants.

The meal-related activities cited by the commenter fall within the definition of adult day health so the provider could bill for the time associated with them as long as they are part of a participant's individual service plan.

Providers may choose to continue to offer lunch and may now charge participants for the meal, but individuals may not be required to purchase the meal as a condition of participation in the program.

INDIVIDUAL EMPLOYMENT SUPPORT

47. One commenter noted that certain employment rates are proposed to be reduced and asked for the rationale.

As with all services, the proposed rates are based on a series of assumptions incorporated in a rate model. For most services, DOH-DDD is recommending an increase in the rate, but there are exceptions, including the rates for Individual Employment Support. This rate was more than doubled in July 2015, but that increase was not based on a thorough rate-setting process. Without any historic details, it is impossible to determine the particular elements of the current rate that are overstated.

The proposed rates are still at least 60 percent greater than those in effect prior to the 2015 increase. Further, providers will now be permitted to bill for certain indirect job development activities that they cannot currently bill.

BENEFITS PLANNING

48. One commenter asked why the rate on the Big Island is less than the rate for services on other islands.

The original proposed Benefits Planning rate for services on the Big Island was less than the rate for services on other islands because it did not include travel, which is the cause of the higher rates on the Big Island. After further consideration, however, DOH-DDD believes that some travel by staff providing Benefits Planning services will occasionally be necessary and the rate models have been revised to reflect the associated costs. As a result, the rate for services on the Big Island is now greater than the rate on the other islands.

NON-MEDICAL TRANSPORTATION

49. Two commenters objected to any reduction in mileage rates. One of these commenters suggested that the assumed wage is too low.

As with the proposed rates for all services, the rate model for Non-Medical Transportation is based on assumptions related to provider costs. DOH-DDD believes that the rates proposed for the service are sufficient and consistent with service requirements.

50. One commenter noted that a provider cannot begin billing until the participant is in the vehicle. Another commenter noted that the number of assumed miles per week is the same on the Big Island as on other islands.

The rate model for Non-Medical Transportation recognizes that providers cannot bill for 'deadhead' miles when no participant is being transported (that is, driving to a pick-up or returning after a drop-off). The original proposed rates assumed that staff on all islands drive the same number of total miles based on the same 40-hour workweek and the same assumed driving speed, but that there were more deadhead miles for transportation on the Big Island. Consistent with the changes to the assumed driving speed discussed in the response to comment 7, however, the number of assumed miles on the other islands has been reduced downwards.

TRAINING AND CONSULTATION

51. Several commenters objected to the proposed Training and Consultation rates, specifically mentioning occupational therapists (particularly in regards to occupational therapists providing environmental accessibility adaptations and vehicle modifications), behavior analysts, and

registered nurses. These commenters noted that the proposed rates are less than those paid by other programs and insurers.

The commenters did not provide specific suggestions regarding changes to the rate model assumptions so it is unclear what components of the rate model they believe are inadequate. As a result, no changes to the models have been made. DOH-DDD has decided to maintain the existing rate for occupational therapists working on environmental accessibility adaptations and vehicle modifications.